

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

FFY 2012-2013
(October 1, 2012 – September 30, 2013)

Abridged Document

STATE OF CALIFORNIA

Maternal Child and Adolescent Health Program
Center for Family Health
Department of Public Health

Children's Medical Services Branch
Department of Health Care Services

Preliminary Draft
06/12/2012

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A. Overview

>Geography

California is the most populous state and, in terms of total land area, the third largest state in the nation. Covering over 156,000 square miles California is home to numerous mountain ranges, valleys and deserts. [1] It is bordered by Oregon to the north, Mexico to the south, Nevada and Arizona to the east, and the Pacific Ocean to the west. Depending on how urban and rural areas might be classified, as much as fifteen percent of California could be designated as rural. [2] There are 58 counties in the state with a land area ranging from 47 square miles in San Francisco to 20,053 square miles in San Bernardino. Most counties cover an area greater than 1,000 square miles. The regions with the largest land area include Inyo, Kern, and Riverside Counties. Each of these counties covers an area greater than 7,000 square miles. The smallest regions -- those with less than 600 square miles of land area -- include Santa Cruz, San Mateo, San Francisco, and Amador Counties. [1]

>Population

In 2010, an estimated 39.1 million people resided in California, an increase from 34.1 million in 2000. [3] California's population growth is expected to continue over the next 10 years to reach 44.1 million by 2020. [3] Currently, in 2010, an estimated 42% of the population is White, 37% Hispanic, 12% Asian, 6% African American, 2% multi-race, 0.6% American Indian, and 0.4% Native Hawaiian/Pacific Islander. Trends in the racial/ethnic composition of California's population through 2020 predict a continuing decline in the White population proportion and an increase in the Hispanic population, which will become the largest racial/ethnic group in California. The proportions of other racial and ethnic groups in California will remain relatively stable through 2020.

California's diversity is shaped by the multitude of racial and ethnic sub-groups across the state. For example, California's Asian population, the largest in the nation, demonstrates substantial diversity. The largest Asian sub-groups in California are Chinese, Tagalog and Vietnamese. Within each Asian group is variation in language and culture. While the largest numbers of Asians reside in the large population centers of Southern California in Los Angeles (L.A.), Orange, and San Bernardino counties, counties with the largest percentage of Asian residents are in the San Francisco Bay Area. [3] Hispanic groups in California are predominantly Mexican (83%), followed by other Hispanic or Latino groups from Central and South America (15%). Less than 2% are Puerto Rican or Cuban. Due to shifts in immigration patterns, an increasing number of indigenous Mexicans have settled in California. [4] [While Southern California has the largest numbers of Hispanic residents, at 77%, Imperial County has by far the largest proportion of Hispanic residents in California. In addition, more than 50% of the population in the agricultural counties of Central California is Hispanic. [5] /2012/In 2009, 28.1% or 147,766 of 526,774 births

were to foreign-born Hispanic women and 23.2 % or 122,187 of 526, 774 births were to US-born Hispanic women.//2012//

>Age Distribution

In 2010, an estimated 49.4% of the child population 0-18 years of age was Hispanic, followed by White (30.5%), Asian (9.9%), and African American (5.7%). Children identified in multiple race categories were 3.6%. American Indian (AI; 0.5%) and Pacific Islanders (0.4%) made up a small proportion of the overall child population. By 2020, over 52% of children are expected to be Hispanic. The number and percent of Asian children will increase, though not as substantially as Hispanic children. The number and proportion of the White and African American children are expected to decline. Other groups are expected to remain stable. Young children 0-5 years of age are in a particularly sensitive developmental period, and experiences during this time have great influence over subsequent life course health trajectories. The population of children 0-5 years of age has increased from 3 million in 2000 to 3.3 million in 2010, and is projected to reach 3.8 million by 2020. The 2010 racial/ethnic distribution of the young child population was similar to children overall. As with the overall population, the proportion of children ages 0-5 who are Hispanic is expected to continue to increase through 2020, while the proportion that is White is expected to continue to decline. Other racial/ethnic groups are projected to remain fairly stable through 2020. [3] In 2010, there were 8.1 million women of reproductive age (ages 15-44) in California. The largest group was Hispanic women (41%), followed by White (37%), Asian (13%) and African American (6%). The percentage of Hispanic women is expected to continue to increase among this age group through 2020 to 47%, and the percentage of White women is expected to decline to 32%. Other groups are expected to remain somewhat stable. Of particular interest is the youngest women of reproductive age who demonstrate increased risks and poorer birth outcomes compared to their older counterparts.[6], [7] In 2010, there were an estimated 1.5 million females ages 15-19 and 875,000 females ages 15-17 in California. Hispanic females were the largest racial/ethnic group among the 15-19 year olds (47%), followed by White (33%), Asian (10%), and African American (7%). Racial/ethnic distribution was similar among females ages 15-17. /2012/ In 2011, the population of children and reproductive age women increased. Among children and reproductive age women, the Hispanic population proportion increased to 49.8% and 41.9%, respectively, the White population proportion decreased to 30.0% and 36.0%, respectively, and small or no changes were observed in other racial/ethnic groups. [3] //2012//

>Immigration

California is home to 9.9 million immigrants, the largest number and percentage of foreign born residents in the United States. [8] International immigration has accounted for 40% of California's population growth since 2000. Further, since 44.5% of California births are to women born outside the U.S., [9] the well-being of this population has a strong influence on overall status of the MCAH population in California. Most of California's immigrants are from Latin America (56%) or Asia (34%). The leading countries of origin for immigrants are Mexico (4.4 million), the Philippines (750,000)

and China (659,000). [9] Immigration status is related to poverty among children in California, which in turn is a strong predictor of health outcomes. Overall, 48% of California's children have immigrant parents: 34% have at least one legal immigrant parent and an estimated 14% have at least one undocumented immigrant parent. Among these children, 24% of children with legal immigrant parents are poor and 38% of children with undocumented immigrant parents are poor. [10] California has the largest number and proportion of undocumented immigrants of any state. [11]] Many undocumented immigrants in California experience difficulty in meeting basic needs and accessing services, while facing additional health risks related to low wage jobs that lack protections and benefits. In 2008, approximately 2.7 million undocumented immigrants lived in California, an increase from 1.5 million in 1990. [12]In 2004, approximately 41% of California's undocumented immigrants resided in L.A. County. [10] **/2013/Reversing prior trends, the population of undocumented immigrants is estimated to have stabilized between 2008 and 2010 with high concentrations of undocumented found not only urban and agricultural regions, but also in sub-county areas.** [13]//2013//

> Diversity

According to 2010 US Census, California's population was 40.1% Non-Hispanic White, 6.2% Black or African American, 13.0% Asian, 1.0% American Indian, 0.4% Pacific Islander and 4.9% from two or more races. 37.6% of the total population are Hispanics or Latinos of any race.[14] No single racial or ethnic group forms a majority of California's population, making the state a minority-majority state.

In addition to its overall population expansion, California continued to experience growth in its ethnic diversity. The fastest growing groups are Hispanics and Asians, rising more than three times faster than that of whites, creating a need for more health and social services for these populations, according to census data. The rise in adults 55 years and older in those groups is particularly pronounced.

The increase in older Asian and Hispanic adults is partly due to the aging of immigrants who came to the U.S. for jobs or to seek refuge from war. Another reason is that some established immigrants are bringing parents from their native country. Also, some Asians and Hispanics have especially long life expectancies. Whites remain the largest group of older people. But growth in the 55-plus population between 2000 and 2010 for Asians was 74 percent and for Hispanics 73 percent. That compares with only an 18 percent growth rate for whites and 34 percent for blacks..

Racial/ethnic diversity and a large immigrant population contribute to linguistic diversity in California.

>Languages Spoken

Limited English proficiency (being able to speak English less than 'very well') poses challenges for educational achievement, employment, and accessing services, and results in lower quality care for immigrant communities--each of which influences MCAH outcomes. Among California's population over 5 years of age, 14.3 million speak a language other than English at home and 6.7 million have limited English proficiency. [8] California's linguistic diversity requires the MCAH system to develop linguistic competence in multiple languages. Among youth in California's public schools, one in four is an English Language Learner (ELL) who is not proficient in English. These 1.5 million students speak 56 different languages, but over 1.2 million of ELL students are Spanish speakers. Other common languages are Vietnamese, Filipino, Cantonese, and Hmong. ELL students reside in every county in California, and in 14 counties in California's Southern, Central Valley, and San Francisco Bay areas, ELL students make up over 25% of the student population. [15]

>Education

In California, one in five individuals over the age of 25 has not completed high school and nearly 10% has not completed 9th grade. Further, measures of educational attainment show that while graduation rates have declined only slightly from 69.6% in 2000 to 68.5% in 2008, drop-out rates have risen sharply from 10.8% in 2000 to 18.9% in 2008. [16] Educational attainment varies greatly by race/ethnicity and gender. The 2007-08 dropout rate was higher than the state average for African Americans (32.9%), AI /Alaska Natives (AN; 24.1%), Hispanics (23.8%), and Pacific Islanders (21.3%), and was lower than the state average for Whites (11.7%), Filipinos (8.6%) and Asians (7.9%). [17] California's high school graduation rate for African Americans (59.4%) and Hispanics (60.3%) was substantially lower than for Whites (79.7%) and Asians (91.7%). The graduation rate for females (75.8%) is higher than for males (67.3%) overall, and for each racial/ethnic group. [18] /2012/ In 2009, the drop-out rate increased across racial/ethnic groups. [19] In 2009, the graduation rate increased to 70%. [20] //2012//

>Income

According to the most recent census data, over 4.6 million Californians, 13% of the population, have incomes at or below 100 percent of the federal poverty level (FPL). The 100 percent FPL in 2008 was \$21, 200 for a family of four. African Americans, Hispanics, and AI have the highest rates of poverty in California. [21] Among children under age 18 the rate is higher: 16% of the population is in poverty, or approximately 1.6 million children. [22] Projections of child poverty rates through 2012 anticipate that child poverty in California will increase as a result of the recession, peaking at 27% in 2010 before declining slightly to 24% in 2012. In L.A. County, home to 25% of California's children, one in three children is projected to be in poverty in 2010. California child poverty varies tremendously by region. Counties with the highest child poverty rates are

in the Central Valley, Northern Mountain, or border regions of California: Tulare (31%), Lake (28%), Fresno (28%), Del Norte (28%), and Imperial (27%). Counties with the lowest rates of child poverty (below 10%) are in the San Francisco Bay Area, Wine Country, and the Lake Tahoe/mountain recreational area. [22] Only examining the federal poverty level obscures the struggles faced by many families in California because of the high cost of living in this state. An alternate measure of poverty is the self-sufficiency standard, a measure of the income required to meet basic needs (housing, child care, transportation, health care, food, applicable taxes and tax credits and other miscellaneous expenses) that accounts for family composition and regional differences in the cost of living. While 1.4 million (11.3%) of California households are below the FPL, an additional 1.5 million households in California lack adequate income to meet basic needs. [23] [24]Income insufficiency is highest among households with children. Among households with children, 36% of married couple households, 47% of single father households, and 64% of single mother households have insufficient income to meet basic needs. Households headed by single mothers in some racial/ethnic groups have even higher rates of income insufficiency. Nearly 8 out of 10 Hispanic single mother households and fully 7 out of 10 African American single mother households experience income insufficiency. The major financial stressors for households with children are housing and child care; many of these families struggle to meet the most basic needs, cannot afford quality child care, and have limited financial resources to address crises. [24]It is also worthwhile to note that rates of poverty and low income are higher during pregnancy than when measured among children. This means that many more infants are born into financial hardship than statistics on children indicate. [25] /2012/ Poverty among children under age 18 rose to 19.9% in 2009. Another poverty indicator, the percent of public school students eligible for free or reduced price school lunch, increased from 51.0% in 2006 to 55.9% in 2010. [12] While employment grew in 2010, the unemployment rate also increased to 12.4%, the third highest rate in the U.S. [12] Economic recovery has been uneven with some LHJs experiencing continued job losses in 2010. The construction and retail industries experienced continued employment decline in 2010 by more than 10%. [12] //2012// **/2013/ The percent of public school students eligible for free or reduced price lunch increased to 56.7% in 2011.[** [12]//2013//

>Housing

California's high housing costs create a burden for families, resulting in less income available for other resources needed to maintain health. [26]Lack of affordable housing also forces families to live in conditions that negatively impact MCAH outcomes: overcrowded or substandard housing or living in close proximity to industrial areas increases exposure to toxins such as mold and lead, as well as increased stress, violence, and respiratory infections. [27] It also exposes families to urban deserts, i.e., neighborhoods lacking sidewalks, public parks, grocery stores and parks. In 2010, the fair market rent in California ranged from \$672 in Tulare County to \$1,760 in San Francisco Bay Area counties. [28] Even for working families, the high cost of fair market rent is out of reach. In California, on average, one wage earner working at minimum wage would

have to work 120 hours per week, 52 weeks per year in order to afford a two-bedroom apartment at fair market rent. [29] In 2010, the fair market rent in California ranged from \$672 in Tulare County to \$1,760 in San Francisco Bay Area counties. [29] Even for working families, the high cost of fair market rent is out of reach. In California, on average, one wage earner working at minimum wage would have to work 120 hours per week, 52 weeks per year in order to afford a two-bedroom apartment at fair market rent. [30] The current foreclosure crisis has greatly impacted California home-owner families. In 2008 and 2009 combined, there were over 425,000 residential foreclosures in California. [31] Foreclosure can force families into lower quality homes and neighborhoods, lead to great financial and emotional stress, and disrupt social relationships and educational continuity. Inability to access affordable housing leads to homelessness for some families. More than 292,000 children are homeless each year in California, which is ranked 48th in the percent of child homelessness in the United States, with only Texas and Louisiana having worse rates among children. [32] Homelessness in children has been linked to behavioral health problems, [28] and negatively impacts educational progress. [32] /2012/ Concerns have increased about the effect of foreclosure on renters and community members continuing to live in neighborhoods impacted by high rates of foreclosure. In 2010, there were about 170,000 foreclosures. [31] //2012//

/2013/ In December 2011, California had the second highest rate of foreclosures in the country. [33] Latinos and African Americans were 2.3 and 1.9 times more likely to experience foreclosure than non-Hispanic whites during the current crisis. [34] //2013//

>Public Health System

The California Department of Public Health (CDPH) is the lead state entity in California providing core public health functions and essential services. CDPH has five centers to provide detection, treatment, prevention and surveillance of public health and environmental issues. The Maternal, Child and Adolescent Health (MCAH) Program, the lead entity that manages the Title V Block Grant is housed under the Center for Family Health (CFH). CFH also oversees provision of supplemental food to women, infants and children, family planning services, prenatal and newborn screening (NBS) and programs directed at addressing teen pregnancy, maternal and child health and genetic disease detection. The other Centers within CDPH include the Center for Chronic Disease Prevention and Health Promotion (CCDPHP) which provide surveillance, early detection and prevention education related to cancer, cardiovascular diseases, diabetes, tobacco cessation, injury and obesity; the Center for Environmental Health which is responsible for identifying and preventing food borne illnesses and regulates the generation, handling and disposal of medical waste; the Center for Health Care Quality which licenses and inspects healthcare facilities to ensure quality of care, inspects laboratory facilities and licenses personnel; and the Center for Infectious Diseases which provide surveillance, health education, prevention and control of communicable diseases. To facilitate health planning and coordination and delivery of public health services in the community, California is divided into 61 local health jurisdictions (LHJs), including 58 counties and three incorporated cities. These cities are Berkeley, Long Beach, and Pasadena. In

addition to providing the basic framework to protect the health of the community through prevention programs, LHJs provide health care for the uninsured, which may include mental health and substance abuse treatment services. Given the diversity of these LHJs in size, demographics, income and culture, tremendous diversity also exists in how LHJs organize, fund and administer health programs. MCAH allocates Title V funds to LHJs to enable them to perform the core public health functions to improve the health of their MCAH populations. All LHJs must have an MCAH Director to oversee the local program. LHJs must also conduct a community needs assessment and identify local priorities every five years. LHJs address one or more local priorities in their annual MCAH Scope of Work. LHJs must also operate a toll-free telephone number and conduct other outreach activities to link the MCAH population to needed care and services with emphasis on children and mothers eligible for Medi-Cal. Other LHJ activities include assessment of health status indicators for the MCAH population, and community health education and promotion programs. Specific MCAH categorical programs administered by LHJs include the Adolescent Family Life Program (AFLP), the Black Infant Health Program (BIH), the California Perinatal Services Program (CPSP), the Sudden Infant Death Syndrome (SIDS) education and support services, and Fetal and Infant Mortality Review (FIMR). /2012/ The California Children's Services (CCS) addresses the health service needs of children with special healthcare needs (CSHCN) in the state. These services include diagnostics and treatment, case management, and physical/occupational therapy for children under age 21 with CCS-eligible medical conditions. Larger counties operate their own CCS programs and smaller counties share the operation of their programs with the state CCS regional offices: Sacramento, San Francisco and L.A...//2012//

/2013/ The Office of Family Planning (OFP) is proposed to be moved from CDPH to the Department of Health Care Services (DHCS) effective July 2012. If approved, the Teen Pregnancy Prevention Programs under OFP, including the Information and Education (I&E) Program and the California Personal Responsibility Education Program (CA PREP) will move to MCAH. Currently, MCAH is actively implementing CA PREP. Additionally, the Governor's budget proposes the development of the Office of Health Equity under CDPH, which will consolidate multiple organizational entities in multiple Human and Health Service agencies.

> Access to Health Care

Health insurance coverage plays an important role in influencing access to and utilization of health care among MCAH populations. Healthy People 2020 reinforces the importance of health insurance by promoting 100% insurance coverage of the population. In California, health insurance coverage falls short of this goal across different age groups and racial/ethnic groups. Most of the race/ethnicity insurance rate differences can be attributed to disparities in income. [35]

In California, 19 percent of the population did not have health insurance in 2009/10, compared to 16 percent of the US population [36] Among California's Hispanic population, ages 0-64, 31 percent were uninsured. Among California children through age 18, 11 percent were uninsured. Among California children, 38 percent

were covered by Medicaid, compared to 34 percent for the US. Among the poor and low-income population in California, children were more likely to be covered by public programs than adults. Increasing the enrollment in public insurance programs, especially among immigrants and non-English speaking populations, remain a challenge for the state.

Another challenge is meeting the health care needs of the large number of undocumented immigrants, many of whom are migrant workers. While the number of undocumented immigrants in California is difficult to measure, the Department of Homeland Security estimates that 2.6 million undocumented immigrants were in California in 2010. [37] It is not surprising that, given the complicated nature of eligibility for public assistance coupled with fear of the consequences of having to reveal one's status as undocumented, access and participation in available services among the undocumented population is very low. Other complications arise for undocumented immigrants who seek services in one county and move on to another region for work. Frequent moving for employment makes it difficult to provide consistent and comprehensive services and to track services for this population.

The diverse nature of California's population and geography, coupled with the changing face of the population demographically, socially, and economically, proves to be a continuing challenge for the MCAH and CMS.

> **Healthcare Reform**

The Patient Protection and Affordable Care Act of 2010 (ACA) presents a significant opportunity for MCAH and its partners to improve the health care delivery system overall, promote health and assure that women, children and families have access to quality health care. The scope and impact of many of these provisions included in the ACA will unfold over the coming years.

ACA created a new section in Title V to provide funding to develop and implement evidence-based Maternal, Infant and Early Childhood Visitation models targeted at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal, and newborn health; child health and development; parenting skills; school readiness; juvenile delinquency; and family economic self-sufficiency. This provision provided funding to establish a California Home Visiting Program in March 2010.

The ACA also created an investment in primary and secondary teen pregnancy prevention programs including Replication of Evidence-based Programs, Research and Demonstration Programs, Pregnancy Assistance Fund (PAF) to Support Pregnant and Parenting Teens and Women; and State and Tribal Personal Responsibility Education Program (PREP) totaling approximately \$17.8 M in California. MCAH is a direct recipient of PREP and PAF grants.[38]

ACA creates a new mandatory Medicaid eligibility category for all individuals with income at or below 133 percent of the federal poverty level beginning in 2014. It is estimated that this will add between 2 million and 3 million new enrollees to California's Medicaid program known as Medi-Cal, with a cost of between \$47.7 to \$54.9 billion.[39] An additional 4 million people are expected to enroll in health insurance through the state's health insurance exchange.

In March 2010 ACA created a new mechanism for purchasing health insurance coverage called a Health Benefit Exchange (HBEX) which are state entities that create an organized and competitive market for health insurance. HBEX offer consumers without coverage options to shop for small group and individual health insurance, establish common rules regarding the offering and pricing of insurance and provide information to help consumers better understand the options available to them.

On September 30, 2010, California became the first state in the country to pass legislation to create a HBEX. Its mission is to improve health care quality, lower costs and reduce health disparities through a competitive marketplace that allows consumers to choose their own health plan and providers. HBEX is up and running, funded by a one-year, \$39 million Level I Exchange Establishment grant received from the federal government in August 2011. The California HBEX is a quasi-governmental body that follows the "active purchaser" model of benefits exchanges – that is, it will selectively contract with only some qualified health plans in order to achieve goals relating to plan choice, quality, or value. [40]

HBEX is required to consult with stakeholders as they establish their Essential Health Benefits (EHB). Maternal, Child and Adolescent Health (MCAH) stakeholders, leaders and policymakers have actively participated in providing input to the design of the exchange, especially the EHB. Some of the EHB standards stakeholders identified are as follows:

- California should implement high standards for woman's preventive services
- EHB should ensure robust coverage of woman's health services in addition to preventive services
- The EHB should include comprehensive reproductive health services for woman, men and children
- Ensure that pediatric oral health benefits that are covered in federal plans are also covered in state plans

//2013//

B. Budget

Since the enactment of the Omnibus Budget Reconciliation Act 89, California has maintained the availability of Title V funds under both the maintenance of effort and the match requirements. The California Title V agency will continue to do so in the coming year.

The proposed allocation of Title V funds for California for FFY 2011 is \$43,315,317. Preventive and primary services for pregnant women, mothers, and infants are designated to receive \$12,800,106 (29.55 % of the total), preventive and primary services for children to receive \$14,272,848 (32.95 %) and CSHCN to receive \$13,603,489 (31.41%). /2012/ The proposed FFY 2012 allocation is \$42,300,760 Preventive and primary services for pregnant women, mothers, and infants are designated to receive \$13,160,420 (31.11 % of the total), preventive and primary services for children to receive \$13,476,402 (31.86 %) and CSHCN to receive \$13,235,668 (31.29%). //2012//

> State Match/Overmatch

California expects to receive \$43,315,317 in Federal Title V Block Grant funds for FFY 2011. The required match is \$32,486,488. California's FFY 2011 expenditure plan for MCAH programs includes \$1,290,479,684 in state funds. The dramatic increase in California's expenditure plan for FFY 2011 for the provision and coordination of services to the Title V MCAH population is due to the reporting of CSHCN data on actual expenditures. Previously the Electronic Data Systems (EDS) MR 922 report was used to provide the data for these numbers. However, a change to the EDS system for this report changed something in the data compilation and the numbers were not correct as they were grossly understating the expenditure data. Therefore, numbers from previous years' data submission to this year's data submission show a marked increase for the expenditures as the number is projected upon the actual expenditure data from FY 09/10 instead of the MR 922 report. Reporting of expenditure data has been updated and no longer uses the report it used in prior years.

/2012/ California expects to receive \$42,300,760 in Title V funds for FFY 2012. The required match is \$31,725,570; California's FFY 2012 budget for Title V MCH programs includes \$1,366,907,980 in state funds.

>Administrative Costs Limits

In FFY 2011 no more than 10 percent of the Federal Title V MCH Block Grant funds will be used for administrative costs related to each program component. During FFY 2011, California will expend only 6.09 percent of Title V funds on administrative costs. /2012/ In FFY 2012 no more than 10 percent of the Title V MCH Block Grant funds will be used for administrative costs and California will expend only 5.74% on administrative costs.//2012//

>Definition of Administrative Costs

In this Application, administrative costs are defined as the portion of the Title V dollars used to support staff in the MCAH Division Operations Sections. Funds supporting State

program and data staff (but not administrative staff) in MCAH and CMS are considered to be program rather than administrative costs.

Administrative costs include staff and operating costs associated with the administrative support of MCAH. These support functions include, but are not limited to, contract management, accounting, budgeting, personnel, audits and appeals, maintenance of central contract files, and clerical support for these functions.

>"30-30" Minimum Funding Requirement

At least 30 percent of the MCH Title V Block Grant funds will be used for children's preventive and primary care services delivered within a system which promotes family-centered, community-based, coordinated care. At least 30 percent of the Title V Block Grant funds will be used to provide services to CSHCN delivered in a manner which promotes family-centered, community 187 based, coordinated care.

In some cases, the CDPH uses estimates to assess expenditures for both individuals served and the types of services provided. These estimates are based on the target population and program activities authorized in statute, excluding the State budget, and specified in the scope of work for each contractor. Requiring contractors to bill according to actual amounts spent on each type of individual served and by service provided is not possible within current administrative and fiscal policies. Changing State contractual policies would result in undue financial and administrative hardship to local governments and non-profit community-based organizations. This added burden without increased funding would result in many of them not being able to continue to provide needed services to women and children in the state.

//2013/ Since FY 2008/09, LHJ quarterly time surveys were implemented to ensure that the "30-30" minimum funding requirement is met. //2013//

>Maintenance of State Effort

CDPH has an ongoing commitment to provide maternal and child health services to women and children within the State of California. This commitment includes continued support to local health jurisdictions, local programs, clinics and Medi-Cal providers for maternal and child health services.

It is the State's intent to ensure that State General Fund contributions to these local programs, which are also funded in part by the Federal Title V Block Grant, be administered by MCAH and CMS.

The State's General Fund contribution for FFY 2011 is \$1,290,479,684 which is \$1,203,320,934 greater than the State's General Fund contribution of \$87,158,750 in base year FFY 1989. //2012/The State's General Fund contribution for FFY 2012 is \$1,366,907,980 which is \$1,279,749,230 greater than the State's General Fund contribution of \$87,158,750 in base year FFY 1989. //2012//

>Budget Impact

The combined effect of the state's budget deficit and loss of revenues due to the economic downturn resulted in a budget gap of \$26.3 billion for Fiscal Year 2009-10. All California State General Funds (SGF) for MCAH were eliminated effective July 1, 2009, reducing the state and local MCAH Program budget by \$20.3 million in SGF and \$12 million in related matching Federal Title XIX funds.

The loss of SGF to MCAH Programs, BIH, AFLP, CPSP and CBDMP has resulted in deep cuts to local staffing, public health prevention activities, and the numbers of clients served. At the local level, the loss of SGF has reduced or eliminated the capacity of LHJs to provide public health nurse home visiting programs, as well as the LHJs' ability to provide outreach to the community by educating the MCAH population regarding such issues as SIDS, domestic violence, injury prevention, safety promotion measures and accident prevention, preconception care, early prenatal care, STDs and family planning, access to care, oral health, breastfeeding, childhood nutrition, childhood obesity, and guidance and support.

Statewide, the LHJs allocate approximately 3.25% of Public Health Realignment funds to local MCAH programs. In FY 2006-07, total Public Health Realignment funds transferred to counties equaled \$1,538,651,128. In FY 2008-09, total Public Health Realignment funds transferred to counties equaled \$1,372,049,262 and FY 2009-10 will be further reduced to approximately \$1,310,000,000.

Given that the current fiscal year's public health realignment funding distributions are projected to be approximately \$62 million lower than FY 2008-09 distributions, the MCAH reductions in FY 2009-10 can be estimated to be approximately \$2,015,000 in realignment funding and an additional \$705,000 in matching Title XIX across local MCAH, BIH and AFLP programs.

>State MCAH Support

MCAH has lost the ability to leverage SGF to draw down Title XIX matching funds. The loss of \$3.5 million resulted in an additional loss of approximately \$1 million in federal Title XIX matching 188 funds. It reduced capacity at the local level to collect data has impacted the State's ability to document positive program outcomes and identify and address needed changes. State staffing levels were reduced -- vacant positions have not been filled, creating added work burden for remaining State staff. Resources were reduced to coordinate services across LHJs and advocate for vulnerable at-risk MCAH populations. There was an overall reduction in statewide meetings, which are essential to assuring statewide program equality, information sharing, training, and problem solving. There was travel reduction for state staff to audit and monitor budgets and operations and provide crucial technical assistance.

//2012/State General Fund monies have not been reinstated. Title V federal funds were reduced in FFY 2011, which has resulted in a reduction to local allocations for BIH and AFLP. //2012//

/2013/ State General Fund monies have not been reinstated. In addition, the reduction in Federal Title V funding has resulted in MCAH reducing 6.0 positions and over \$6.8 million in funding expenditure authority for FY 2012/13. Reductions to travel and general expense allocations will limit MCAH's ability to conduct mandatory on-site program reviews, provide technical assistance and respond to information requests from LHJs and MCAH stakeholders. The positions being eliminated are:

- **Nurse Consultant III (Specialist)** – Elimination of this position limits technical assistance capacity to support oversight and effective implementation of newly revised scope of work (SOW) for local MCAH, BIH, and AFLP programs. Nurse Consultant capacity for oversight, development, and long-delayed improvements to the Comprehensive Perinatal Services Program (CPSP) will be reduced by 25 percent. These functions are necessary to ensure CDPH/MCAH compliance with statutory requirements and Title 22 regulations. In addition, the loss of this position will reduce the capacity to develop and implement a health systems framework for coordination and integration of local MCAH, home visiting, and other community programs that make up the local MCAH public health system.
- **Three Associate Governmental Program Analysts** - The elimination of these positions will limit the ability of MCAH to monitor, maintain, and provide technical assistance to LHJs, CBOs, and contractors.
- **Two Staff Service Analysts** - The elimination of these positions will limit the ability of MCAH to monitor, maintain, and provide technical assistance to LHJs, CBOs, and contractors.
- **Public Health Medical Officer III**– The elimination of this position limits the ability of MCAH to address the rising rate of maternal morbidity and mortality, a newly emerged health issue in the last decade.

> **Audits and Investigations (A&I) Division (DHCS)**

A & I performs audits on MCAH local contracts to ensure fiscal accountability and that federal requirements are met. In FY 2012/13 A&I will be reduced to \$182,000 which will result in a reduction in the number of audits to what has historically been performed.

> **APN**

Reductions and redirections of the Title V funds resulted in a 25% reduction in the APN for FY 2011/12. After revisiting the budget situation in January 2012, it became evident that APN was no longer sustainable and was terminated June 30, 2012.

> **CDAPP**

For FY 2011/12 funding for CDAPP was reduced by 50% to about \$600,000. Starting July 2012 CDAPP was eliminated except for a \$200,000 contract to the San Diego RPPC, a resource and training center contracted to provide resource

materials, educational webinars and maintain the CDAPP website and listings of local CDAPP affiliates.

> **Primary and Rural Health Division (PRHD)**

In FY 2012/13 the PRHD will be reduced by \$373,000 and eliminate 4.0 state positions at DHCS. The PRHD provides training, technical assistance, and limited funding to primary care providers in underserved areas throughout the state to sustain and improve the primary care infrastructure. This assistance enables primary care clinics to plan and evaluate their systems of primary and preventive care delivery to meet the needs of high risk, underserved populations, including women and children. Targeted clinics include those located in rural areas and clinics that serve migrant farmworkers and American Indians. Additionally, the PRHD supports the implementation of the American Indian Infant Health Initiative (AIIHI). This program provides home visitation services to high-risk pregnant and parenting American Indian families. Services include assessment, counseling, referrals/follow up to medical and social services providers. The following are the positions that will be eliminated:

- **Word Processing Technician** – Elimination of this position will impact contract oversight and delivery of annual reports. Primary care clinics will be additionally impacted due to delays in Tribal notification of Medi-Cal updates.
- **Associate Governmental Program Analyst** – Elimination of this position will cause delays in grant execution, limited support to DHCS divisions for Tribal notices, and delays in providing technical assistance and support to Indian health clinics.
- **Health Program Specialist I** – Elimination of this position will decrease support to community health centers, Federally Qualified Health Clinics, rural health clinics, and other rural health providers for funding applications.
- **Nurse Consultant III (Specialist)** – Elimination of this position will delay providing clinical technical assistance, limits staff support to mandated Indian health advisory group, and delays development and updates of policy and procedures. //2013//

> CBDMP and CPSP

Of the \$3.5 million SGF budgeted for State Operations, \$1.6 million was for CBDMP. Reduced funding has caused the program to be drastically restructured. Budget cuts to CPSP has resulted in decreased outreach to promote access to early prenatal care, decreased recruitment and training of new CPSP providers or provision of technical assistance to existing and new CPSP providers. Also, there is reduced monitoring and evaluation of CPSP providers.

>LOCAL MCAH PROGRAMS

The elimination of \$2.1 million in SGF from local MCAH programs resulted in a loss of \$2.1 million in Title XIX federal matching funds. Total local MCAH funds lost as a direct result of the elimination of SGF and the related Title XIX federal match was \$4.2 million statewide in FY 2009-10. For every \$1 of SGF cut, LHJs have experienced an additional \$1 in Title XIX matched funding. Statewide, in addition to the loss of SGF and the related Title XIX match, local funds budgeted were reduced by \$1.9 million in FY 2009-10. Title XIX match to local funds will be affected by the reduction in local funds, and is estimated to be a reduction of approximately \$600,000, based on projected invoices.

/2012/The reduction to Federal Title V allocation to the State did not affect local MCAH program budgets for SFY 2011-12, and there were no shifts in funding from MCAH to other Title V programs. SGF remains at zero, and both state and local agencies continue to operate with less money and staff due to hiring freezes and lack of funds.//2012//

>AFLP

In 2009-2010, \$10.7 million SGF and \$5.1 million related Title XIX were eliminated for AFLP. In the 2009-2010 fiscal year, AFLP reductions resulted in 12,027 fewer clients served -- a 70% reduction in clients served. AFLP agencies experienced staff reductions of 170 full-time equivalent (FTE) statewide. Three AFLP programs -- Riverside, San Bernardino, and Siskiyou Counties -- have been discontinued in FY 2009-10 as a result of their inability to continue activities at the current funding levels.

/2012/Due to a reduction to the Federal Title V allocation to the States in FFY 2011, the total AFLP allocation to local agencies for SFY 2011-12 has been reduced by \$250,000. This will reduce the number of clients served by AFLP agencies and put further stress on local programs, which are reported to be experiencing increasing demands for services due to funding reductions to or elimination of other programs like California's CalLearn Program, which provides related services to the AFLP population. //2012//

2013/ During FFY 2012, two AFLP sites discontinued operations. Due to State budget issues, funding for AFLP programs will be reduced by \$1,900,000 relative to FFY 2012 allocations and will be achieved through reductions to local assistance to the remaining sites, with a view to providing minimum necessary funding and to maintain the viability of all existing AFLP sites. This will result in 13,435 fewer months of service in FFY 2013.

>Black Infant Health Program (BIH)

The 2009-2010 California budget eliminated \$3.9 million SGF and \$3.7 million related Title XIX to BIH programs statewide. Budget reductions have caused two sites, Riverside and San Bernardino Counties, to close.

//2012/Due to a reduction to the Federal Title V allocation to the State in FFY 2011, the total BIH allocation to local agencies for SFY 2011-12 had been reduced by \$140,000. These reductions add to the difficulties faced by local agencies due to the loss of the SGF in SFY 2009-10 and continued lower revenues from state realignment funds.//2012//

>CMS

CMS has lost 30 positions since the 2007 reorganization of DHS into CDPH and DHCS, which together with operating expense reductions, have resulted in unmet workload and backlogs in all CMS programs including CCS. Backlogs for some CCS eligibility determinations and service authorizations in CMS Branch Regional Offices that support dependent county CCS programs now exceed three months. As county revenues from sales, vehicle licenses, and property taxes have declined, counties have been unable to support baseline levels of services in their public health, public assistance, and safety net health care programs. The State's actions to contain expenditures, including 189 capping allocations of local assistance funds for CCS county administration and the CCS MTP, have exacerbated these challenges. County CCS programs maintain that the reimbursement they receive under these funding caps is inadequate for case management and care coordination, and they are cutting staff by attrition and layoffs. Some providers report that eligibility determination and authorization delays, along with the unavailability of CCS staff to assist them with claiming and reimbursement problems, may force them to stop participating in the CCS program. As with many other essential safety net programs, CCS is having difficulty meeting the needs of the CSHCN population. DHCS is working with CCS stakeholders to redesign the CCS program to more efficiently and effectively provide services to CSHCNs while maintaining access, quality of care, and optimal outcomes.

//2013/ CMS will see a reduction by \$605,000 in FY 2012-13. Of this reduction, \$200,000 will come from the CMS program's operating expenses and equipment support budget. The remaining \$405,000 will be reduced from HRIF under CCS. The CCS HRIF program was established to identify infants who might develop CCS-eligible conditions after discharge from a CCS-approved Neonatal Intensive Care Unit (NICU). CCS program standards require each CCS-approved NICU ensure the follow-up of discharged high-risk infants and each NICU shall either have an organized program or a written agreement for provision of these services by another CCS-approved NICU.//2013//

> Budget Outlook

All signs point to another tough budget year for California for 2010-2011. The governor had included \$6.9 billion in federal dollars in his January budget plan, but so far the state has received just under \$3 billion. The state was hoping for unexpected gains in state revenues to significantly cut the budget deficit. However, revenues from personal and corporate taxes fell \$3.6 billion short of what was projected for April 2010 the month when the bulk of revenues are collected. A significant carryover of losses from 2008 to

2009 that brought down revenues from capital gains and weakness in small business income partly explains the shortfall. That means the state's budget deficit, which at the start of 2010 was projected at \$20 billion and dipped to about \$18.6 billion after some midyear actions by the Legislature, could exceed the original estimate. And state legislators have stated that they do not intend to seek higher taxes this year to bridge the gap. This leaves lawmakers and the governor to face decisions such as the wholesale elimination of certain programs. More than ever, California faces the specter of this being the most damaging year for the health of children, the poor and the disabled.

Recent budget actions and proposals have targeted cutting MediCal services, HF and safety-net programs for low-income women, children and those with disabilities. CalWORKS, the state's version of TANF, provides cash assistance for low-income families with children, while helping parents find jobs and overcome barriers to employment. CalWORKS is primarily a children's program: Kids make up more than three out of four recipients (77.9 percent), equivalent to 1.1 million of the more than 1.4 million Californians who are projected to receive CalWORKS cash assistance in 2010-11. Women comprise more than three-quarters (77.7 percent) of all adult recipients, and women make up an even larger share (92.5 percent) of single parents who receive cash assistance. The SSI/SSP Program provides cash assistance to help low-income seniors and people with disabilities meet basic living expenses. More than half (57.3 percent) of SSI/SSP recipients are women, equivalent to approximately 666,500 of the 1.2 million adults who are projected to receive SSI/SSP grants in 2010-11. The In-Home Support Services (IHSS) Program helps low-income seniors and people with disabilities live safely in their own homes, thereby preventing more costly out-of-home care. More than three out of five IHSS recipients (63.1 percent) are women and girls, equivalent to approximately 300,500 who are projected to enroll in IHSS in 2010-11. Women also make up the majority of caregivers that receive IHSS employment. IHSS provides a range of services, including assistance with dressing, bathing, and medications in addition to domestic tasks such as cleaning, shopping, and meal preparation. Women comprise more than three out of five adults enrolled in the major safety-net programs that provide these benefits and services.

Medi-Cal, the state's version of Medicaid, provides comprehensive health coverage to 7.2 million Californians, including reproductive and prenatal care, and is a key component of California's safety net for low-income families. Women comprise nearly two-thirds of adult enrollees in the program. In addition, more than half of women enrolled in the program are in their peak reproductive years, a period where women seek more health services than men. Medi-Cal is also an important source of affordable coverage for unmarried women and their children. Nine out of 10 single parents enrolled in Medi-Cal are women. Because women make up a large share of adult Medi-Cal enrollees, women and their children are disproportionately affected by reductions to the program. State lawmakers made significant cuts to MediCal, CalWORKS, SSI/SSP, and 190 IHSS in 2009. Governor Schwarzenegger's Proposed 2010-11 Budget in January 2010 includes even deeper reductions to these programs to help close the budget gap identified by the Governor in January.

Nearly one million children and teens in California depend on HF, the state's version of SCHIP, a federal-state partnership for working poor families. HF was launched in 1998 for parents who earn too much to receive Medi-Cal coverage but who are priced out of the private insurance industry. One way for California to keep programs alive, including HF is getting the \$6.9 billion in federal funds. Since California has not received the anticipated federal dollars, the threat to eliminate HF based on the May revise budget proposal is becoming more imminent. These health and safety net programs are not administered by Title V although Title V funding is used to support the maternal and child health needs of populations that utilize these programs. The wholesale elimination of certain programs for children, the poor and the disabled will further exacerbate and create additional challenges for existing Title V administered programs to meet the needs of the vulnerable population it serves.

/2013/ The State's budget shortfall for FY 2012/13 stands at \$15.7 billion.

Federal decisions could further strain California's budget. The Budget Control Act of 2011 requires \$1.2 trillion in automatic cuts to federal programs; California could lose an estimated \$1.3 billion in FFY 2013 alone. Targeted programs include Child Welfare Services and the Child Care and Development Block Grant. California's long-term revenue forecast assumes that Congress will restore a provision that gives states a portion of federal estate tax. Without these funds, State revenues would fall short by an additional \$45 million in 2012-13, rising to \$1.2 billion in 2015-16 [41].

The State's economic recession hit single women supporting families particularly hard reducing employment far more than it did for married parents, and single moms who remained employed saw the largest decline in their average workweek in at least two decades. The majority of women's job losses was in the public sector and was largely driven by a decline in employment with K-12 public schools and community colleges as well as with cities and counties. [42]

Funding for k-12 schools can have an additional \$5.6 billion dollars in cuts by November 2012 if the tax initiative to increase state taxes is not passed.

Recent budget actions have affected programs that low-income women rely on to support their families and gain the education and skills they need to find and retain jobs. Forecasters anticipate continued shortfalls for the foreseeable future threatening the programs and services that California's women and their families depend on.

In addition, the California May Revise contained a number of state government proposals for downsizing and achieving efficiencies. This will include reorganization of State government down to 10 agencies from the current 12 agencies by consolidating and aligning like agencies; elimination of 22 Boards, Commissions and Advisory groups; improved budget processes through zero basing and outcome-based approach (CDPH has been identified as one department that will incorporate

the Outcome-based approach into their budget) and elimination of some 700 legislative reports.

The State budget reflects the FPACT program (California's family planning program for eligible low income individuals) being redirected to DHCS along with Every Woman Counts and Prostate Cancer Treatment programs. These programs are considered 'direct care services' and therefore they were moved to DHCS. There is active discussion to reduce staff work hours and pay by 5%//2013//

C. Major State Initiatives

The process used by MCAH to prioritize and address current and emerging issues impacting the health of the MCAH population through its major initiatives is multifaceted. This process includes monitoring the MCAH population health status, consultation with our stakeholders, collaboration with local MCAH directors, partnering with programs within CDPH and with staff from other departments such as the California Department of Education (CDE), the California Department of Social Services (DSS), the DHCS and Alcohol and Drug Programs (ADP) and with a variety of public health educators, clinicians and organizations concerned with the well-being of the State's Title V populations. The process also includes support of ongoing MCAH priorities and priority needs identified through the needs assessment process. The process includes consideration of public input, alignment with CDPH's strategic plan and priorities, availability of resources and the political will to address these factors. /2012/ A more in-depth discussion of the major state initiatives is included as an attachment to this section.//2012// Given this multifaceted approach, California's Title V major state initiatives include the following:

>1115 Waiver, Promoting Organized Systems of Care for Children with Special Health Care Needs (CSCHN)

California's Medicaid Section 1115 waiver for hospital financing and uninsured care expires on August 31, 2010. The need to submit a new waiver application presents the Department of Healthcare Services (DHCS) with an opportunity to transform the delivery of health care to children enrolled in CCS and provide services in a more efficient manner that improves coordination and quality of care through integration of delivery systems, uses and supports medical homes and provides incentives for specialty and non-specialty care.

As authorized by legislation (Assembly Bill (AB) x4 6, August 2009), DHCS has entered into a process to submit a new and comprehensive Section 1115 Medicaid waiver. This legislation sought to advance two policy objectives in restructuring the organization and delivery of services to be more responsive to the health care needs of enrollees to improve their health care outcomes and slowing the long-term rate of Medi-Cal program expenditures.

A Stakeholder Advisory Committee, as authorized in statute, consists of 39 individuals representing the populations for whom the delivery of care would be restructured through the waiver design – seniors and persons with disabilities; CSHCN; individuals with eligibility for both Medi-Cal and Medicare and those in need of behavioral health care services. Reporting to the Stakeholder Advisory Group are technical workgroups (TWG) constructed to discuss each of the populations and make recommendations to DHCS on what could be included in the 1115 Waiver that would improve the delivery of care for CSHCN. The CCS TWG workgroup has assisted in specifically recommending several delivery models to pilot test in order to determine if any one of them can be used to more effectively provide care for CCS clients. The CCS TWG has advised retention of the successful parts of the CCS program including quality standards and the network of providers.

Members of the CCS TWG represent families, provider organizations (California District of the American Academy of Pediatrics [AAP-CA], Children’s Specialty Care Coalition, California Association of Medical Product Suppliers, and California Children’s Hospital Association); County CCS programs and County Health Administrators; foundations and MCMC health plans. The activities of the CCS TWG have been supported by the Lucile Packard Foundation for Children’s Health. Specific information on the CCS TWG can be found at: <http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupCCS.aspx>.

//2012//The “Bridge to Reform” Section 1115 Waiver was approved in November 2010. On April 15, 2011 the Request for Proposal to implement the CCS portion of the Waiver was released seeking applications from qualified entities to develop and administer Demonstration Projects for a group of CCS clients. Applications are due to the Department on July 15, 2011 for entities interested in implementing one of four Project models – an Enhanced Primary Care Case Management plan; an Accountable Care Organization; a Specialty Health Care Plan or a Medi-Cal managed care (MCMC) plan that would be responsible for all of CCS clients’ health care.//2012//

//2013/ CCS received proposals for 1115 Waiver Pilot Projects. Five projects were selected with 4 different models of care through which CCS children will have all their health care needs met through a single coordinated health system. The models are 1) Utilization of MCMC Plans, 2) Specialty Health Care Plan (SHCP), 3) Enhanced Primary Care Case Management (EPCCM) and, 4) Provider-based Accountable Care Organization (ACO). Projects have projected phased in start dates from June 2012 to 2013. An extensive evaluation program is under development with UCLA Center for Health Policy Research.//2013//

>Child Health Insurance Coverage

State legislation AB 1422, along with funding from the First Five Commission and program savings enacted by the MRMIB will allow the Healthy Families Program, California’s low cost insurance for children and teens who do not qualify for Medi-Cal, to continue providing health care coverage to current enrollees.

From July 2003 through December 2009, over 4 million children receiving assessments were pre-enrolled for up to two months of no cost, full-scope Medi-Cal benefits. The number of families utilizing the CHDP via this process appears to gradually increase due to the number of families losing private health insurance due to the economy. /2012/ From July 2003 through 2010, over 4.4 million children were pre-enrolled.//2012// /2013//**From July 2003 through 2011, over 5.8 million children were pre-enrolled.**//2013//

> Obesity

MCAH has been actively involved in a number of obesity prevention related initiatives through state level collaborations and local level initiatives. Detailed discussion of activities can be found in the narrative related to National Performance Measure 14 and State Performance Measure 6.

>Breastfeeding

Due to state budget cuts in August 2009, funds were reduced for the BBC a hospital-based breastfeeding continuous quality improvement (QI) project which promotes model hospital policies to improve in-hospital exclusive breastfeeding rates. Funding continues for RPPC in L.A. to develop a report on Birth and Beyond (BBC) pilot project findings and provide technical assistance for all other RPPC regions for 2 years. To date, 20 hospitals fully participated and 2 of the funded RPPC regions have obtained other funds to continue the BBC work. BBC curricula and tools will be posted on the MCAH breastfeeding website.

/2012/ In addition to the original 23 hospitals that participated in the BBC project, 13 more hospitals have successfully completed this program without the support of CDPH funding. The BBC project has generated national interest as other healthcare systems and hospitals strive to improve care to mothers and babies. It was highlighted at the first California Hospital Breastfeeding Summit held in January 2011. //2012//

//2013// **MCAH in collaboration with PAC-LAC, Regional Perinatal Programs of California (RPPC) Regions 6.3-6.6, released the “BBC: A Hospital Breastfeeding Quality Improvement and Staff Training Demonstration Project Report” which describes BBC implementation, evaluation and lessons learned. Curricula, trainer notes, evaluation tools, and other supportive materials for hospitals interested in implementing this project are posted at <http://cdph.ca.gov/BBCProject>. The results of this project were highlighted at the Hospital Breastfeeding Summit in January 2012. MCAH was once again a key supporter of this Summit.**//2013//

MCAH is in the process of releasing 2008 in-hospital exclusive breastfeeding data. The fourth annual letter to hospital administrators is being prepared and will again include

hospital data and links to resources to help hospitals improve their exclusive breastfeeding rate.

In December 2009, MCAH and the Women, Infants and Children (WIC) Supplemental Nutrition Program, in collaboration with the California Breastfeeding Coalition, and the California WIC Association began the California Breastfeeding Roundtable. The Roundtable met for the second time in June 2010 and has drafted a strategic plan that will be used by the CDPH Nutrition, Physical Activity and Obesity Prevention Program grant funded by the Centers for Disease Control and Prevention (CDC). MCAH has continued to have a staff person attend the US Breastfeeding Committee and be involved in its national promotion of workplace lactation support. MCAH has been advocating for a new CDPH lactation policy and piloting a bring-your-infant to work lactation supportive policy.

CCS is partnering with the California Perinatal Quality Care Collaborative (CPQCC) in a breast milk nutrition quality improvement collaborative for 2010 involving 11 community and regional Neonatal Intensive Care Units (NICUs) with a goal of collaboratively improving by 25% any breast milk at discharge for <1500 gm. infants. The baseline period is 10/1/08 through 9/30/09 and the intervention timeframe is 10/1/09 through 9/30/10. Each NICU has its own goal statement and is also collecting data on process and balancing metrics. In addition to monthly calls and exchanges via e-mail, there are three face-to-face learning sessions in 2010. /2012/This Collaborative ended October 8, 2011. The goal of improving by 25% any breastfeeding at discharge for <1500gm infants was met./2012//

/2013//Per California legislation, California Health & Safety Codes § 123360, WIC and MCAH finalized a web-based hospital breastfeeding policy curriculum for hospital administrators. This curriculum was posted on the CDPH web site. In 2011, the Infant Feeding Act (California Health & Safety Codes § 123366) was passed requiring that all maternity hospitals have an infant feeding policy that supports breastfeeding by January 2014. MCAH and WIC have begun discussing the provisions of this new law./2013//

>Comprehensive Black Infant Health (BIH) Program assessment

MCAH places a high priority on addressing the persistent poor birth outcomes that disproportionately impact the African American community. MCAH has focused efforts to address social disparities to close the gap--BIH is central in these efforts.

In 2006, MCAH contracted with the University of California, San Francisco (UCSF) Center on Social Disparities in Health to complete an assessment report of the BIH Program that was released in 2008. The conclusions from the literature review of the report found no definitive scientific evidence showing the best path to decrease disparities, but current knowledge suggests promising directions by addressing: (1) health and social conditions (including stress) across the life course, (2) social support, (3)

empowerment/capacity building of individuals and communities, and (4) group-based approaches. The report also found that the current BIH program models lacked standardization across sites and were out-dated. The data collection requirements also were not standardized, limiting the ability to measure the program's effectiveness.

The report recommended the development and implementation of a single core model for all local BIH program sites to enhance the impact on African American infant and maternal health. MCAH convened groups of key stakeholders including local BIH and MCAH staff, state MCAH staff, and UCSF Center on Social Disparities in Health staff to develop various aspects of the revised model and comprehensive evaluation plan. The revised model integrates the most current scientific findings, and state and national best practices. The revised model is strength-based and empowers the women to make better health choices for themselves and their families, and encourages broader community engagement to address the problem of poor birth outcomes. Services are provided in a culturally competent manner that respects clients' beliefs and cultural values.

The revised model will ensure linkages to prenatal care as well as empowers women to improve their ability to manage stress related to the social, cultural, and economic issues that are known to influence health. The program starts with an intake to assess clients' needs and identify strengths. There is an individual intervention that is primarily case management based on each client's identified needs. Central to this model is the 20 session group intervention (10 prenatal and 10 postpartum) that encourages and supports behaviors to help African American women become strong individuals and effective parents. The evaluation and data collection process has been fully revised to assess the program's effectiveness. In addition, MCAH has program standards and quality assurance measures in place to ensure the revised model's fidelity. In June 2010, a panel of national experts was convened to assess the new BIH model. The panel endorsed the concept; felt the model was scientifically supported and made recommendations for refinement.

Training on the new model and pilot implementation was conducted at approximately half of the BIH sites in summer of 2010.

/2012/ In November 2010, eight of the 15 BIH sites began to implement the revised model. Initial qualitative reports indicate that clients are well engaged and find the group intervention positive and empowering. Whereas MCAH anticipated client retention would be a primary challenge, many of the early stumbling blocks have been associated with client recruitment. An early assessment by MCAH finds that sites have found two major issues: (1) state and local administrative and logistical challenges delayed implementation and transition between the former model and revised model, resulting in loss of recruitment sources, and (2) local sites have not changed their recruitment messages to reflect the revised model. MCAH, working collaboratively with UCSF Center for Social Disparities in Health, and local sites are currently addressing client recruitment. BIH sites will be required to complete a client recruitment plan to outline the type of outreach conducted and the number of clients currently in the program. MCAH will be transitioning the remaining sites through technical assistance (TA) and training, to begin implementation in November 2011.*//2012//*

/2013// In November 2011, implementation of the revised model was initiated in 6 additional sites. All sites with the exception of Los Angeles have started the new model. In March 2012, MCAH published the report entitled: Black Infant Health Program Pilot Implementation (Phase I) Preliminary Assessment Report. The report findings indicated that a group-based approach, supported by individual case management, would be optimal for African American women. The revised model has proven to be well received by staff, clients, and community members. The benefits of this updated model of services could extend far beyond women's program participation by helping to strengthen African American families and communities. In 2012, MCAH will be conducting site profiles of each local health jurisdiction (LHJs) to learn more about the needs and gaps in implementing the revised model. In 2012, MCAH will be launching an upgraded management information system, the BIH MCAH MIS. The MCAH BIH MIS is a web-based application that collects data for the updated BIH model related to program evaluation, case management and group sessions. Currently the MCAH BIH MIS is being piloted in three BIH LHJs. After the pilot period and system revisions are implemented, the MCAH BIH MIS will be rolled out to the remaining LHJs before the end of 2012.//2013//

> Preconception Health

While the main goal of preconception care is to provide health promotion, and screening and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies, MCAH takes a broader approach. Implicit in its Preconception Health and Health Care Initiative (PHHI) is a life course perspective that promotes health for women and girls across the lifespan, regardless of the choice to reproduce, and recognizes the impact of social and environmental factors on maternal and infant outcomes. MCAH partners with organizations and stakeholders across the state to provide direction for the integration of preconception care into public health and clinical practice, develop policy strategies to support preconception care and promote preconception health messaging for women of reproductive age.

/2012/ The Preconception Health Council of California//2012// (PHCC), established in 2006 through a partnership between MCAH and the March of Dimes (MOD), remains at the center of preconception health activities in the state. In May 2009, the PHCC launched a comprehensive preconception health website—Every Woman California. Supported with Title V funds, the website features information about health considerations for women of childbearing age –including low-literacy PDFs on 21 preconception health topics – as well as resources, tools and best practices for providers. The website has a partner registration feature to encourage networking and resource sharing among those interested in preconception health and health care and features interactive event calendars and discussion forums:

<http://www.everywomancalifornia.org>. /2013/The website was updated in 2012 to more easily integrate new social media, increase navigability, and improve user-

friendliness. The new web design prominently features reproductive life planning and new preconception health clinical resources and statewide initiatives. //2013//

/2012/California MCAH has also worked to incorporate preconception health messaging into other existing programs by including interconception curriculum content in BIH program and the trainer module for California Diabetes and Pregnancy Program (CDAPP).//2012//

Other preconception health activities spearheaded by MCAH include a folic acid awareness campaign implemented in early 2009. Designed to address findings showing lower rates of folic acid consumption among Latinas and women of lower education attainment in California, the campaign featured Spanish language radio Public Service Announcements (PSAs); outreach to the community through health promoter training; and vitamin distribution and education through local public health programs. It resulted in a 1200% increase in calls to referral line and 45,000 bottles of vitamins distributed.

California MCAH was a recipient of First Time Motherhood grant funds from Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA/MCHB) to implement a preconception health social marketing campaign. /2012/ California's data indicated that the lowest prevalence of daily folic acid use was among Latinas, and the lowest prevalence of healthy weight and smoking abstinence were among African Americans.//2012// California's project will test "preconception health" and "reproductive life planning" (RLP) messages and message delivery mechanisms, including web- and mobile-based strategies, with different populations, especially African-American women, Latinas and youth of color. The campaign will place preconception health and reproductive life planning in a life course context and address broader societal influences on health. MCAH will be working on this campaign through early 2011. /2013/**The PHHI collaborated with AFLP Positive Youth Development (PYD) intervention to develop the RLP guiding framework and tool for the client-centered goal setting teen pregnancy prevention program. //2013//**

MCAH staff continues to participate in a number of national preconception health-related workgroups including the national preconception health indicators workgroup /2013/, **the national expert panel on life course metrics //2013//** and the Centers for Disease Control and Prevention's (CDC's) preconception health consumer workgroup.

The PHCC serves as a coordinating hub for preconception health activities across the state such as the Interconception Care Project of California (ICPC), American Congress of Obstetricians and Gynecologists (ACOG), District 9 project funded by MOD that is charged with developing postpartum care visit guidelines for obstetric providers. The goal of the project is to provide physicians with the tools needed to address issues at the post-partum visit that could affect a subsequent pregnancy and counsel the patient about /2012/ways to improve their health status and //2012// plans for future children.

/2013/The ICPC guidelines were completed and publicized on www.everywomancalifornia.org/postpartumvisit. The materials include English and

Spanish provider algorithms and patient handouts on 21 common postpartum conditions. Statewide trainings have been conducted to inform providers of their availability and train them in their clinical use. //2013//

Local MCAH health jurisdictions have also undertaken activities related to preconception health. The L.A. Collaborative to Promote Preconception/Interconception Care has produced a curriculum for public health providers; published a data brief on preconception health in LA County; established a website; held a second preconception health summit for providers in the county; and developed an evaluation framework for the collaborative. It also oversees local preconception health projects that have had promising results such as the California Family Health Council's effort to develop and introduce a pre/interconception care curriculum into nearly 80 Title X clinics and the Public Health Foundation Enterprises WIC's WOW project (WIC Offers Wellness) which extended its integration of interconception health into WIC from one center to 61 centers throughout L.A. and Orange County. **//2013/PHHI staff worked to develop preconception health scope of work objectives and provide technical assistance to local MCAH programs interested in starting or expanding preconception health initiatives. State and local MCAH staff are partnering to implement the Federal Office of Minority Health Peer Preconception Health Program in community colleges and universities throughout the state to expand on preconception health outreach efforts. //2013//**

>High-Risk Infants

The HRIF Program screens babies who might develop CCS-eligible conditions after discharge from a NICU and assure access to quality specialty diagnostic care services. All CCS-approved NICUs are required to have a HRIF Program or a written agreement for services by another CCS-approved HRIF Program.

In 2006, CCS redesigned HRIF and started the Quality of Care Initiative (QCI) with CPQCC. The QCI developed a web based reporting system to collect HRIF data to be used in quality improvement activities. As of March 1, 2010, 60 of the 74 CCS-approved HRIF Programs are reporting on-line, with a reporting of over 2,000 HRIF Program referrals and 1500 HRIF Program visits. //2012/As of March 1, 2011, 62 of the 65 CCS-approved HRIF Programs are reporting on-line, with over 10,860 HRIF Program Referrals/Registrations and 7,181 HRIF Program Standard Core Visits.//2012//

//2013/As of February 17, 2012, 65 of 66 CCS-approved HRIF Programs are reporting on-line, with a reporting of over 19,055 HRIF Program Referrals/Registrations and 17,079 HRIF Program Standard Core Visits. The HRIF Executive Committee established a quality improvement (QI) workgroup in February, 2012 to develop QI projects for HRIF Programs.//2013//

>Neonatal Quality Improvement Initiative

CMS and the California Children's Health Association (CCHA) sponsored a statewide QI Collaborative, partnering with CPQCC, to decrease Central Line Associated Blood Stream Infections (CLABSIs) in NICUs using the Institute for Healthcare Improvement (IHI) model for quality improvement (QI). Thirteen regional NICUs participated in 2006-07, reducing CLABSIs by 25 percent for all weight groups. In the second year, all 22 Regional NICUs participated, aided by a Blue Shield Foundation grant. The CLABSI rate in 2008 was 2.33 per 1000 line days and 3.22 in 2007, but some of this reduction was due to a CDC definitional change for CLABSIs beginning Jan. 1, 2008. After the grant extension ended June 30, 2009, 14 regional NICUs continued the CLABSI prevention collaborative and for 2010 they are adding bloodstream infection (BSI) prevention. For 2009 the CLABSI rate for the 14 NICUs was 2.05 for all weights, and competing priorities have been the greatest barrier to infection prevention. /2012/For 2010, the CLABSI rate for all weights had decreased to 0.97, which is a 77% decrease since the inception of the Collaborative in 2006. The Collaborative is continuing in 2011 and will be inviting more Regional NICUs to join.//2012//

/2013/ The collaborative is sustaining its gains and improving further. By mid-2011, the reported CLABSI rate decreased another 70 percent from 2009; for all birth weights combined it has declined to 0.65 infections / 1000 central line-days. Participating NICUs are currently implementing practice policies intended to prevent other types of bloodstream infection via evidence-based management of ventilatory support, enteral feeding, and skin puncture.

In order to comply with Section 2701 of the Patient Protection and Affordable Health Care Act, elements of the NICU CLABSI collaborative will be brought to all CCS approved NICUs and PICUs beginning July 2012. The goal is to have approved insertion and maintenance bundles for central lines in all NICU/PICU's. //2013//.

>Pediatric Critical Care

CMS has structured a system of 21 CCS-approved pediatric intensive care units (PICUs) to assure that infants, children and adolescents have access to appropriate quality specialty consultation and intensive care services throughout the state. CCS sets standards for all CCS-approved PICUs and periodically conducts PICU site visits to help ensure standards are followed. Included in the standards is a requirement to submit annual morbidity/mortality data to CCS. /2012/There are 22 PICUs; PRISM III data are collected.//2012//

CMS and the University of California, Davis conducted a survey of PICU medical directors to assess the infrastructure for Pediatric Critical Care quality care and the need for statewide benchmarking standards to direct QI efforts. CMS will focus on collaboration with PICU leadership in developing a statewide data collection and reporting system for QI purposes. /2012/Work is progressing on the comprehensive severity-adjusted PICU database and finalizing standards for Community Level PICUs.//2012//

//2013/ As of February 2012, there were 23 CCS-approved PICUs. Outcome reporting from PICUs includes annual database reports stratified according to the PRISM III scores for the previous calendar year or PICU data is provided through Virtual PICU Performance System (VPS) which has exported data into the Pediatric Intensive Care Unit Evaluation (PICUEs)-PRISM III program. An Institutional and Comparative Report is submitted by PICUs. A second level PICU, designated as “Community PICU” has been developed and the first such unit approved. A PICU Regional Cooperative Agreement (RCA), similar to the NICU RCA, is under development to facilitate communication and interchange between the current PICUs, to be renamed “Regional PICU,” and the Community PICUs. //2013//

>Pediatric Palliative Care

CMS submitted a 1915(c) waiver to the Centers for Medicare and Medicaid Services which was approved December 2008. Many stakeholders across California and in other states participated in the development of the waiver program. The program, which began to enroll children in January 2010, allows Medi-Cal clients to receive hospice-like services at home while concurrently receiving curative treatments. The program partners with hospice and home health agencies to provide a range of services to improve the quality of life for eligible children and their families including care coordination, family training, expressive therapies, respite care and bereavement counseling for caregivers. The initial three year program started in five counties: Alameda, Monterey, Santa Cruz, Santa Clara, and San Diego, and will expand to 13 counties by the third year. /2012/A request for amendment was submitted to CMS and approved to add the service: ‘pain and symptom management’ (by hospice providers) in October 2010. Year 2 has started in Marin, Orange, SF, and Sonoma counties and is projected to expand to Fresno and LA counties this fall; these (including the first 5) are the targeted 11 counties.//2012//

//2013/The waiver was originally approved April 2009 through March 2012. As of March 2012 there are 11 counties participating (2 of the original 13 counties chose not to participate, one for lack of providers and provider collaboration and reimbursement issues in a rural area and the other for financial reasons). Medical eligibility criteria were expanded in August 2011 to include any child with a life-threatening or life-limiting CCS-eligible condition with anticipation of 30 inpatient days in next year, who would benefit from the supportive palliative services offered by PFC. The five year waiver renewal application has been submitted. //2013//

>Maternal Health

Maternal mortality has doubled in California since 1998 to 16.9 deaths per 100,000 live births in 2006, well above the Healthy People 2010 benchmark of 4.3 deaths per 100,000

live births. African-American women were roughly four times more likely to die from pregnancy-related causes with 46.1 deaths per 100,000 live births compared to 12.9 for Hispanic women, 12.4 for White women and 9.3 for Asian women. /2012/ In 2008, maternal mortality dropped slightly. However, the disparity ratio for African –American mothers continued to rise to ./2012// Subsequently, MCAH has supported diverse efforts to identify and address factors that appear to be contributing to increasing rates of maternal morbidity and mortality in California under the “Safe Motherhood” initiative.

First, MCAH gathers and manages statewide and local data needed to analyze factors related to poor birth outcomes and perinatal morbidity and mortality such as the MIHA and California Women’s Health Survey (CWHS). MCAH conducts PAMR which is the first statewide fatality review of maternal deaths in California. Pregnancy-related deaths from 2002 and 2003 have been reviewed and a report on findings is in development. /2012/ The California Pregnancy-Associated Mortality Review: Report on cases reviewed from 2002-2003 was released in April 2011. The report describes the methodology for the review, the key findings and recommendations from the Committee. Some of the findings have already informed MCAH strategies for addressing the rise in maternal mortality. //2012// The Maternal Quality Indicator Work Group (MQI) trends maternal morbidity data and tests methods for monitoring national obstetric quality measures in California. /2012/ Just as for mortality, the MQI group has found significant change in maternal morbidity with increased rates of diabetes, maternal hypertension, asthma and preterm deliveries.//2012// **/2013/ The MQI work group is also working to obtain better data regarding costs of care for maternal morbidities. In 2010, the maternal mortality rate in California declined to 9.2 deaths per 100,000 live births and when the timeframe of death was widened to a year postpartum (also known as the pregnancy-related mortality rate), the rate dropped to 15.7 deaths per 100,000 births. Similarly, the racial disparity ratio also slightly declined to 4.5 pregnancy-related deaths among African-American for every pregnancy-related death among White women.//2013//**

Secondly, MCAH promotes a regionalized approach to create collaborative networks of care and ensure that patients access care appropriate to their level of risk. RPPC is a statewide regional network that provides consultation to all delivery hospitals. RPPC uses current statewide and hospital-specific outcomes data to implement strategies to improve risk-appropriate care for mothers and their babies and collaborates with perinatologists for high-risk mothers and their infants. /2012/ RPPC is contracted to work with obstetric hospitals to incorporate two obstetric care toolkits; “Improving the Health Response to Obstetrical Hemorrhage” and “Elimination of Non-Medically Indicated Deliveries prior to 39 Weeks Gestation.”//2012// The California Perinatal Transport System (CPeTS) facilitates transport of mothers with high-risk conditions and critically ill infants to regional intensive care units as well as collecting transport data for regional planning and outcome analysis. MCAH also provide support for local programs to improve maternal health through maternity care improvement projects (Local Assistance for Maternal Health). Currently, San Bernardino County is providing leadership to reduce non-medically indicated labor induction with anticipated health benefits to mother and infant. L.A. County is leading a collaborative effort to improve hospital response to obstetrical

hemorrhage, a leading cause of maternal morbidity and mortality. /2012/ The projects in San Bernardino and L.A. County will come to a close at the end of June 2011 and two more counties have been selected to lead county wide efforts in a maternity care quality improvement project.//2012// **/2013/ Due to reduced funding, instead of local quality improvement projects, MCAH will work regionally through RPPC to promote adoption of toolkit strategies in obstetric hospitals.//2013//**

Thirdly, MCAH has developed a MHF to guide program development, including improvements for current programs and opportunities to create new programs. The MHF considers social and ecological contributing factors to maternal health in 3 phases of a life course perspective: prior to pregnancy, during pregnancy and following pregnancy to restore a mother to health should a health complication arise during pregnancy./2012/ The MHF is being shared with all LHJs and external stakeholders as an example of an application of life course theory to real world public health policy and program planning. //2012//

For Phase I, the Preconception Health programs (described elsewhere) are focusing on maximizing health of women and girls of reproductive age before they get pregnant. Some programs target pregnant women with the goal of maximizing health during pregnancy.

For Phase II, the BIH program addresses health disparities for African-American mothers and children by facilitating access to prenatal care and providing health education and social support services to mothers. CPSP provides enhanced prenatal services to meet nutrition, psychosocial and health education needs of clients. AFLP provides case management and education to pregnant and parenting adolescents to promote healthy pregnancy outcomes, effective parenting and socioeconomic independence. The Office of Family Planning (OFP) provides comprehensive education, family planning services, contraception and reproductive health services with the goal of reducing unintended pregnancies and optimizing maternal health prior to pregnancy.

Finally, in Phase III, MCAH provides programs and services to address common complications of pregnancy. CDAPP recruits, educates and provides consultation and technical assistance to providers who deliver comprehensive health services for high-risk pregnant women with pre-existing diabetes or women who develop diabetes while pregnant. CMQCC has developed two QI toolkits: one to reduce morbidity of obstetrical hemorrhage, a common complication of pregnancy and one to reduce elective inductions of labor prior to 39 weeks gestation which appears to be associated with higher rates of cesarean delivery. /2013/ **The toolkit to reduce elective inductions prior to 39 weeks gestation has been licensed to the MOD for national dissemination. The toolkit to improve healthcare of obstetrical hemorrhage will be translated into Spanish and distributed throughout Mexico based on an agreement with a Mexican national perinatal treatment center and the California Office of Binational Border Health. A third toolkit to improve the quality of care for preeclampsia is now in development and is based upon the findings from the CA-PAMR regarding identified opportunities for quality improvement.//2013//**

WIC contributes to optimizing health outcomes throughout all three phases of the MHF. WIC accomplishes this by linking families to local community and public health services and by providing lactation support, nutrition education and nutritious food to low income pregnant women, new mothers and children.

>Data and Surveillance

In 2010, MCAH began collaborating with WIC on several applied, public health research projects. The goal of the first project is to combine WIC program data with data from the Birth Statistical Master File and with data from MCAH programs in order to identify areas in California where there is a need for WIC services, to identify opportunities to better target WIC services to MCAH populations, and to evaluate outcomes associated with the receipt of WIC services. GIS and hotspot maps will be used to examine results at local levels. /2012/Analyses were completed for linked 2008 data during the past year. Choropleth maps and hot-spot analyses were completed for specific counties and used by WIC to target resources in a funding announcement. Choropleth maps were then generated and disseminated to other WIC program areas for local planning and outreach. Data for 2009 were also linked and will get analyzed in 2011 for similar resource allocation and planning purposes. MCAH also provided training and technical assistance to State WIC staff as well as local WIC providers and agencies on how to interpret and use choropleth maps; trainings included several hands on sessions at the 2011 California WIC Association Conference. //2012// **/2013/ In 2012, WIC program data for pregnant women, post-partum women, and infants were linked to the 2010 birth file in order to determine participation before and after pregnancy. MCAH has begun to develop maps using the 2010 data, as well as a detailed report on participation in WIC around the time of pregnancy. //2013//**

Second, California's MIHA Survey will be expanded in 2010. The sample size will increase and women who are eligible for, but not on WIC, will be oversampled. MIHA data will allow for the analysis of attitudes, risk factors, and behaviors of recent mothers relating to pregnancy outcomes and the child's early infancy, as well as the analysis of WIC clients and income-eligible clients not on WIC. Specifically, the data will be used to produce state- and select county-level descriptions of income-eligible women who are not enrolled in WIC, descriptions of WIC participants, and a statewide evaluation of WIC impact. Both of these efforts will help WIC better target and allocate resources and are necessary to fulfill mandated federal reporting requirements

/2013/ For the first time, MIHA released county-level data for the 20 counties with the largest number of births using 2010 data. County, regional and statewide data tables, comparison maps, charts and reports were published online. In the first three weeks after posting, the MIHA webpage received nearly 1,800 hits and there were over 2,000 surveillance product downloads. //2013//

/2012/ MIHA achieved a high response rate with the 2010 expanded sample, assuring adequate sample size for the proposed state and select county-level analyses of income-eligible women who are not enrolled in WIC. For the first time in 2010, women were asked their reasons for not being on WIC. These preliminary results were shared with WIC. The final 2010 data set will be available in July 2011 and MCAH and WIC are working to identify priority analyses and applied uses of these data. //2012//**2013/ Using MIHA 2010 data, MCAH has started drafting a report that will include state- and select county-level descriptions of income-eligible women who are not enrolled in WIC. The report will also describe reasons why eligible women do not enroll in WIC during pregnancy. //2013//**

Over the past year, MCAH has also collaborated with CDC to develop seven proposed Healthy People 2020 measures, which will combine data from the Pregnancy Risk Assessment Monitoring System (PRAMS) and MIHA. PRAMS has not been used as a data source for HP indicators in the past because without California it did not represent a large enough proportion of births. The combined estimates will allow tracking of key MCAH indicators, including infant sleep position, substance use and weight gain during pregnancy, postpartum smoking, and preconception/interconception care, many of which are otherwise unavailable from other data sources, and will represent approximately 85% of all births in the United States.

/2012/ Six PRAMS-MIHA Healthy People 2020 measures have been accepted as part of the Maternal, Infant, and Child Health topic area, elevating these health topics to a higher national visibility. Joint CDC-MCAH analyses provided baseline data for each topic that have been posted to the Healthy People 2020 website. Additionally, MCAH collaborated with researchers at UCSF and CDC to submit an abstract to the 3rd National Preconception Health Conference in Florida in June 2011. The abstract highlights the new HP 2020 objectives related to preconception/interconception health, current baseline estimates and targets for 2020, and ways that states can use PRAMS-MIHA data to monitor and inform efforts to achieve HP 2020 targets. //2012//

/2013/ MCAH has started analyzing baseline data from MIHA 2010 for the new HP2020 indicators. The analyses will focus on describing California's rates in relation to the HP2020 goals, as well as rates for specific populations in California (e.g., counties, regions, and race/ethnic, income, and age groups). We hope to make this information available on our website for our stakeholders soon. MCAH continues to coordinate efforts with CDC PRAMS. //2013//

2010 marks the 6th series of regional workshops to improve birth data quality on the birth certificate. Since 2004, the Office of Vital Records and MCAH have collaborated to plan Birth Data Quality Workshops across California. Joint meetings target area hospitals with missing data and RPPC leaders are recruited to assist with presentations supporting staff who collect birth data to better understand the items on the birth certificate, definitions of medical terms listed, and how the data helps to improve care for women and their infants. To accomplish this we bring together local and state birth registrars, county MCAH

Directors, local hospital administration, perinatal nursing staff, medical records and birth data collection staff, and we recognize hospitals for improvement and high achievement.

/2012/ 2011 marks the seventh series of regional workshops to improve birth data quality on the birth certificate. Since 2004, the Office of Vital Records and MCAH have collaborated to plan Birth Data Quality Workshops across California. Joint meetings target area hospitals with missing data and RPPC leaders are recruited to assist with presentations supporting staff who collect birth data to better understand the items on the birth certificate, definitions of medical terms listed, and how the data helps to improve care for women and their infants. To accomplish this we bring together local and state birth registrars, county MCAH Directors, local hospital administration, perinatal nursing staff, medical records and birth data collection staff, and we recognize hospitals for improvement and high achievement. During the past year, a workshop was offered via webinar for the first time. In 2010, more than 530 participants attended a workshop.

./2013/ 2012 is the 8th year for these workshops to improve birth data quality. Presentations will be made at seven regional meetings and one webinar. RPPC has taken a larger role this year presenting the information about the importance of correct data and emphasizing reporting of specific terms and conditions.//2013//

MCAH is making a concerted effort to increase surveillance capacity with geographic information systems (GIS) through use of enhanced address standardization and geocoding techniques; complex spatial analyses; automated map development with use of the Python coding language; and map building and sharing through interactive online maps. Thematic maps, spider diagrams, and statistically based hot-spot analyses of data from multiple sources (MCAH, WIC, vital statistics, the American Community Survey and others) have been used to locate regions at the state, county and local level in need of enhanced public health services. Hot-spot analyses were conducted, for example, to locate statistically significant clusters of women in need of WIC services, and to find clusters of families living in poverty that could benefit from home visiting program services.

As an applied example of our increased GIS capacity, specialized spider diagram maps were developed to analyze National Performance Measure 17. Geospatial associations between place of residence of mothers with very low birth weight (VLBW) infants, their delivery hospital and nearest NICU have illustrated the role that distance can play in access to appropriate care for VLBW infants.

Existing LHJ data books, which are used for local surveillance and needs assessment activities, are being revised by FHOP to enhance local surveillance. New indicators will be added to align with the new state priorities, State Performance Measures, and social determinants of health. For each indicator, presented data will include statistically-tested trends and comparisons to state rates, as well as stratification by race. For LHJ indicators with small cell values, data books will be modified to ensure that surveillance data is available even for small populations. Data books will be updated each year to support regular community-level monitoring, as is required by the new LHJ scopes of work.

Each year, MCAH disseminates breastfeeding initiation rates to all maternity hospitals and provides them with technical assistance to implement evidence-based policies and practices that support breastfeeding. Since 2006, the California WIC Association (CWA) has used these data to publish a report that ranks hospitals based on breastfeeding rates generating mass media attention. The 2011 report was released at California's first Breastfeeding Summit, which was attended by over 350 health professionals. At the Summit, MCAH presented statewide results of a national survey of maternity care practices related to breastfeeding, known as the Maternity Practices in Infant Nutrition and Care (mPINC) Survey. MCAH also released Regional mPINC Benchmark reports, which allow comparison of State and local data on seven dimensions of care and provide data to support local breastfeeding promotion efforts. California breastfeeding data are available at: <http://cdph.ca.gov/breastfeedingdata>.

//2013// MCAH continues to post hospital initiation breastfeeding data on the web annually. These data were utilized by the CWA to publish the 2012 Hospital Breastfeeding Rates Report & County Fact Sheets: Maternity Care Matters: Overcoming Barriers to Breastfeeding, results of which were highlighted at Breastfeeding Summit held January 2012. At this summit, MCAH also released MIHA data showing the association between hospital experiences that support breastfeeding and long-term exclusive breastfeeding success as well as updated statewide mPINC data. In April 2012, MCAH released updated regional mPINC benchmark reports.//2013//

In collaboration with CDC, MCAH linked mPINC and in-hospital breastfeeding data to explore the association of maternity care policies and practices with exclusive breastfeeding rates among California hospitals. This study demonstrated that hospitals with higher mPINC scores had higher exclusive breastfeeding initiation rates. MCAH was invited by the CDC to share these findings at the American Public Health Association (APHA) Conference. The attention generated by these enhanced breastfeeding surveillance activities has motivated many hospitals to seek changes in their maternity care policies and practices to better support breastfeeding. //2012//

/2013/ CCS performance measure data is reported annually by counties. For the Medical Home performance measure, 83% of CCS clients have medical homes, based on county reports of clients with Medical home, which range from 42% to 99%.//2013//

>California's Primary and Secondary Teen Pregnancy Prevention Initiatives

In January, 2012, the Governor's budget proposed transfer of the Office of Family Planning/Family PACT from CDPH to DHCS. In accordance with the Governor's proposal, the I&E Program and the California Personal Responsibility Education Program (CA PREP) currently administered by the Teen Pregnancy Prevention Program in the Office of Family Planning would remain in CDPH and administered by MCAH. The incorporation of OFP's teen pregnancy prevention programs into

MCAH affords an opportunity for statewide, comprehensive service delivery that will address both primary and secondary teen pregnancy prevention efforts. //2013//

> AFLP PYD

/2012/In September 2010, MCAH received notification of a Support for Pregnant and Parenting Teens at High Schools and Community Service Centers award from the U.S. Department of Health and Human Services (HHS), Office of Adolescent Health. MCAH received \$2 million per year for 3 years, beginning 2010- 2011. MCAH seeks to improve and increase capacity of the pregnant and parenting services currently offered to eligible youth served through its Adolescent Family Life Program and the California Schoolage Families Education Program (Cal-SAFE) . The intent is to maximize use of limited resources through the AFLP provision of case management and support services and the Cal-SAFE provision of child and developmental services to support AFLP client school completion.

/2013/ The goals of the program focus on secondary teen pregnancy prevention.//2013// This funding will link a positive youth development (PYD) case management intervention to school-based childcare services in order to support school completion, decrease repeat teen pregnancy, promote maternal and inter-conception health, and link teens and their children to community services. Activities will be founded in PYD principles and will promote Reproductive Life Planning (RLP) through use of the “My Life Plan” tool which facilitates goal setting and behavioral changes. **/2013/ The tool has been refined to further focus on building youth resiliency and promoting positive youth development constructs. The pilot of the tool will begin in July 2012. //2013//**

Grant funding is being made available to counties identified with the highest need and service gaps through a competitive process. **/2013/ In June 2011, CDPH/MCAH awarded funds to 11 of 37 local AFLP program sites for AFLP PYD based on need and service gap as demonstrated through an application process and five key HSIs (teen birth rates, median family income, school drop-out rates, Hispanic population, and chlamydia rates). The sites awarded are from the following counties: Alameda/Contra Costa, San Joaquin, Tehama, Kern, Fresno, Madera, Merced, Tulare, Imperial, L.A., and Ventura. //2013//** Foundational training and tools developed for the intervention will be made available to funded sites to maximize professional development and transition toward a standardized, evidence-based intervention. **/2013/ Local staff participated in a series of professional development opportunities between November 2011 and June 2012 to increase capacity in preparation for piloting the new positive youth development case management intervention with integrated life planning. //2013//** Outcome data will be used to standardize the delivery of services to eligible youth in all AFLP agencies upon conclusion of the evaluation under this grant.//2012//

[/2013/ >California Personal Responsibility Education Program \(CA PREP\)](#)

In 2009, the Department of Health and Human Services, Administration on Children, Youth and Families (ACYF), Family and Youth Services Bureau (FYSB), provided a funding opportunity for states to apply for a teen pregnancy prevention grant. Funds were made available through the Patient Protection and ACA Affordable Care Act of (2010) amendment to Title V of the Social Security Act that included a new formula grant program entitled the Personal Responsibility Education Program (PREP). PREP is a program designed to educate adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections (STIs), including HIV/AIDS, through the use of evidence-based program models, adulthood preparation subjects, linkage to family planning clinical services, and increased community support in the development of healthy youth and the reduction of their risky behaviors.

CDPH, Office of Family Planning (OFP) submitted an initial application for PREP funds and received notification of funding on September 27, 2010, in the amount of \$6,553,554. CDPH/OFP submitted a Post-Award State Plan in February, 2011, and on June 13, 2011; CDPH/OFP received notification that the Post-Award State Plan was approved. PREP funding is available for FYs 2011 – 2014. In January, 2012, responsibility for CA PREP was moved from OFP to MCAH based on the proposal in the Governor’s budget. As such, MCAH completed the development of the CA PREP RFA in January 2012, released the RFA on February 2, 2012, and final award announcements were made on April 30, 2012.

Nineteen (19) of California’s counties with teen birth rates significantly higher than the 3-year average state teen birth rate from 2007-2009, were selected as eligible to apply for CA PREP funding. The major activities of CA PREP sub-awardees will include (1) development and maintenance of a local stakeholder coalition; (2) serving the highest risk population in each selected county between the ages of 10-21, with a priority of services to Hispanic and African American youth; (3) conducting evidence-based program models (EBPM’s) with fidelity; (4) conducting at least three adulthood preparation subjects; (5) providing information support to health care and other support services; (6) establishing formal partnerships with Family PACT providers to ensure access to family planning and reproductive health services; and (7) conducting evaluation through collection, monitoring, and reporting on outcomes through performance measures.

There are also five Tribal awardees in California totaling approximately \$1.7M.

[<Information and Education Program \(I&E\)](#)

Funding for I&E is through California State General funds and matching Title XIX Federal Financial Participation Funds from the Centers for Medicare and Medicaid

Services. The most recent RFA for this program was released on November 29, 2010, and made funding available from June 1, 2012 – September 30, 2016.

I&E is a 30 year-old, innovative community-based program designed to provide adolescents with comprehensive pregnancy and sexually transmitted infection (STI) prevention information and education and provide linkages to clinical health care. The overarching goal of the program is to decrease teenage pregnancies through education programs that equip teens at high risk for pregnancy with the knowledge, understanding, and behavioral skills necessary to make responsible decisions regarding at-risk behaviors.

I&E target populations include at-risk youth in schools, juvenile justice facilities, and foster care programs; pregnant and parenting teens; runaway and homeless youth; out of school youth; parents of high-risk youth; and other adults responsible for serving youths at risk such as teachers, counselors, coaches and social service workers. Program services are offered in diverse settings such as mainstream and alternative schools, social service agencies, juvenile detention facilities, and youth centers. I&E includes a core intervention of life skills education that is based on scientific evidence-based program models that have demonstrated significant positive behavioral outcomes for pregnancy prevention and STI and HIV/AIDS prevention. All I&E grantees incorporate the use of youth development principles into their interventions and all include linkages to reproductive health and clinical services.//2013//

> Home Visiting Program

/2012/The Maternal, Infant and Early Childhood Home Visiting Program was established on March 23, 2010 by ACA of 2010, which amended Title V of the Social Security Act by adding Section 511. MCAH is designated as the single State entity to oversee and administer home visiting funds on behalf of California. To receive funding from HRSA and ACF, MCAH began working in partnership with DSS, ADP, the California Head Start State Collaboration Office (CHSSCO) of the CDE, and local stakeholders from each of California's 61 LHJs in order to develop California's Home Visiting Program application (submission, July 9, 2010), Needs Assessment (submission September 20, 2010), and Updated State Plan (submission June 9, 2011). **/2013/MCAH submitted an application and was awarded the Home Visiting Expansion Grant to increase the number of communities served. This effort targets particularly high risk and difficult to enroll and retain populations and evaluate individual, program and community factors affecting enrollment and retention. MCAH anticipates implementation of home visiting programs by mid-year 2012.**

Two evidence-based models, Nurse-Family Partnership (NFP) and HF America , were selected to meet the needs of the 21 funded communities identified as “at-risk” through a formal Needs Assessment, a geospatial hot-spot analysis using

quantitative data, and qualitative information from local MCAH Directors in response to the CHVP Request for Supplemental Information.//2013//

The over-arching goal of the California Home Visiting Program (CHVP) is to provide leadership for integrated, collaborative, high-quality maternal and early childhood interventions across multiple systems of health and human services to address the complex needs of diverse families throughout California. California's investment to empower pregnant women and families with children will positively impact maternal health and childhood development, which leads to improved health and well-being over the life course, and ultimately cultivates resilient communities. The Objectives for CHVP are: 1) Promote maternal health and well-being, 2) Improve infant and child health and development, 3) Strengthen family functioning, 4) Cultivate strong communities, and 5) Provide leadership for the coordination of maternal and early childhood systems and supports to advance federal, state and local efforts to improve health and well-being for families in California.

MCAH is utilizing the five protective factors in the Strengthening Families approach as a healthy life course framework for CHVP. Strengthening Families is an approach, centered on five protective factors, for working with children and families in a variety of settings. The five, research-based, protective factors have been found to be linked to the reduction of child abuse and neglect, and children's optimal development. The protective factors are the conditions in families and communities that when present, increase the health and well-being of children and families. Focusing on protective factors helps develop circumstances that promote healthy behaviors and decrease the chance children will engage in risky behaviors as they grow up. In addition, a life course approach which emphasizes strengths and protective factors will provide a foundation for effective systems integration of supports for pregnant women and mothers. Finally, this life course approach to promoting maternal, infant and early childhood health and well-being will provide an opportunity to identify and address systemic social inequities and their contribution to health disparities.

The protective factors demonstrate the commonality of practice across all of the agencies working with children and families. They provide an approach for coordination across diverse initiatives, using common language and goals for families at all levels of work. Applying the protective factors at a state level will help to shift policy, resources, cross-system relationships, and support structures that will serve to support local program implementation, leading to the optimal development of all children.

MCAH is utilizing protective factors approach to serve as an overarching frame for building collaborations across the early childhood system. MCAH will play a leadership role in cross-systems work at the state level, using the protective factors framework to bring together multiple players around a common set of goals. Strategies in our protective factors approach include: engaging multi-disciplinary partners including social services, First 5, mental health, FRCs, Early Head Start, Head Start, foundations, advocacy groups, education, child abuse and prevention, childcare planning groups, the medical

community, developmental services, and families; linking to cross-system planning efforts by coordinating our planning and implementation with other state early childhood initiatives such as the Early Learning Advisory Council and the California Early Childhood Coordinating Systems; promoting the use of the protective factors to define a shared set of outcomes for families across systems and disciplines, a priority for many existing California initiatives; and, partnering with others to identify agencies that fund maternal and early childhood initiatives and engage these agencies in planning and implementing family strengthening activities.

Throughout the implementation of CHVP, MCAH will integrate home visiting into ECCS efforts involving the key early childhood system components of health care/medical home, early care and education, social and emotional development, family support and parenting education. Specifically, MCAH will develop approaches to: establish linkages to existing collaboratives and initiatives to support the integration of program services into wider state system of care; integrate home visiting as one component of a continuum of services for children; improve and expand timely and early identification of children with developmental delays or at risk of delays and provide early intervention to help children reach full potential; develop interagency partnerships to address barriers to services for children who fall through the cracks due to lack of insurance or ineligibility to entitlement services; improve effective prevention and early intervention services and provide information, education and training to parents, professionals and decision makers, and others; address common barriers that limit parent's ability to parent and work from a strength-based perspective; streamline and improve services through cross-departmental planning and governance that builds on existing initiatives and services; work to ensure that services are continuous for children, especially during transition from home visiting to other services, and for those with special needs; improve cross-agency coordination between home visiting and early childhood programs to strengthen referral mechanisms to services that are part of the broader linked system or care; develop Memorandum of Understandings to promote formalized linkages and coordination among public and private sector partners and to ensure that interagency and cross-systems protocols and practices are effectively implemented and evaluated; engage in meaningful interdepartmental collaboration leading to the alignment of policy priorities and objectives, and making targeted improvement to cross-system efforts and interactions; and, promote better communication and coordination between county and private agencies serving children and their families.//2012//

/2013/In order to ensure that home visiting is part of a continuum of early childhood services within the State, MCAH organized the CHVP Workgroup from the current State Interagency Team (SIT). Members of the CHVP Workgroup are: DSS, ADP, CDE, DDS, First 5 California, California Head Start Collaboration Office, DHCS, CDPH, Domestic Violence Leadership Group, LHJs representing urban and rural counties, AAP-CA, California Project LAUNCH, California Early Childhood Comprehensive Services, Family Resource Center, Heising-Simons Foundation, CDPH/State and Local Injuries Control.

The primary function of the CHVP Workgroup is to provide insight into strategies to support the planning and implementation of CHVP. The Workgroup will work to improve the quality, efficiency, and effectiveness of home visiting through interagency collaboration. Focus areas include: program implementation, training and technical assistance, continuous quality improvement, interagency efforts to improve referrals, interagency coordination and data sharing, and collaboration with other child-serving agencies at state and local levels.//2013//

/2013/> Health Communications and Public Health Successes

Pursuant to the CDPH's revised strategic map that include objectives related to develop and implement public health branding and developing communication strategies for educating staff, the public and key partners, MCAH continue its strong partnership and open dialogue with its key partners including local MCAH programs. MCAH provides programmatic updates in the bi-annual MCAH Action meeting and holds quarterly phone conferences with the MCAH Action leadership.

MCAH was actively involved in crafting CDPH news releases and media talking points. For Folic Acid Awareness Week in January 2012, MCAH developed a news release, stressing the consumption of folic acid as an inexpensive and effective way to reduce neural tube defects (NTDs), one of the most common birth defects, by 50 to 70 percent. CDPH, the U.S. Public Health Service and the Centers for Disease Control and Prevention recommend that all women of childbearing age take 400 mcg of folic acid daily, even if they have no immediate plans to become pregnant. This is because approximately half of all births in California are unplanned.

In California, Hispanic women have the lowest rates of folic acid consumption and the highest risk of having a pregnancy with NTDs. While only 49.6 percent of non-pregnant women ages 18-44 reported consuming folic acid at least once per week in the statewide California Women's Health Survey, consumption was lowest for Hispanic women (38.1 percent) and highest for White women (57.8 percent) and African-American women (53 percent). As part of Folic Acid Awareness Week activities, CDPH has partnered with Raley's® and SaveMart® stores in California to display educational posters and distribute consumer pamphlets about folic acid in English and Spanish.

In March 2012, CDPH developed a news release to highlight a milestone in teen birth rates. California's 2010 teen birth declined to 29.0 births for every 1,000 females ages 15-19, from the rate of 32.1 births in 2009. The teen birth rate has declined since 1991 when it reached a record high of 70.9 births. Teen pregnancy has been a long-standing public health challenge associated with increased maternal and infant morbidity and mortality. Early teenage childbearing has been recognized to have negative health and social consequences to adolescent mothers.

Teen birth rates also declined in all major racial/ethnic groups. Teens age 18-19 experienced a decline of 9 percent (from 53.5 in 2009 to 48.6 in 2010), and teens age

15-17 saw a drop from 17.5 to 15.2, representing a 13 percent reduction. While Hispanic teens age 15-19 continued to have the highest birth rate in 2010, they demonstrated the second highest decline at 11 percent between 2009 and 2010. Hispanic teen birth rates dropped from 50.8 in 2009 to 45.0 in 2010. In 2009, the African-American teen birth rate was 37.0, dropping to 34.0 in 2010, representing a decrease of 8 percent. Asian/Pacific Islander teens and White teens had reductions of 14 and 8 percent, respectively. California's teen population appears to be leveling-off, however changes in its composition can influence the teen birth rate. In 2000, nearly equal proportions of female teens were Hispanic (39%) and White (38%); by 2010, Hispanics comprised 47% and Whites 33%.

Declines reflect the impact of strong teenage pregnancy prevention messages that accompany a variety of public and private efforts to focus adolescents' attention on the critical importance of avoiding early childbearing, including the Information and Education Program, the Adolescent Family Life Program, and the Family PACT (Planning, Access, Care and Treatment) Program.

In May 2012, MCAH developed a news release to highlight California's infant mortality rate, which reached a record low in 2010 of 4.7 infant deaths per 1,000 live births, down from 4.9 infant deaths per 1,000 live births in 2009. African Americans experienced the largest decline, from 10.6 infant deaths per 1,000 live births in 2009 to 9.5 in 2010. While this is a significant improvement, racial/ethnic disparities in infant mortality persist. African-American infant deaths occurred 2.3 times more frequently than Caucasian infant deaths in 2010. The infant mortality rate among Caucasians remained unchanged between 2009 and 2010 (4.1 deaths per 1,000 live births) and dropped from 5.0 to 4.9 among Hispanics. Among the factors that may have contributed to the declining infant mortality rate is the decline in the percent of births born prematurely (less than 37 weeks' gestation). The percent of births born prematurely in California declined from 10.4 percent in 2009 to 10.0 percent in 2010. California had the fourth-lowest infant mortality rate among all 50 states.

CDPH has accepted the Association of State and Territorial Health Officers (ASTHO) /March of Dimes (MOD) challenge to reduce preterm births by 8% by 2014.

MCAH staff subject matter experts provided data, consultation and review of MCAH fact sheets developed by FHOP on topics such as teen pregnancy, preconception health, breastfeeding and healthy weight and pregnancy and made available through the FHOP website (http://fhop.ucsf.edu/fhop/htm/ca_mcah/fact_sheets.htm). The fact sheets were developed to highlight the health issues confronting the MCAH population, its consequences and economic impact to the individual and the community, provide most current state and local data, as well as underscore the contribution and value of local and state MCAH programs, emphasize the need for policy, environmental and systems change and provide examples of local evidence-based and promising practices to address the health issue.

>Strategic Map

CDPH has developed and will implement a Strategic Map which is a graphic representation of CDPH's strategy over the next three years. Map components identify the central challenge of leveraging key opportunities to define and shape the future of public health in a changing environment; identifies strategic priorities; strategic objectives and cross-cutting strategic priorities. MCAH staff has provided significant feedback to the Department in the development of this Strategic Map and will actively participate in the Departments strategic priorities and objectives.

C. Agency Capacity

California has a statewide system of programs and services that provides comprehensive, community-based, coordinated, culturally competent, family-centered care. For example, Special Care Centers (SCCs) and hospitals that apply to become CCS-approved must meet specific criteria for family-centered care (FCC). FCC is assessed by the CMS Branch as part of the ongoing review process of CCS-approved SCCs and hospitals. Local CCS programs facilitate FCC by assisting families to access authorized services, such as pediatric specialty and subspecialty care, and by providing reimbursement for travel expenses, meals, and motel rooms during extended hospital stays.

MCAH and CMS Programs

MCAH and CMS programs provide direct services, enabling services, population-based services and/or infrastructure-building services. A table is attached as a guide to identify the lead agencies with which these programs are affiliated, the primary population these programs target; pregnant women; mothers and infants; children, adolescents, and CSCHN) and the availability of the program at the local or community level. These programs were created or permitted by statute and include the following:

>Adolescent Family Life Program (AFLP)

AFLP aims to promote healthy development of adolescents and their children, healthy lifestyle decisions, including immunization and pregnancy prevention and continuation of adolescents' education. It uses a case management model to address the social, medical, educational, and economic consequences of adolescent pregnancy, repeat pregnancy and parenting on the adolescent, her child, family, and society. It also links clients to mental health, drug and alcohol treatment, foster youth, family planning and dental care services and direct services available through Medi-Cal and Temporary Assistance for Needy Families (TANF) or CalWorks as it is known in California . AFLP targets services to pregnant and parenting teens and is providing services to approximately 6000 adolescents in 38 programs throughout the State. In many counties, AFLP is the only case management program available for pregnant and parenting teens. /2012/ The caseload for 2010 was 8,902 clients in 37 programs /2012// /2013/ **Through a grant from the federal**

Office of Adolescent Health, MCAH awarded 11 local AFLP agencies to increase program capacity and professional development in the area of positive youth development. //2013//

>Black Infant Health (BIH)

BIH which has the goal of reducing African American infant mortality in California uses case management and group interventions to support African American women in their pregnancies and improve birth outcomes. The BIH program is currently serving approximately 3000 women in 16 programs in the State. /2012/BIH revised services to include a client-centered, strength-based group intervention with case management. //2012//

>California Birth Defects Monitoring Program (CBDMP)

CBDMP collects and analyzes data to identify opportunities for preventing birth defects and improving the health of babies. The 2006 birth year information was recently linked to vital statistics live birth and fetal death information, creating a database of more than 129,000 pregnancies affected with birth defects from a base population of 6.25 million births. Birth year 2007 linkage will be completed soon. /2013/ **Birth year information is linked to vital statistics data for 8 counties The CBDMP Registry has data for more than 140,000 babies with birth defects from approximately 13,850,000 pregnancy outcomes (live births and fetal deaths) since 1983. //2013//**

>California Children's Services (CCS) Program

CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions.

Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae.

The program authorizes medical and dental services for CCS-eligible conditions, establishes standards for providers, hospitals, and SCCs for the delivery of care, and provides physical and occupational therapy and medical case conference services at selected public school sites for children with specific medically eligible conditions. Thirty-one "independent" counties fully administer their own CCS programs, and 27 "dependent" counties share administrative and case management activities with CMS Branch Regional Offices. Social Security Income (SSI) beneficiaries with a CCS medically-eligible diagnosis are served by the CCS program. /2012/The CCS caseload for FFY 2009 is 179,306 of which 76.1% are in Medi-Cal; 14.3% in HF, and 9.6% in state only

CCS.//2012// **/2013/ There were 246,301 clients in the CCS Program in SFY 10-11, based on the CMS Net system. //2013//**

CCS has a regional affiliation system with 114 CCS-approved NICUs. NICUs providing basic level intensive care services are required to enter in to a Regional Cooperation Agreement (RCA) with NICUs that provide more extensive services, to facilitate consultation and patient transfers as needed. CCS approves the designated level of patient care (Intermediate, Community and Regional) provided in each NICU, and verifies that the RCA is in place. Starting with 2004 data, all CCS NICUs are required to submit their CCS data through CPQCC.

/2013/CCS added Dr. Joseph Schulman, MD, a nationally recognized leader in Neonatal Medicine and Quality Outcomes, to coordinate the multidisciplinary efforts around CLABSI, Health Care Associated Complications and “never events” in the NICU.//2013//

>California Diabetes and Pregnancy Program (CDAPP)

CDAPP promotes optimal management of diabetes in at-risk women, before, during and after pregnancy. Regional teams of dietitians, nurses, behavioral specialists and diabetic educators provide training and technical assistance to promote quality care provided by local Sweet Success providers and to recruit and train new Sweet Success providers in areas of need. **/2013/As of July 2011, CDAPP funding was cut 50% thus eliminating the availability of regional services. A resource and training Center, however, will continue to maintain a website, supply educational materials and provide webinars for affiliates who provide direct services.//2013//**

>California Early Childhood Comprehensive Systems (ECCS)

ECCS promotes universal and standardized social, emotional and developmental screening. ECCS collaborative efforts provide CHDP with guidance on validated and standardized developmental/social-emotional health screening tools for earlier identification of children with developmental delays. The revised guidelines were an important collaboration between CHDP and the MCAH led team of the national Assuring Better Child Health and Development (ABCD) Screening Academy Project. The work to enhance California’s capacity to promote and deliver effective and well-coordinated health, developmental and early mental health screenings for young children, ages 0-5, continues through the Statewide Screening Collaborative (SSC), which served as the stakeholders in the ABCD project. **/2013/The work of the SSC continues under the umbrella of ECCS//2013//**

ECCS is partnering with Alameda County to develop early childhood programs of care for children 0 to 8 years of age California Project Launch. **/2012/ Project Launch’s goal is**

to show the feasibility and impact of recommended policy changes to establish and maintain a developmental continuum that prepares children to learn. //2012//

/2013/California Home Visiting Program staff has recently convened the State Interagency Team (SIT) Workgroup, whose stakeholder members include ECCS and California Project LAUNCH (CPL). SIT will work to improve the quality, efficiency and effectiveness of home visiting through interagency collaboration.//2013//

>Child Health and Disability Prevention (CHDP) Program

CMS administers the screening component of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, called the CHDP Program. CHDP provides preventive services and referral to diagnostic and treatment services for Medi-Cal participants up to age 21. Uninsured children up to age 19 in households at or below 200% of the FPL can pre-enroll in Medi-Cal through the Gateway process

CHDP provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutrition assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment.

>Comprehensive Perinatal Services Program (CPSP)

CPSP provides comprehensive perinatal care including obstetrical, nutrition, health education, and psychosocial services from qualified providers to Medi-Cal eligible women. There are 1566 active CPSP providers in California /2012/(1592 for 2010)//2012//. MCAH develops standards and policies; provides TA and consultation to the local perinatal services coordinators; and maintains an ongoing program of training for all CPSP practitioners throughout the state. Local MCAH staff /2012/ monitor service delivery, recruit new providers and//2012// offer TA and consultation to potential and approved providers in the implementation of CPSP program standards.

>Fetal Infant Mortality Review Program (FIMR)

Sixteen local LHJs have FIMR Programs that enable them to identify and address contributing factors to fetal and infant mortality. A Case Review Team examines selected fetal and infant death cases, **/2013 conducts maternal interviews, //2013//** identifies factors associated with these deaths, and determines if these factors represent systems problems. Recommendations from the Case Review Team are presented to a Community Action Team that develops and implements interventions that lead to

positive changes. **/2013/ MCAH is building an aggregated data base for FIMR with data reporting from all 16 jurisdictions.//2013//.**

>Genetically Handicapped Persons Program (GHPP)

GHPP provides case management and funding for medically necessary services to people with certain genetic conditions. Most GHPP clients are adults, but 4.6 percent are children under 21 years. The GHPP serves eligible children of higher family incomes who are ineligible for the CCS program.

GHPP client enrollment is stable, with 1750 clients for 2008-2009. **/2013/GHPP client enrollment for 2010-2011 was 1537 clients.//2013//**

> Hearing Conservation Program (HCP)

HCP helps to identify hearing loss in preschoolers to 21 years of age in Public Schools. All school districts are required to submit to CMS an annual report of hearing testing. **/2013/ HCP identified that for the school year 2009/10, 780 school districts reported their hearing screening results and 1.9 million students were screened. //2013//**

>Health Care Program for Children in Foster Care (HCPCFC)

HCPCFC is a public health nursing program **/2013/ administered by the local CHDP Program, is //2013//** located in county child welfare service agencies and probation departments to provide public health nurse expertise in meeting the medical, dental, mental and developmental needs of children and youth in foster care.

>High Risk Infant Follow-up (HRIF)

Infants discharged from CCS-approved NICUs are followed in NICU HRIF clinics. Three multidisciplinary outpatient visits are authorized by CCS up to age three to identify problems, provide and complete referrals, and monitor outcomes.

The HRIF program continues to provide three multidisciplinary outpatient visits to identify problems, institute referrals, and monitor outcomes. The QCI developed a web based reporting system to collect HRIF data for quality improvement activities. Statewide trainings were provided to all NICU and HRIF Program staff before implementation and a follow-up training was held in February 2010.

/2012/

>California Home Visiting Program (CHVP)

CHVP aims to improve service coordination for at-risk communities to promote improvements in maternal and infant health, school readiness, reduction of child

maltreatment, improved community referral systems, and reductions in crime and domestic violence. //2012//

//2013//The primary focus of CHVP will be on the implementation of maternal, infant and early childhood home visiting programs that provide comprehensive and coordinated services to improve outcomes for families residing in identified at-risk communities. Two evidence-based home visiting models for implementation were officially selected in California: Nurse Family Partnership (NFP) and HF America. Selection of these two models was based on findings from the Home Visiting Evidence of Effectiveness Review (HomVEE) Study, funded by HRSA, which distinguished NFP and HF America as having the most favorable ratings for primary and secondary outcomes in the legislatively-mandated benchmark areas.//2013//

>Human Stem Cell Research Program (HSCR)

HSCR develops comprehensive guidelines to address the ethical, legal, and social aspects of stem cell research and ensure the systematic monitoring and reporting of HSCR activity that is not fully funded by Proposition 71 money granted through the California Institute for Regenerative Medicine. A diverse group of 13 national and international specialists serve on a HSCR Advisory Committee to advise CDPH on statewide guidelines for HSCR.

>Local Health Jurisdiction (LHJ) Maternal Child and Adolescent Health Programs (LHDMP)

61 LHJs receive Title V allocations that support local infrastructure, including staff, to conduct culturally sensitive collaborative and outreach activities to improve services for women and children, refer them to needed care, and address state and local priorities for improving the health of the MCAH population.

>MCAH Toll-free Hotline

MCAH staff responds to calls and refer callers to local MCAH programs. LHJs also have local toll-free numbers that provide information and referrals to clients. Local MCAH contact information is made available online.

>Medical Therapy Program (MTP)

MTP provides physical and occupational therapy services to children with CCS MTP eligible conditions. There is no financial eligibility requirement. MTP conducts multidisciplinary team conferences to support case management and care coordination.

The number of clients enrolled in the MTP has shown a slight declining trend over the past 5 years of 7% and is currently 24,777 /2012/in 2010 and 24,433 for 2011.//2012//

>Newborn Hearing Screening Program (NHSP)

NHSP helps identify hearing loss in infants and guide families to the appropriate services needed to develop communication skills. In California, 243 hospitals are certified to participate in the NHSP as of December 2009. **/2013/As of January 2012, there are 5 hospitals pending certification and 253 hospitals certified as Inpatient Infant Hearing Screening Providers.//2013//**

>Pediatric Palliative Care Waiver Program

This program allows for the provision of expanded hospice type services and curative care concurrently. This program is designed to improve the quality of life for children with life limiting or life threatening conditions, and their family members. It is anticipated that cost neutrality will be achieved by reduced hospital stays, medical transports and emergency room visits in addition to other costs avoided while the child is enrolled in the program. **/2013/As of March 2012, there were 9 active hospice or home health agency providers and one pending in the 11 participating counties. //2013//**

>Regional Perinatal Programs of California (RPPC)

RPPC promote access to risk-appropriate perinatal care to pregnant women and their infants through regional QI activities. RPPC facilitate local perinatal advisory councils to provide regional planning, coordination, and recommendations to assure appropriate levels of care. In addition the local perinatal advisory councils perform hospital surveys and perinatal assessments of regional and statewide significance; develop communication networks locally; disseminate educational materials and produce a statewide newsletter; provide resource directories, referral services, and hospital linkages to the Northern and Southern CPeTS; and assist hospitals with QI activities, data collection protocols, and quality assurance policies and procedures. **/2013/ Production of a statewide newsletter was terminated.//2013//**

CPeTS maintains a web-based bed availability list, locate beds for high-risk mothers and infants and provide transport assistance, transport data reports, and perinatal transport quality improvement activities, including emergency triage and transport in the event of a disaster. Maternity hospitals can obtain information 24 hours a day, 7 days a week to facilitate transfers.

>Sudden Infant Death Syndrome (SIDS) Program

SIDS is funded in all 61 LHJs to provide support to families that experience a SIDS death, conduct prevention activities, and enable staff to attend annual training. The SIDS Program provides statewide technical assistance and support to healthcare and public safety personnel and parents including education about SIDS, grief counseling, and information on prevention to reduce the risk of SIDS.

> **Technical Assistance**

MCAH places high priority on providing stakeholders and partners with quality assistance where necessary to improve MCAH program performance. The following programs were created to address the developmental assistance needs in the state:

>**Breastfeeding Technical Assistance Program**

This program promotes and supports efforts to make breastfeeding the infant feeding norm. Its website (<http://www.cdph.ca.gov/programs/breastfeeding/Pages/default.aspx>) contains targeted breastfeeding information for families and providers. It has piloted BBC to assist hospitals to improve their exclusive breastfeeding rates and collaborated with MediCal, WIC and the CA Breastfeeding Coalition to improve hospital support for breastfeeding.

/2013/Nutrition and Physical Activity Technical Assistance Initiative

This initiative integrates healthy eating and physical activity promotion within MCAH and its local programs. Strategies include providing technical assistance to LHJs, promoting the development of healthcare policies, training and guidelines; supporting MCAH partners throughout the state in the development and participation in local healthy eating and physical activity-related coalitions; and using epidemiological information from multiple sources to design, implement, and evaluate nutrition and physical activity initiatives.//2013//

>**Oral Health Technical Assistance Program**

Oral Health Program provides local technical assistance and state level coordination and collaboration to address the oral health needs of pregnant women, mothers, children and adolescents, especially within low-income families, by expanding access to dental care and preventive services, and by encouraging local MCAH Programs to work in collaboration with new and existing dental and health-related programs. This year, 18 local MCAH programs have chosen oral health as a priority objective. Another 25 /2012/ 21 //2012//local MCAH programs collaborate on various community tasks forces involving oral health issues. Further, direction has been provided by updating oral health educational components in the CPSP “Steps to Take” Guidelines, BIH prenatal and postpartum curriculums, AFLP “Infant Feeding” Guidelines and CDAPP’s Sweet Success Guidelines. /2012/MCAH is disseminating perinatal clinical oral health guidelines to assist providers deliver oral health services.//2012//

>Preconception Health and Healthcare

MCAH is partnering with organizations and stakeholders across the state to provide direction for the integration of preconception care into public health practice, develop policy strategies to support preconception care, and promote preconception health messages to women of reproductive age. /2012/Reproductive life planning concepts and tools are being integrated into BIH and AFLP programs.//2012// **/2013/MCAH provides preconception health training and technical assistance throughout California and is participating in the CDC work groups to ensure our efforts are aligned with the national preconception health agenda and strategies. //2013//**

Major Collaboratives

MCAH and CMS value the input provided by its stakeholders across communities and has actively fostered collaboratives, task forces and advisory/work groups to address MCAH and CSCHN health issues. These collaboratives, task forces and advisory/work groups also serve to coordinate preventive and health care delivery with other services at the community level as well as with the health components of community-based systems. These include the following:

> Adolescent Sexual Health Work Group (ASHWG)

ASHWG is a collaborative of 23 organizations from CDPH, CDE and non-governmental organizations who address sexual and reproductive health needs of youth. Its vision is to create a coordinated, collaborative, and integrated system among government and non-government organizations to promote and protect the sexual and reproductive health of youth in California. Current activities focus on core competencies for /2012/youth//2012// providers and educators, integrated data tables (available at: http://www.californiateenhealth.org/download/ASHWG_Integrated_Data_Tables.pdf) and youth development.

> California Perinatal Quality Care Collaborative (CPQCC)

CPQCC is a cooperative effort of public and private obstetric and neonatal providers, insurers, public health professionals and business groups. It develops perinatal and neonatal quality improvement infrastructure at state, regional, and hospital levels. For 2010, CPQCC membership is at 128 NICUs, with all of the 114 CCS-approved NICUs as members/2012//; for 2011, there were 129 NICUs, with 115 CCS-approved NICUs as members.//2012// **/2013/CPQCC includes 131 member hospitals, representing over 90% of all neonates cared for in California NICUs, including all CCS-approved intermediate, community, and regional NICUs.//2013//**

The Perinatal Quality Improvement Panel (PQIP), is a standing subcommittee of CPQCC, that provides oversight for all quality functions of CPQCC by creating, initiating and conducting statewide quality projects and/or prospective trials; publishing and disseminating new and updated QI toolkits; analyzing the CPQCC database and

designing supplemental data collection tools; and initiating and implementing research projects focused on QI. /2012/PQIP revised its charter and re-designed its structure, developing 4 sub-committees.//2012// **/2013/ The major goal is to support benchmarking and performance improvement activities for perinatal care. CPQCC-led collaboratives were associated with significant improvements in breastfeeding rates for very low birth weight infants and marked reductions in CLABSI. Current CPQCC/CCS collaboration aims to improve delivery room management of the newborn. CMS and CPQCC plan to model NICU length of stay to inform efforts to optimize NICU resource use and narrow adjusted variation among hospitals.//2013//.**

> California Maternal Quality Care Collaborative (CMQCC)

CMQCC is the statewide umbrella organization for assessing the current state of knowledge of maternal illness and complications and transforming this knowledge into targeted, evidence-based, data-driven clinical quality improvement interventions and public health strategies statewide and at the local level. CMQCC's mission is to end preventable maternal morbidity and mortality by improving the quality of care women receive during pregnancy, childbirth, and postpartum. CMQCC maintains an informative website of resources and policies for both public and private use (www.cmqcc.org) and provides educational outreach to health professionals /2012/ CMQCC convenes the Pregnancy-Associated Mortality Review (PAMR) Committee and provides TA to local maternity care quality improvement projects. CMQCC also developed and disseminated two toolkits for obstetric care providers: "Improving the Health Response to Obstetric Hemorrhage" and "Eliminating Non-Medically Indicated Deliveries Before 39 Weeks of Gestational Age". //2012// **/2013/ CMQCC is preparing a third toolkit to improve identification and effective therapy for preeclampsia/eclampsia and is developing a maternal data center to track real time maternity care quality improvement efforts at enrolled hospitals//2013//**

Family Voices of California (FVCA)

FVCA helps CSCHN families through a coordinated network of regional, family-run FVCA Council Member agencies. FVCA continues to provide information to families and professionals on issues relating to a Medical Home, including organizing healthcare information and navigating health systems.

FVCA collaborated with DHCS and other partners on various committees, taskforces, senate hearings, and stakeholder groups related to 1115 Waiver, CCS redesign, and the Title V Needs Assessment. FVCA has ensured that parents and community members are involved in these processes, has provided financial support to families to enable their involvement, and has facilitated providing parent and community member input through key informant interviews and focus groups.

/2012/> Maternal Quality Indicator (MQI) workgroup

The MQI workgroup conducts trend analysis of maternal morbidity rates, chronic

conditions that compromise maternal health **//2013 analyzes composite healthcare costs of maternal morbidities. //2013//** and suggests strategies for monitoring quality benchmarks for obstetric hospitals. **//2012//**

>Prenatal Substance Use Prevention

MCAH's efforts related to perinatal substance use prevention are conducted through partnerships and collaboration. MCAH representatives participate in the California Fetal Alcohol Spectrum Disorders (FASD) Task Force, an independent, public-private partnership of parents and professionals from various disciplines committed to improving the lives of Californians affected by FASD and eliminating alcohol use during pregnancy. MCAH also participates in the State Interagency Team FASD workgroup, composed of members from the MCAH, (DSS, Department of Mental Health (DMH), CDE, Department of Developmental Services (DDS) and ADP acting as lead. The goal of the workgroup is to identify interagency and systems issues that provides potential opportunities for prevention/intervention of FASD. **//2013/The FASD Workgroup completed its work and gave its recommendations in May 2010.//2013//**

MCAH LHJs have identified perinatal substance use prevention as a priority. They have engaged in community mobilization and capacity building, and implemented screening, assessment, and referral to treatment programs that address their particular needs.

>Preconception Health Council of CA

One of the key ways that MCAH partners with other entities is through PHCC which was established in 2006 by MCAH and MOD, California Chapter. In May 2009 the PHCC launched its official website: www.everywomancalifornia.org, which is supported by Title V funds. The website contains information for both consumers and providers and includes an interactive section for health professionals featuring discussion forums, opportunities for networking and resource-sharing, and an event calendar. MCAH also received a First Time Motherhood grant from HRSA/MCHB to develop a preconception health social marketing campaign reaching women at increased risk for poor pregnancy outcomes. **//2013/ The Interconception Care Project of California and the California Guidelines for Preconception Care are clinical tools developed through the PHCC that are available to clinicians to guide clinical practice. //2013//**

>Transition Workgroup

CMS recognizes the importance of transitioning health care for CSHCN from pediatric to adult services. During site reviews of new SCCs and CCS programs, the issue of health care transition planning and age and developmentally appropriate care for CSHCN is reviewed and discussed.

CMS formed a statewide Transition Workgroup comprised of healthcare professionals, experts in transition care, former CCS clients and family representatives who worked together on the Branch's Transition Health Care Planning Guidelines for CCS programs. The Guidelines were released in 2009, as a CCS Information Notice.

CMS collaborates with the California Health Incentives Improvement Project (CHIIP) and funded by the Medicaid Infrastructure Grant from the Centers for Medicare and Medicaid Services. As staffing allows, CMS will participate on the CHIIP Youth Transition Advisory Committee.

Business Partners

To further enhance current capacity to provide community based preventive and health care services, expertise in health related services through provision of technical assistance is improved via contractual relationships with clinical and academic health experts. These include:

>Advanced Practice Nurse Program (APN)

APN maintains accredited advanced practice nursing programs. The program goals are to (increase the availability of quality reproductive health care services for childbearing women in underserved areas by preparing nurses in a program that meets state and national guidelines and recruit and enroll students. //2012// **/2013/APN was eliminated effective July 2012.//2013//**

>Branagh Information Group

MCAH contracted with the Branagh Information Group to develop, maintain and provide technical assistance for LodeStar, a comprehensive software package for AFLP agencies conducting case management for pregnant and parenting teens and their children. Branagh Information Group also was contracted to develop and maintain BIH Management Information Services (MIS), a software package for BIH agencies conducting case management. **/2013/Branagh Information Group was contracted to provide Help Desk support and training for the BIH MCAH MIS, a new database for BIH.//2013//**

>The California Adolescent Health Collaborative (CAHC)

MCAH has a contract with CAHC to provide adolescent health expertise, address current adolescent health concerns through technical assistance to the local MCAH programs and other partners. CAHC also supports core activities of ASHWG. //2012/ Through Internet Sexuality Information Service, CAHC reaches adolescents using digital media. //2012//

>California State University, Sacramento (CSUS)

CSUS provides //2012/ and coordinates //2012// CPSP Provider //2012/ Overview and Steps To Take //2012// Training, is developing on-line provider training, and supports statewide //2012/CPSP//2012// meetings.

>Childhood Injury Prevention Program

To reduce injury-related mortality and morbidity among children and adolescents, MCAH contracts with the Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University. CIPPP provides technical support for local MCAH

programs and their partner agencies via face to face meetings, teleconferences, e-mail, a list serve, and literature reviews of the latest injury prevention research.

>Family Health Outcomes Project (FHOP) at the University of California, San Francisco

FHOP provides technical assistance and training, analyzes data for LHJs, provides a current web listing of useful resources, assists in establishing guidelines, and prepares special state reports for MCAH and CMS./2012/FHOP is working with CMS on developing and implementing a family survey for use over the next 5 years./2012//

>Health Information Solutions

With direction from MCAH, Health Information Solutions developed and maintains the Improved Perinatal Outcomes Data Reports (IPODR) website. IPODR allows users to view and download the most recent demographic and hospital data about California mothers and infants. The data are available in tables for the most recent year available, in maps aggregating the past three years, and in graphs displaying a 15-year trend. Information is available at the state, county, and zip code levels.

>Perinatal Profiles at the School of Public Health, University of California at Berkeley

This project produces an annual report that provides information on sentinel indicators of perinatal quality care for all the maternity hospitals and regions in California that may reveal where efforts are needed for the purpose of continuous quality improvement.

/2012/ >Public Health Institute (PHI)

Together with MCAH, PHI conducts medical record abstraction and assists in the data analysis for -PAMR./2012//

>Maternal and Infant Health Assessment (MIHA) with the Center on Social Disparities in Health, University of California in San Francisco

MIHA is an annual survey that collects population-based information about maternal health status, health behavior, knowledge, and experiences before, during and shortly after pregnancy. Findings are disseminated through conference presentations, reports and posting of survey results through the MCAH website.

Select Statewide Programs Serving the MCAH Population

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

As of January 2010, there were 878,005 children enrolled in HF, an approximately 1.6% decrease from the previous year. Of those children, approximately 2.9% (25,878) are being served by CCS for their special health care needs.

Specific to infants, Medi-Cal, HF and Access for Infants and Mothers (AIM) provide health insurance for infants. Medi-Cal reaches infants in households below 200% of FPL. HF reaches infants in households up to 250% of FPL; monthly premiums and co-payments are required. AIM provides state-subsidized third party insurance for infants in households at 200-300% of FPL.

State law requires MRMIB to enroll infants of AIM mothers into HF. AIM infants above 250% will be able to continue in HF up to 2 years of age before having to meet current eligibility. As of January 2010, CCS serves 418 AIM children. /2012/ As of February 2011, 865,480 children were enrolled in HF. Of these, 2.6% (22,130) are served by CCS.//2012//

Rehabilitation services

Services such as physical therapy for SSI beneficiaries under the age of 16 with a CCS medically-eligible diagnosis are served by MTP. Children with mental or developmental conditions receiving SSI are served by the DMH, DDS and CDE. In FY 2009-2010, CCS received 86 referrals. Of these, five were not medically eligible for CCS and two could not be verified. CCS will continue to work with the Disability Evaluation Division to train local staff to conduct CCS medical eligibility evaluations which should result in fewer referrals to CCS.

Family-centered, community-based coordinated care (FCC) for CSHCN

SCCs and hospitals that treat CSHCN who wish to become CCS-approved must meet specific criteria, for FCC. FCC is assessed and recommendations are made as part of the review process by the CMS Branch.

CCS facilitates FCC services for families of CSHCN. CCS allows a parent liaison position in each county CCS to enable FCC. County programs assist families to access authorized services, such as pediatric specialty and subspecialty care, and provide reimbursement for travel expenses, meals, and motel rooms during extended hospital stays. Many county CCS are terminating parent liaison contracts due to state budget cuts.

In 2009 the Children's Regional Integrated Service System (CRISS) annual FCC conference focused on mental health services for children and youth with special health care needs. The conference was co-sponsored with the University Center on Excellence in Developmental Disabilities (UCEDD), FVCA, and CMS. /2012/In 2010 CRISS FCC conference was "Working Together in Challenging Times: CCS, Families and the Community".//2012//

The CRISS NICHQ project to promote medical homes for children with epilepsy in a Sonoma County Federally Qualified Health Center (FQHC) was completed in 2009. CRISS worked with the Sonoma County CCS program to take on responsibility for continuing to convene the project's local oversight committee, and FQHC is continuing activities to support medical homes for children with epilepsy.

Additionally, CRISS makes the parent health notebook and other medical home materials available on its website www.criiss-ca.org. /2013/ **CCS is partnering with CRISS to provide local medical home projects. The first project, the Alameda Medical Home Project is implemented through provider training in medical home concepts, resources, and referral pathways with pediatric practices and clinics that have high volumes of children with special health care needs (CCS).**//2013//

L.A. Partnership for Special Needs Children (LAPSNC), which promotes parent involvement in meetings and on committees, cosponsored an all-day conference entitled “Weathering Difficult Times: Resources for Children with Special Needs and their Families”. Parents served on the planning committee for this meeting and 130 providers and parents were in attendance. /2012/LAPSNC is planning a conference in 2011 focusing on the impact of the 1115 waiver on CSHCN.//2012//

FVCA continues its active role as a significant resource for families and professionals on issues relating to a medical home, including organizing healthcare information and navigating health systems.

In 2009, FVCA created a youth council, Kids As Self Advocates (KASA), that meets once a month via conference call and face to face every other month. CCS has attended some of the KASA meetings, and KASA youth have provided input to CCS on transition issues. KASA youth have received leadership training, and FVCA provides staff time for a youth group coordinator and provides youth with stipends for participation at meetings and travel.

In addition to youth leadership training, FVCA is developing the FVCA Parent Leadership Training Curriculum to prepare families to partner in decision-making and has piloted trainings at the annual Family Resource Supports Institute.

In 2009, FVCA was a collaborative member of “Partners in Policymaking” and worked to provide leadership training to 35 self-advocates and parents of children with developmental disabilities in L.A. County. The 2010 training will be in San Bernardino County.

Over the last eight years, FVCA in collaboration with advocates across the state convened annual statewide Health Summits that have brought together families, professionals, agency representatives, advocates, insurers, health policy experts and legislators to discuss access to affordable and appropriate health care for CSHCN and to develop strategies to address the challenges families face. FVCA funds this conference through its federal MCHB grant and private sponsors, thus providing families with travel scholarships and stipends to be able to attend.

Other FVCA 2009 activities have included: Council’s monthly meetings to address parent and community involvement; hosting 9 statewide webinars for families and professionals on topics such as the Family Opportunity Act, health care transition, nutrition for CSHCN, and impacting legislators; and participation in the Prematurity

Coalition's Summit, providing and organizing a panel on Home Based Community Care to address parent and community involvement during and after hospital stays for families with babies born prematurely.

In 2009 and 2010, FVCA collaborated with DHCS and other partners on various committees, taskforces, senate hearings, and stakeholder groups related to 1115 Waiver, CCS redesign, and the Title V Needs Assessment, ensuring that parents and community members are involved in these processes. FVCA has provided financial support to families to enable their involvement, and has facilitated parent and community member input for interviews, focus groups, and surveys. **/2013/FVCA holds monthly webinars with families of CSHCN. CCS is now participating in these sessions./2013//**

Approaches to Culturally Competent Service Delivery

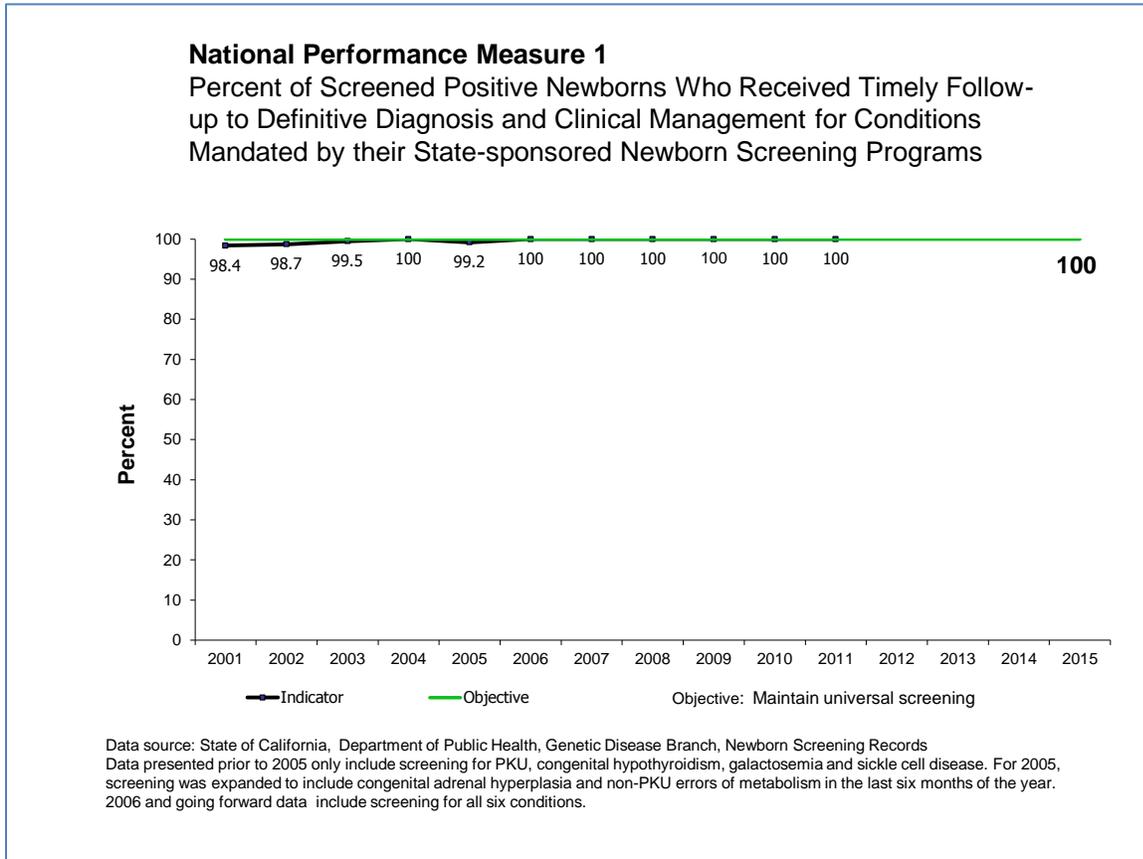
Because California is a cultural melting pot, it is paramount that both MCAH and CMS interact and provide services in a culturally, linguistically and developmentally competent manner with people of diverse backgrounds. Both MCAH and CMS value and respect the diversity of clients our programs serve. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures. Both MCAH and CMS have mechanisms to promote culturally and linguistically competent approaches to service delivery such as:

- BIH delivers culturally competent services to address the problem of disproportionate African American maternal and infant mortality.
- **/2013/CDAPP Resource and Training Center has brochures and teaching aids in English and Spanish, and a food guide in six different languages./2013//**
- MCAH and CMS collect and analyze data according to race, ethnicity, age, etc. to identify disparities.
- MCAH and CMS program materials are mostly published in English and Spanish, and translated to other languages as needed.
- FIMR has posted a guide and tool on the MCAH website for assessing cultural and linguistic competence among their funded agencies.

D. Data Tables

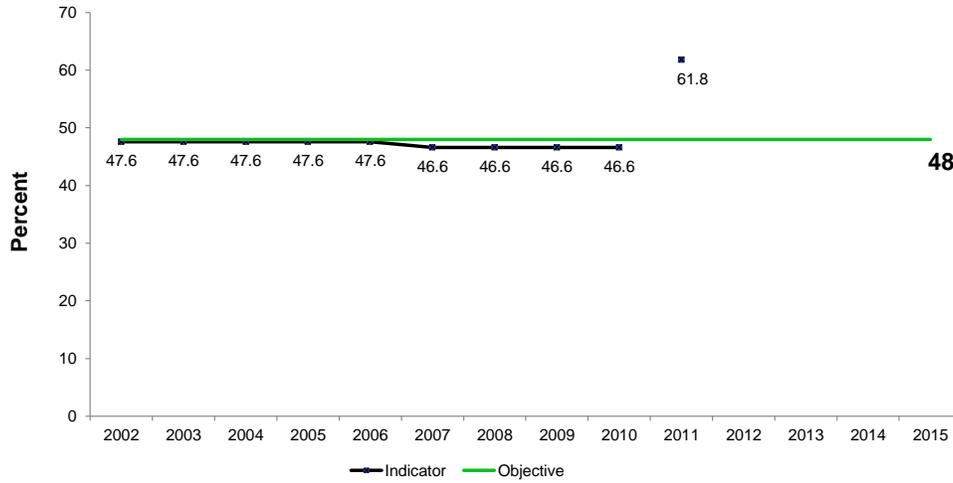
The charts show the trend line for health measures and indicators reported in the Title V Block Grant Application/Annual Report. Proposed targets or annual objectives for performance measures are included in the trend charts.

National Performance Measures



National Performance Measure 2

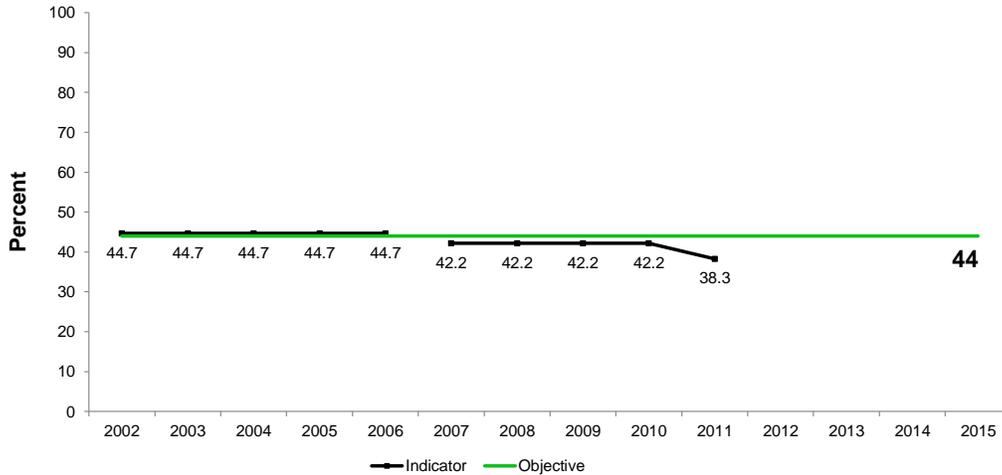
Percent of children with special health care needs age 0 to 18 years of age whose families partner in decision making at all levels and are satisfied with the services they receive



Data source: Centers for Disease Control and Prevention. National Center for Health Statistics, State and Local Area Integrated Telephone Survey. National Survey of Children with Special Health Care Needs (CSHCN)
For 2011, indicator data come from the CSHCN 2009-2010 for which there were wording changes and additions to the questions used to generate this indicator. Therefore data reported for 2011 are not comparable data reported in prior years.

National Performance Measure 3

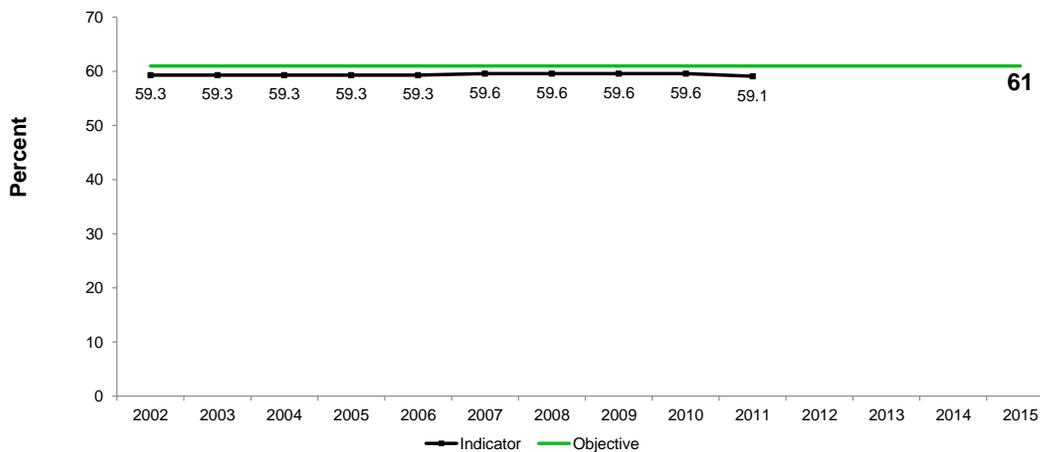
Percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home



Data source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey of Children with Special Health Care Needs (CSHCN)
For the 2005-2006 and 2009-2010 CSHCN Survey there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for 2007 onward.

National Performance Measure 4

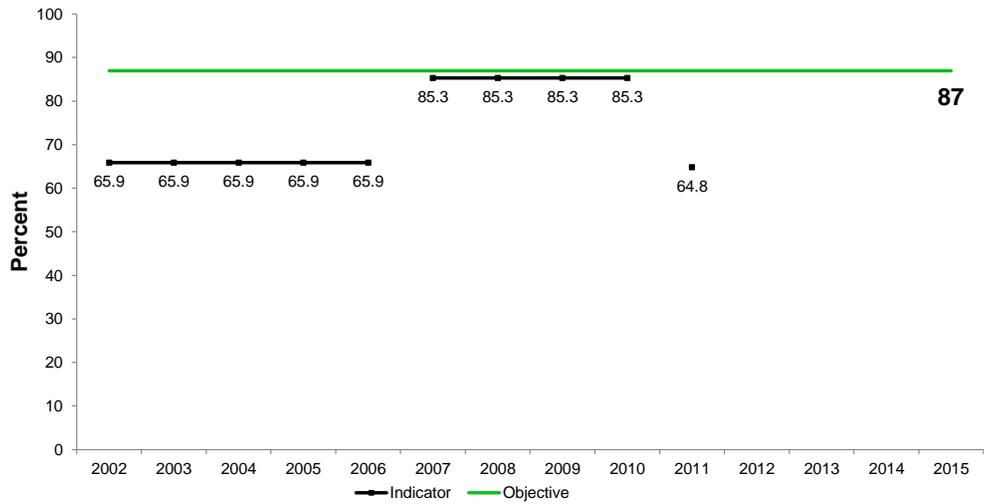
Percent of children with special health care needs age 0 to 18 whose families have adequate private and /or public insurance to pay for the services they need



Data source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs (CSHCN).

National Performance Measure 5

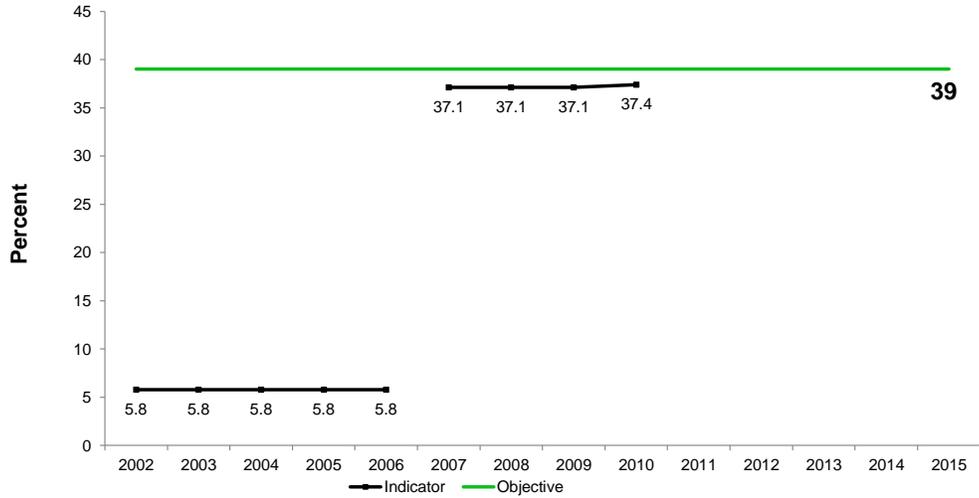
Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily



Data source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs (CSHCN)
Compared to the 2001 CSHCN Survey (used to report indicator for years 2006 and prior), there were revisions to the wording, order, and number of questions used to generate this indicator compared to 2005-2006 CSHCN Surveys (used to report indicator for 2007-2010). The questions were also revised extensively for the 2009-2010 CSHCN Survey. Therefore, none of the three rounds of the surveys are comparable.

National Performance Measure 6

Percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence

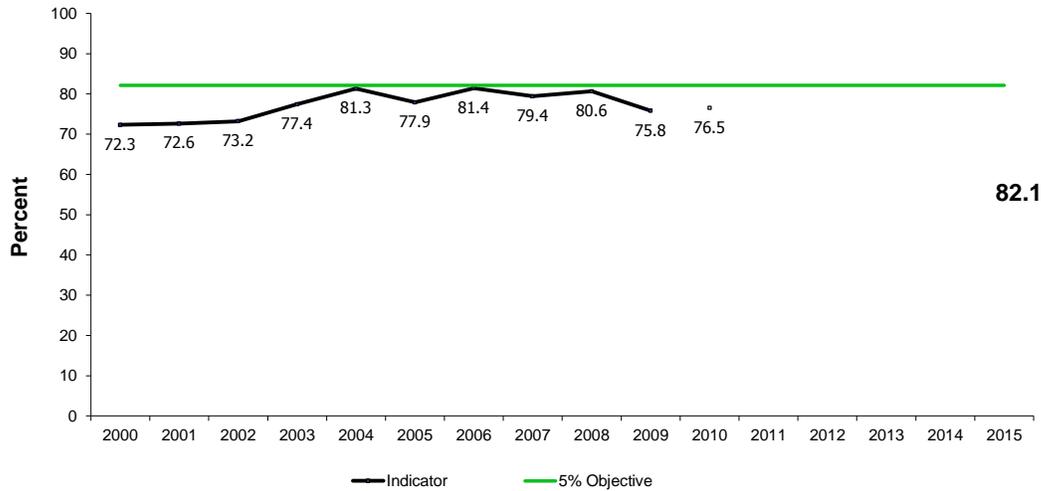


Data source: Centers for Disease Control and Prevention. National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs (CSHCN)
Compared to the 2001 CSHCN Survey (used to report indicator for years 2006 and prior), there were revisions to the wording, order, and number of questions used to generate this indicator compared to 2005-2006 CSHCN Surveys (used to report indicator for 2007-2010). The same questions were used to generate the indicator for 2011 using 2009-2010 CSHCN Survey.



National Performance Measure 7

Percent of 19 to 35 Month Olds Who Have Received Full Schedule of Age Appropriate Immunizations Against Measles, Hemophilus Influenza, Hepatitis B (4:3:1:3:3)

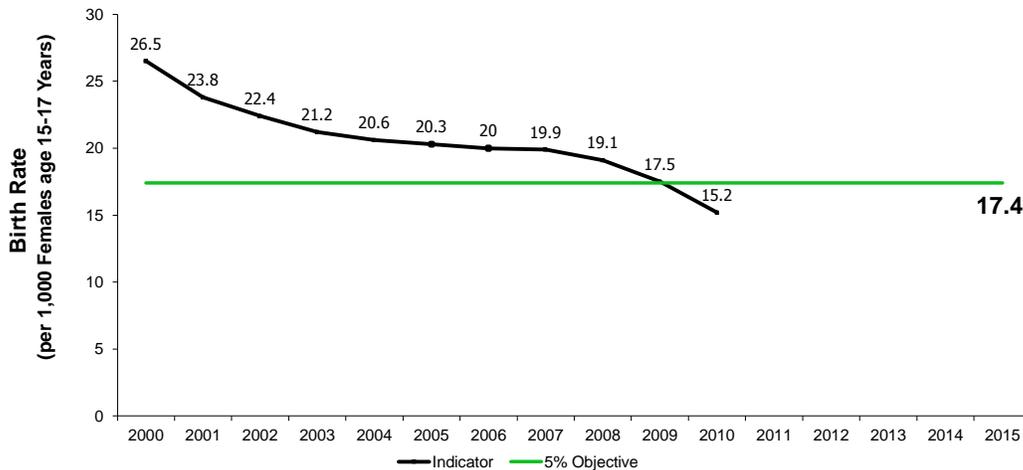


Data source of percent immunized: CDC, U.S. National Immunization Survey, Estimated Vaccination Coverage with 4:3:1:3:3 Among Children 19-35 Months of Age by Race/Ethnicity and by State and Local Area. 2010 data should not be compared to previous years' data due to change in the way Hepatitis B vaccine is measured



National Performance Measure 8

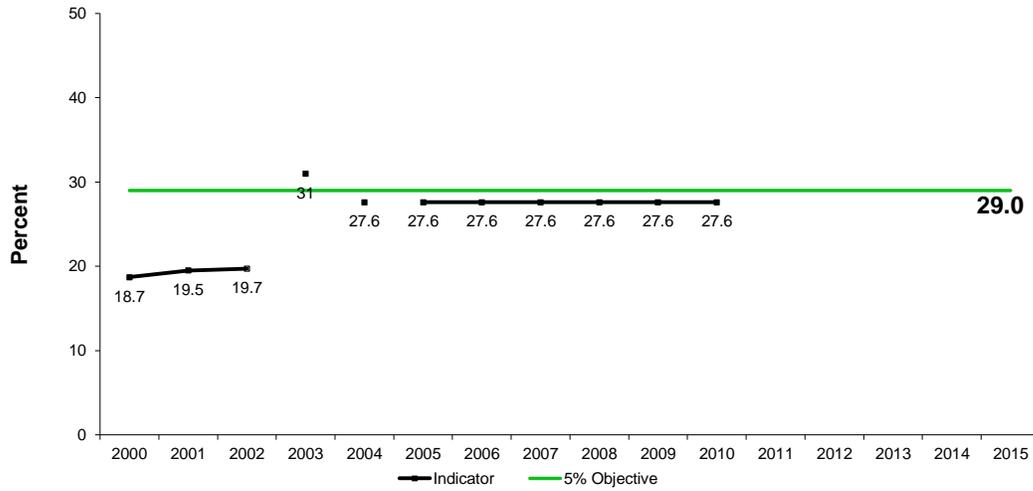
Birth rate (per 1,000) for teenagers aged 15-17 years



Data sources: State of California, Department of Public Health, California Birth Statistical Master File and the State of California, Department of Finance, Population Projections



National Performance Measure 9 Percent of Third Grade Children Who have Received Protective Sealants on at Least One Permanent Molar

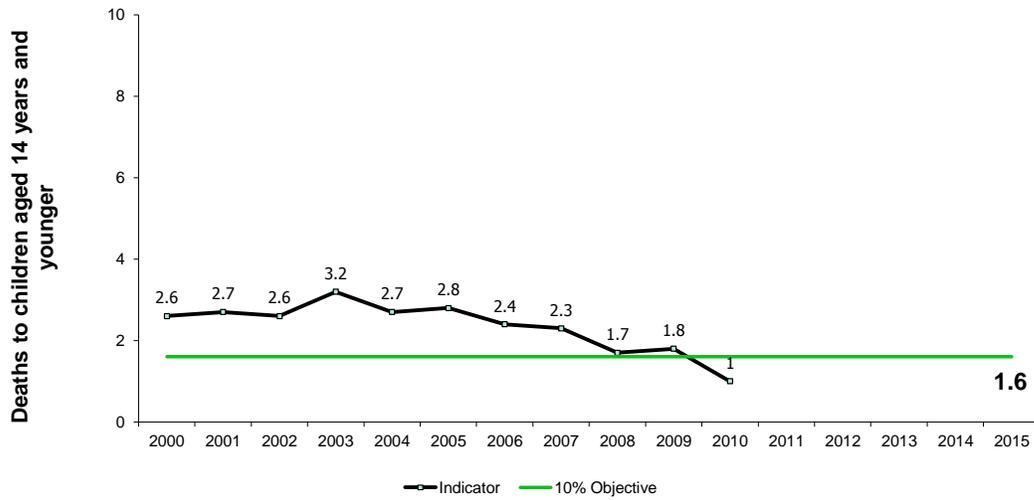


Notes: 2000-2002 data are the California Department of Health Services, Medical Care Statistics Section and Delta Dental Plan, based on 7 to 8 year-old eligible children who received a sealant for that year. Data for 2003 was based on preliminary results of 2005 California Smile Survey conducted by the California Dental Health Foundation. Data starting 2004 was based on the Dental Health Foundation, California Smile Survey: An Oral Health Assessment of California's Kindergarten and 3rd Grade children. The denominator source is the State of California, Department of Education, third graders in 2005.



National Performance Measure 10

Rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children

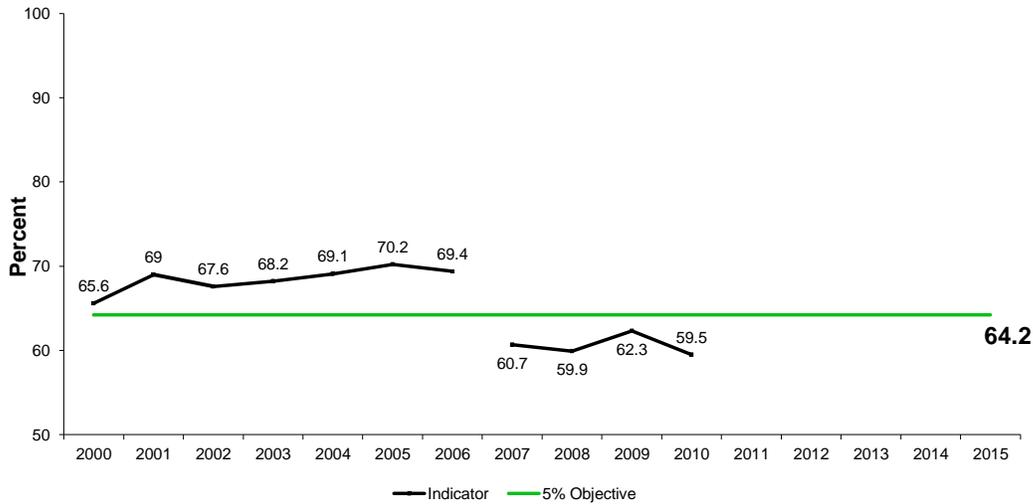


Data source: State of California, Department of Public Health, Center for Health Statistics, California Death Statistical Master File and Department of Finance, Race/Ethnic Population with Age & Sex Detail, 2000-2050, July 2007. Data excludes non-traffic motor vehicle crashes.



National Performance Measure 11

Percent of Mothers Who Breastfeed their Infants at 2 Months of Age

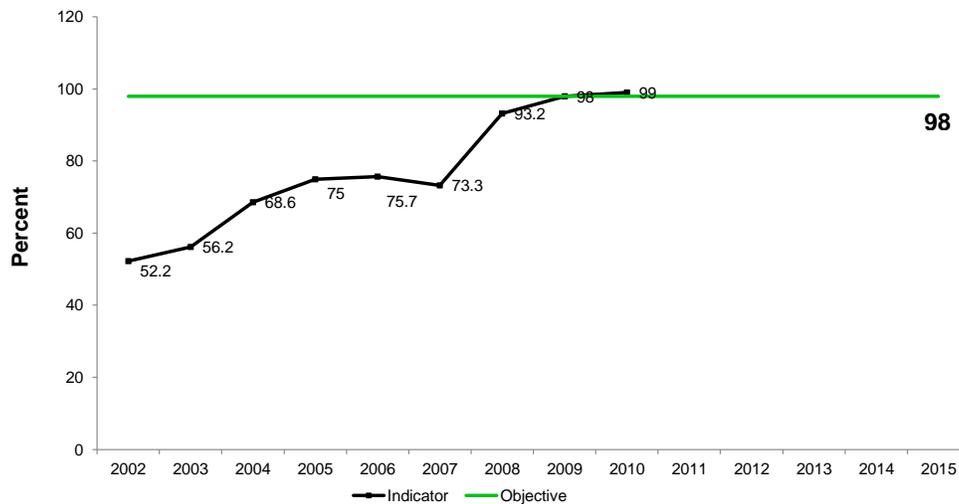


Data source: Maternal and Infant Health Assessment Survey (MIHA), MCAH Program, California Department of Public Health. Beginning in year 2007, the rate presented is for the percent of mothers who breastfeed their infants at 3 months of age. Data should not be compared to prior years, which presents the percent of mothers who breastfeed their infants at 2 months of age.



National Performance Measure 12

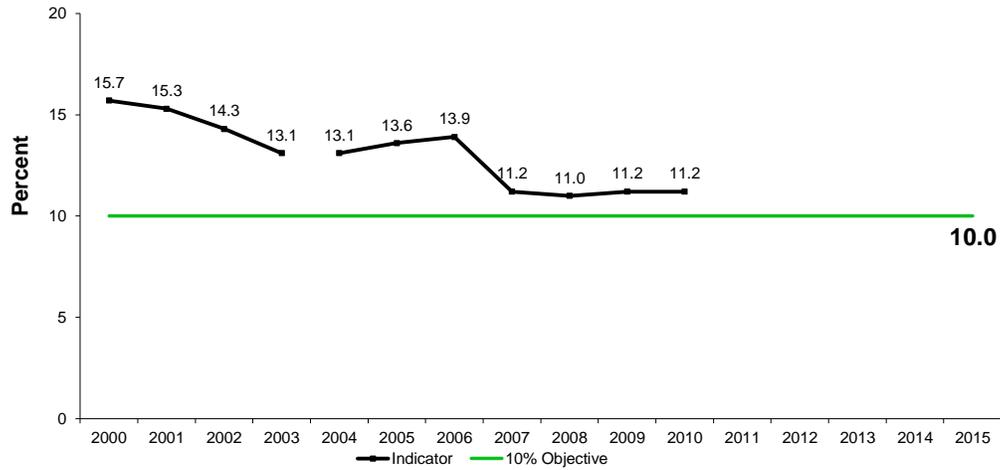
Percentage of newborns who have been screened for hearing before hospital discharge



Data source: State of California, Department of Public Health, Office of Vital Records, birth certificate data.



National Performance Measure 13 Percent of Children Without Health Insurance

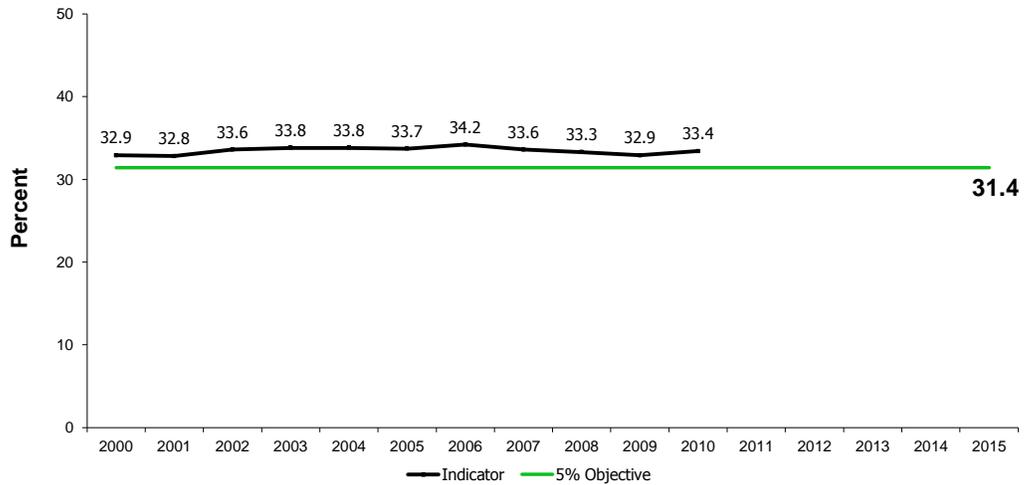


Data source: Data from 2000 to 2002 were from the University of California at Los Angeles, Center for Health Policy Research and based on the Current Population Survey. It includes children from 0 to 18 years of age. Data for 2003 to the current year were from the Kaiser Family Foundation analysis of the Current population survey for children 0 to 18 years of age.



National Performance Measure 14

Percent of Children, Ages 2 to 5, Receiving WIC Services with a Body Mass Index (BMI) at or above the 85th Percentile



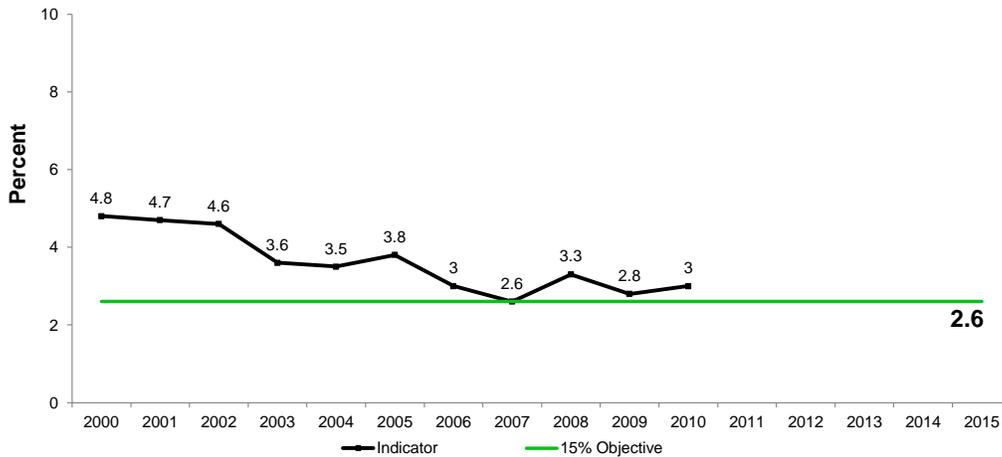
Data Source: CDC, Pediatric Nutrition Surveillance System

Note: Obese: \geq 95th percentile BMI-for-age and gender. Overweight: \geq 85th to $<$ 95th percentile-for-age and gender.



National Performance Measure 15

Percent of Women Who Smoke in the Last 3 Months of Pregnancy

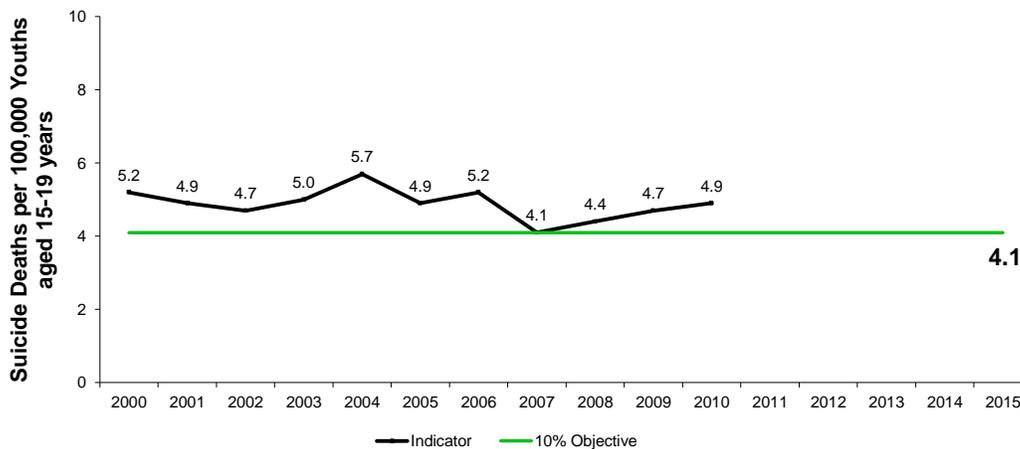


Data source: State of California, Department of Public Health, MCAH Program, Maternal and Infant Health Assessment survey



National Performance Measure 16

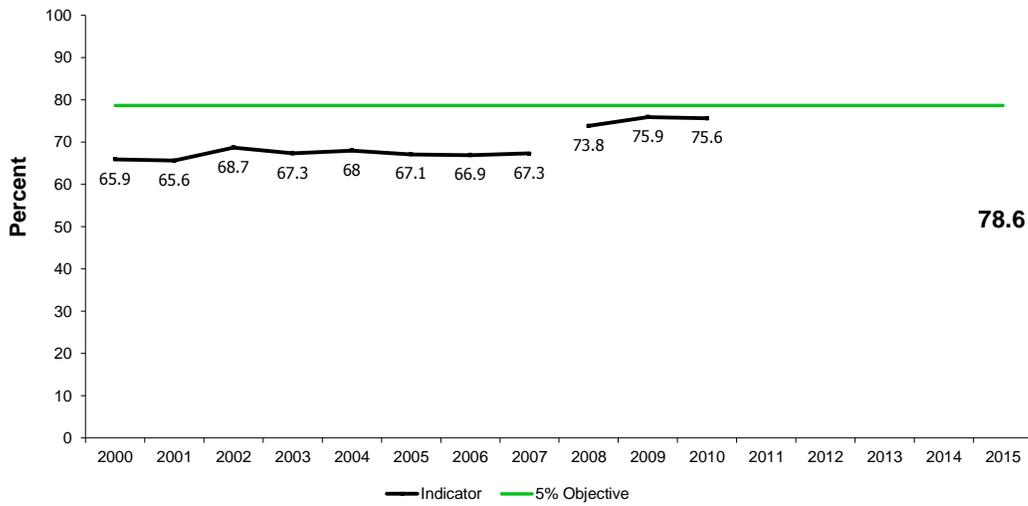
The rate (per 100,000) of suicide deaths among youths aged 15 through 19



Data sources: Deaths: State of California, Department of Public Health, Death Statistical Master Files, 2000-2010; Population projections: State of California, Department of Finance, Race/Ethnic Population with Age & Sex Detail, 2000-2050. Sacramento, CA, July 2007.



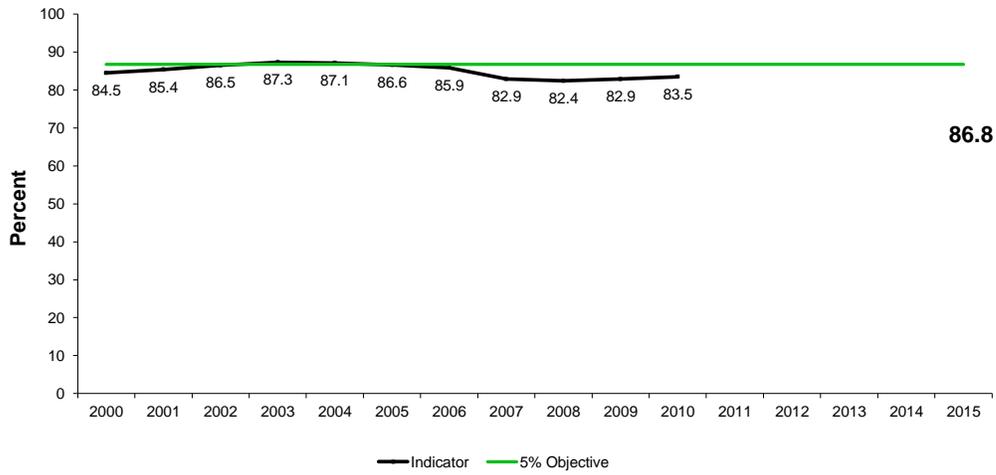
National Performance Measure 17 Percent of Very Low Birth Weight (VLBW) Infants Delivered at High Risk Facilities



Data sources: State of California, Department of Public Health, Center for Health Statistics, Birth Statistical Master File, and State of California, Department of Health Care Services, California Children Services (CCS). Data for 2008-2009 should not be compared to data reported in previous years due to a change in exclusion criteria and methodology.



National Performance Measure 18 First Trimester Prenatal Care Initiation

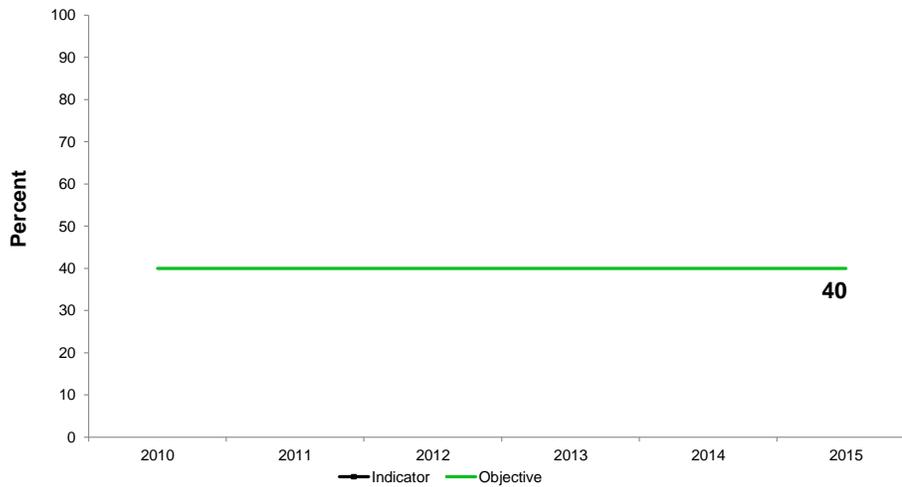


Data source: State of California, Department of Public Health, Center for Health Statistics, Birth Statistical Master File

State Performance Measures

State Performance Measure 1

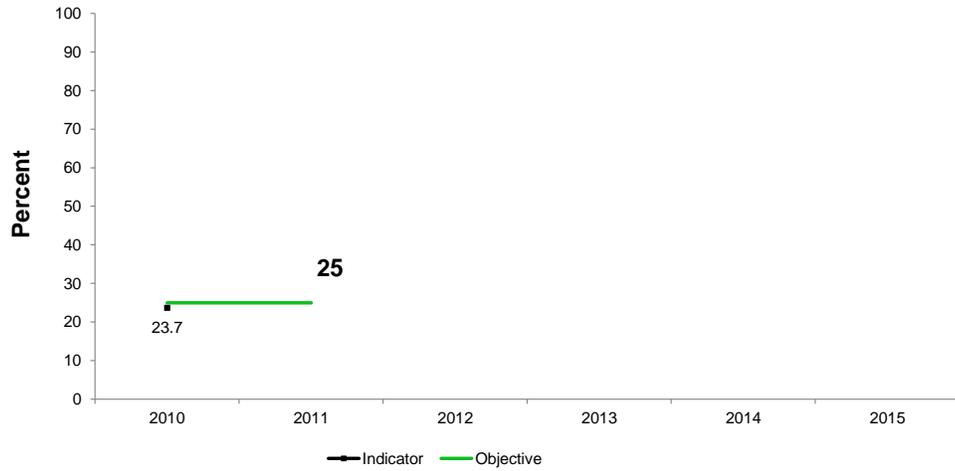
The percent of children birth to 21 years enrolled in the CCS program who have all their health care provided by and coordinated by one health care system



Note: This is a new measure from the 2010 Needs Assessment. The 1115 Federal Waiver CCS Pilot Programs will begin January 2012 so there will be no data for this measure until 2013 for CY 2012.

State Performance Measure 2 (inactivated starting 2011)

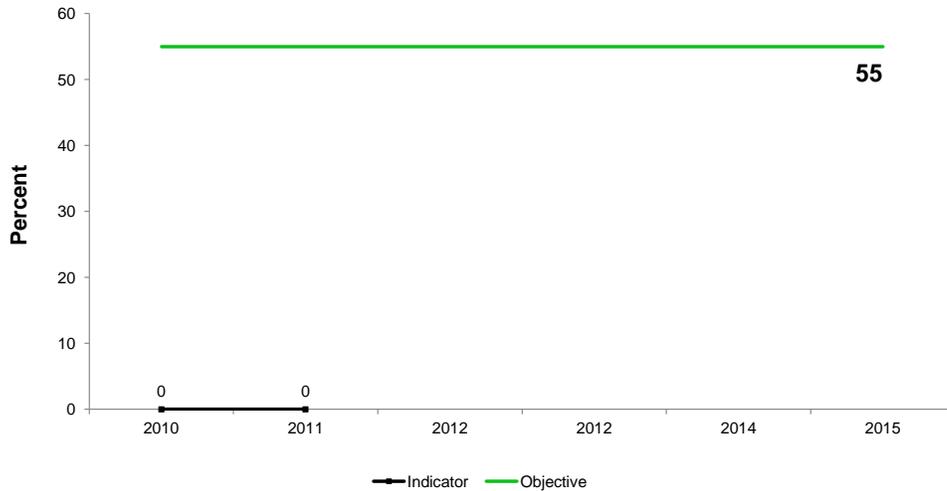
The percent of primary care physicians, approved to participate in the CCS program, who are receiving authorizations for care.



Data source: CCS program listing of approved providers at Cardiac Special Care Centers and CCS ICD 9 codes for cardiac and cardiac related diagnoses for FY 2998-09

State Performance Measure 3

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

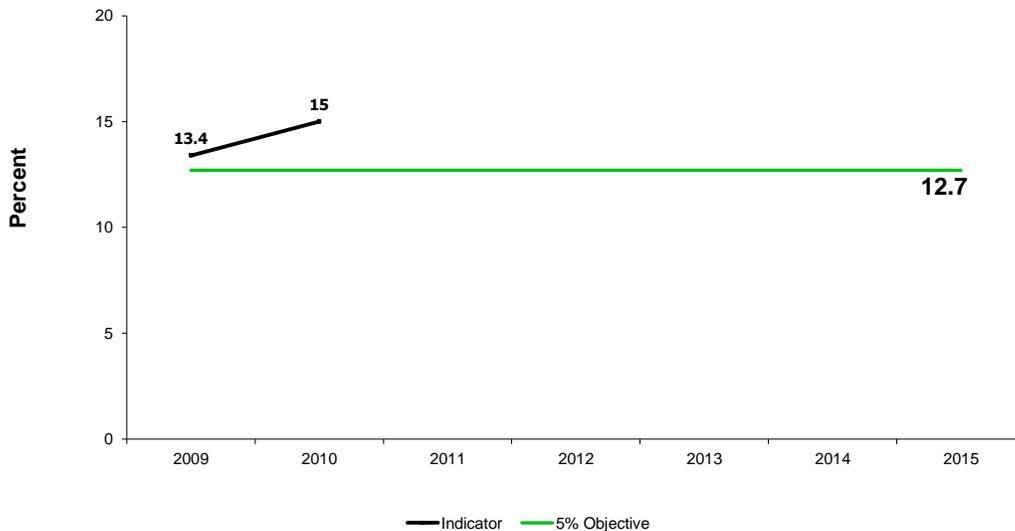


Note: This is a new measure from the 2010 Needs Assessment. No data will be available for this measure until 2013.



State Performance Measure 4

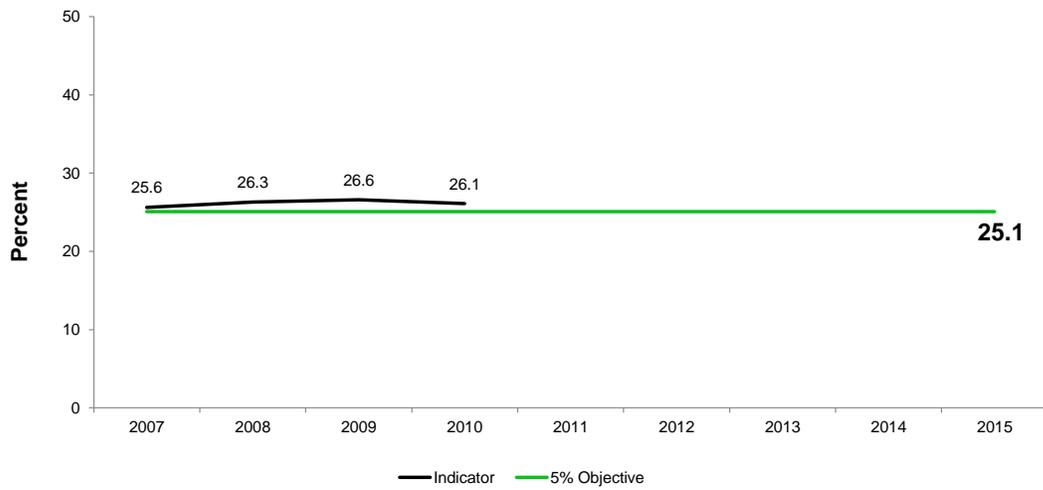
Percent of Women With a Live Birth Who Reported Binge Drinking During the Three Months Prior to Pregnancy



Data source: State of California, Department of Public Health, MCAH Program, Maternal Infant Health Assessment



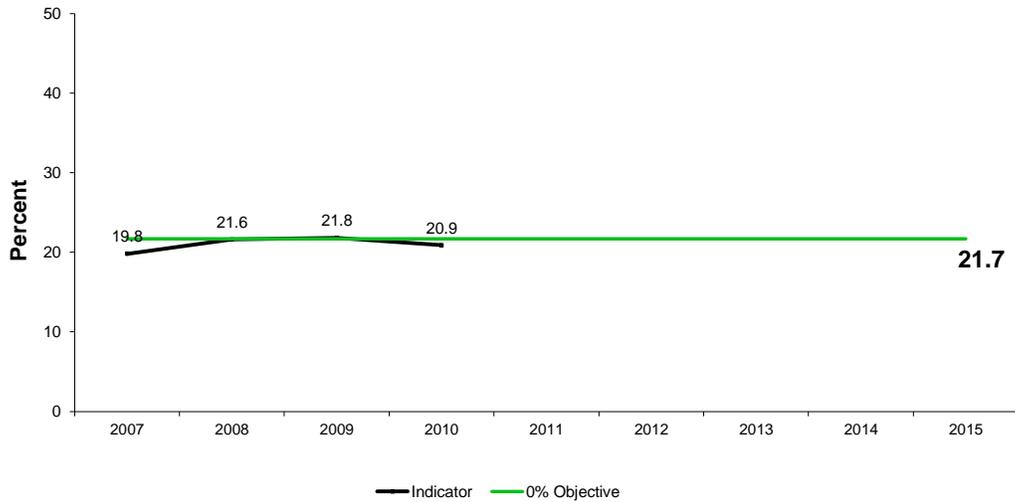
State Performance Measure 5 Percent of Cesarean Births Among Low Risk Women Giving Birth for the First Time



Data source: State of California. Department of Public Health., Center for Health Statistics, Birth Statistical Master File



State Performance Measure 6 The Percent of Women of Reproductive Age Who are Obese

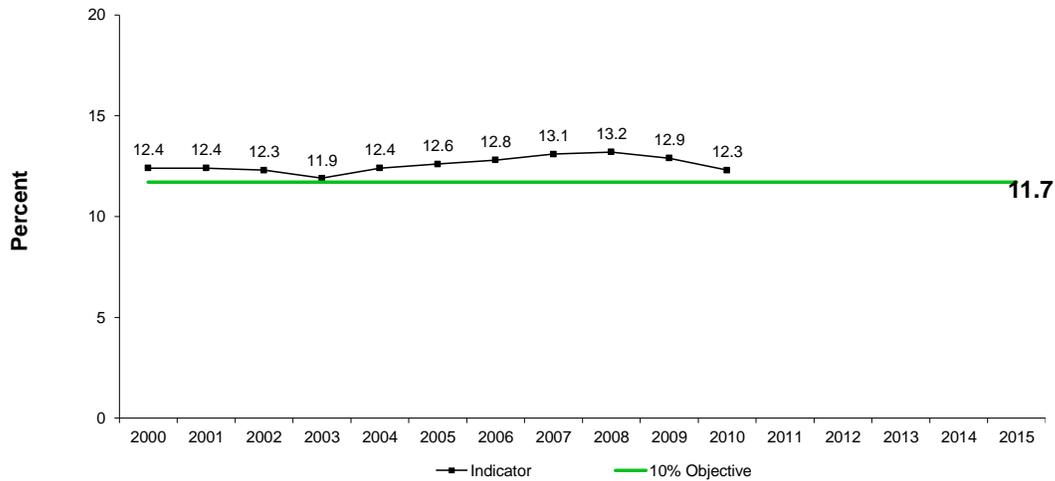


Data source: State of California, Department of Public Health, California Behavioral Risk Factor Survey (BRFS)



State Performance Measure 7

The Percent of Women Whose Live Birth Occurred Less than 24 Months After a Prior Birth

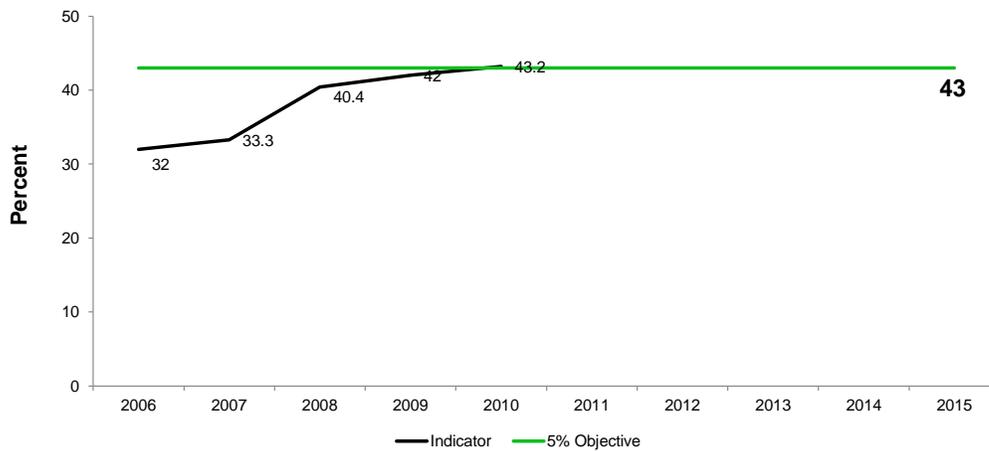


Data source: State of California, Department of Public Health, Center for Health Statistics, Birth Statistical Master File.



State Performance Measure 8

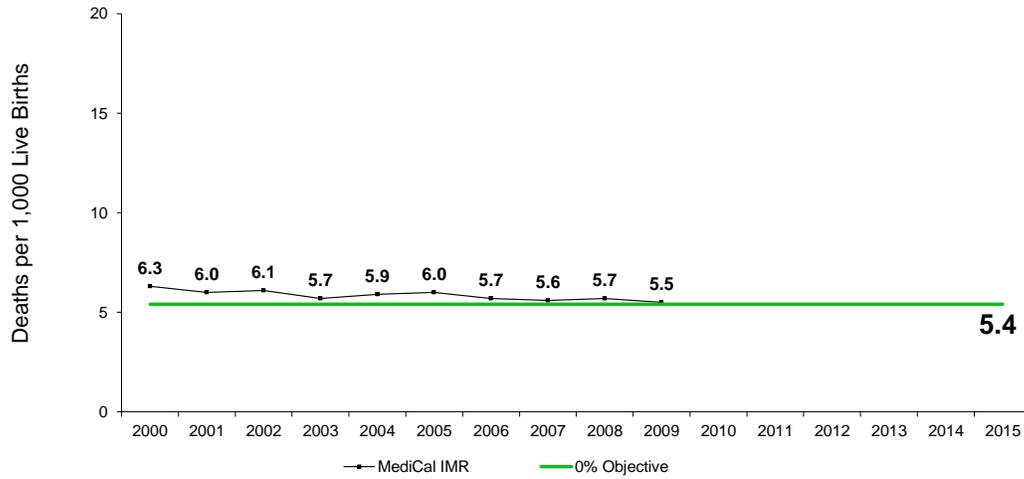
The Percent of Adolescents Reporting a High Level of School Connectedness.



Data source: California Healthy Kids Survey



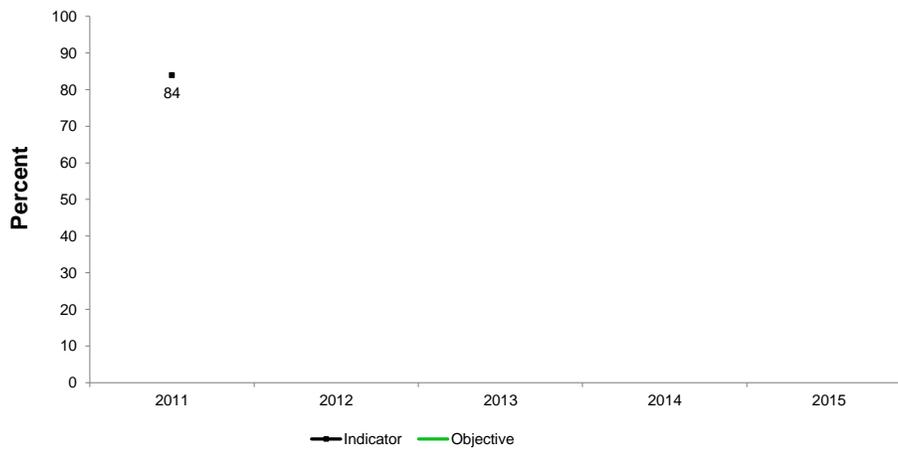
State Performance Measure 9 Low-income infant mortality rate



Data source: State of California, Department of Public Health, Center for Health Statistics, Birth Statistical Master File. Infant mortality rate among MediCal recipients.

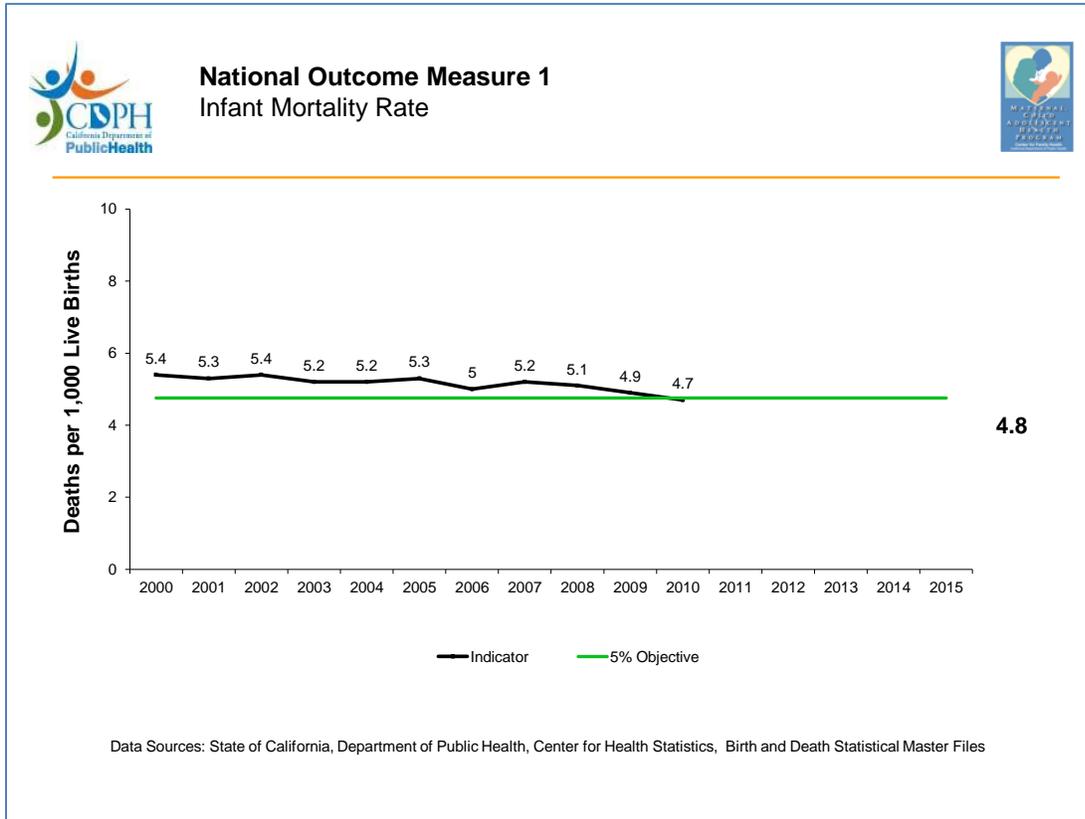
State Performance Measure 10 (active starting 2011)

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



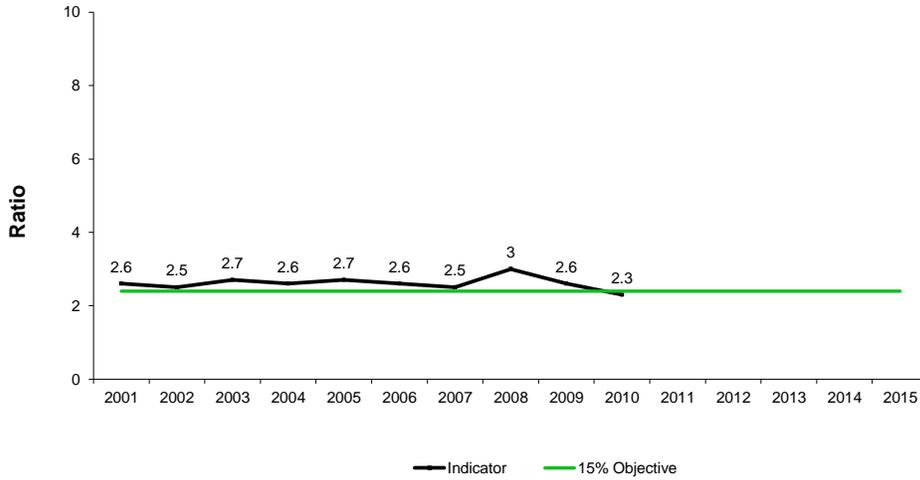
Data source: CCS program listing of approved providers at Cardiac Special Care Centers and CCS ICD 9 codes for cardiac and cardiac related diagnoses for FY 2998-09

National Outcome Measures





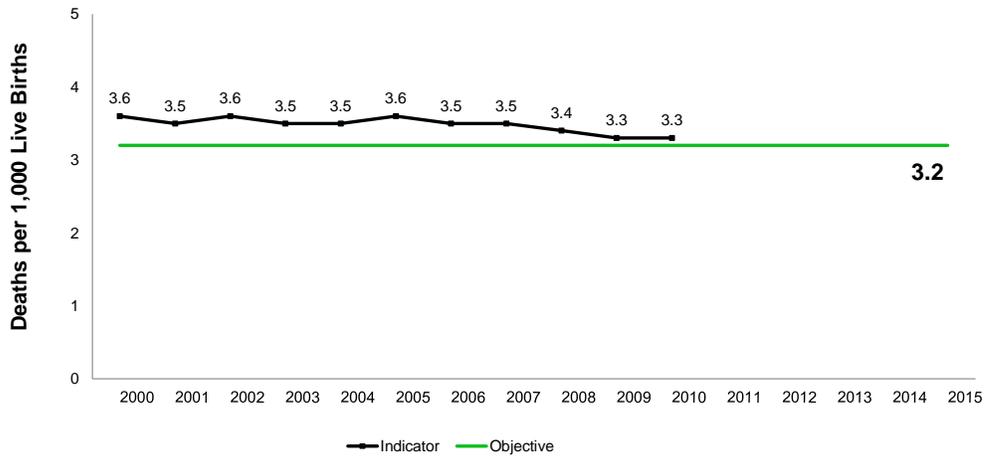
National Outcome Measure 2 Black/ White Infant Mortality Ratio



Data Sources: State of California, Department of Public Health, Center for Health Statistics, Birth and Death Statistical Master Files



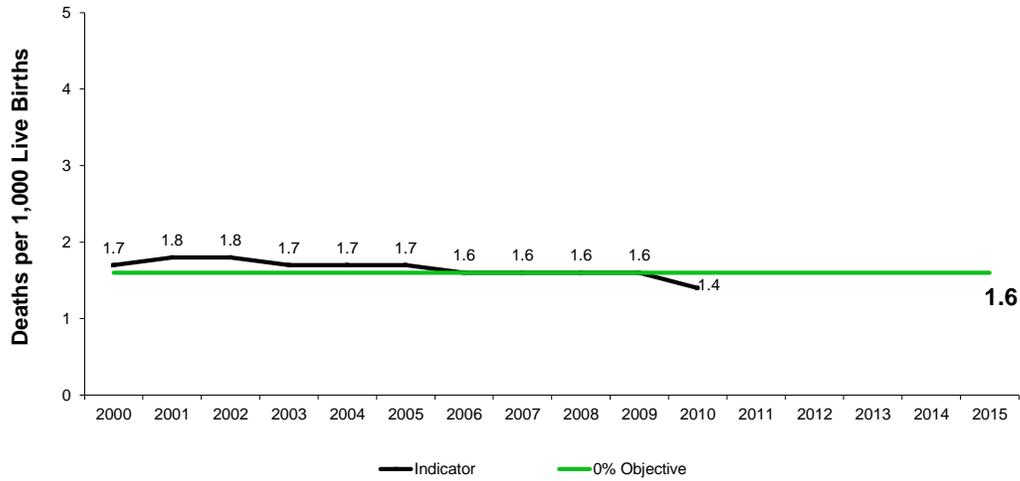
National Outcome Measure 3 Neonatal Mortality Rate



Data source: State of California, Department of Public Health, Center for Health Statistics, Birth and Death Statistical Master File.
Note: Neonatal Mortality: Deaths < 28 days



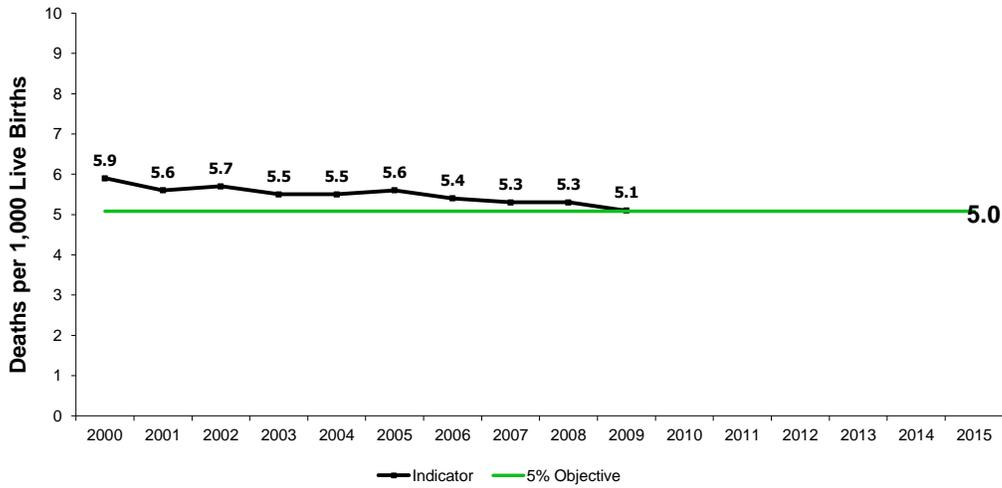
National Outcome Measure 4 Post-Neonatal Mortality Rate



Data Source: State of California, Department of Public Health, Center for Health Statistics, Death Statistical Master File.
Note: Post-Neonatal Infant Mortality: Deaths 28 days to 1 year of age.



National Outcome Measure 5 Perinatal Mortality Rate

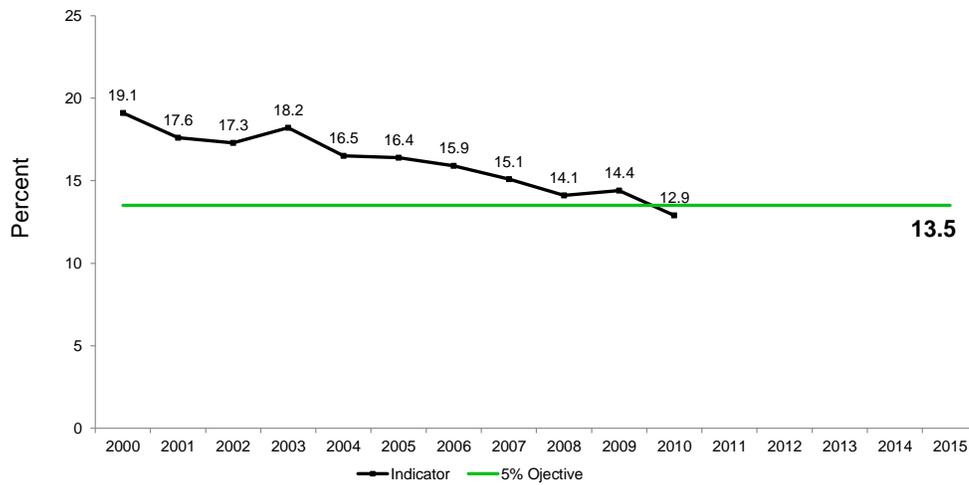


Data source: State of California, Department of Public Health, Center for Health Statistics, Fetal Death, Birth and Death Statistical Master Files.

Note: Perinatal Mortality: Stillbirths and deaths to 1 week of age.

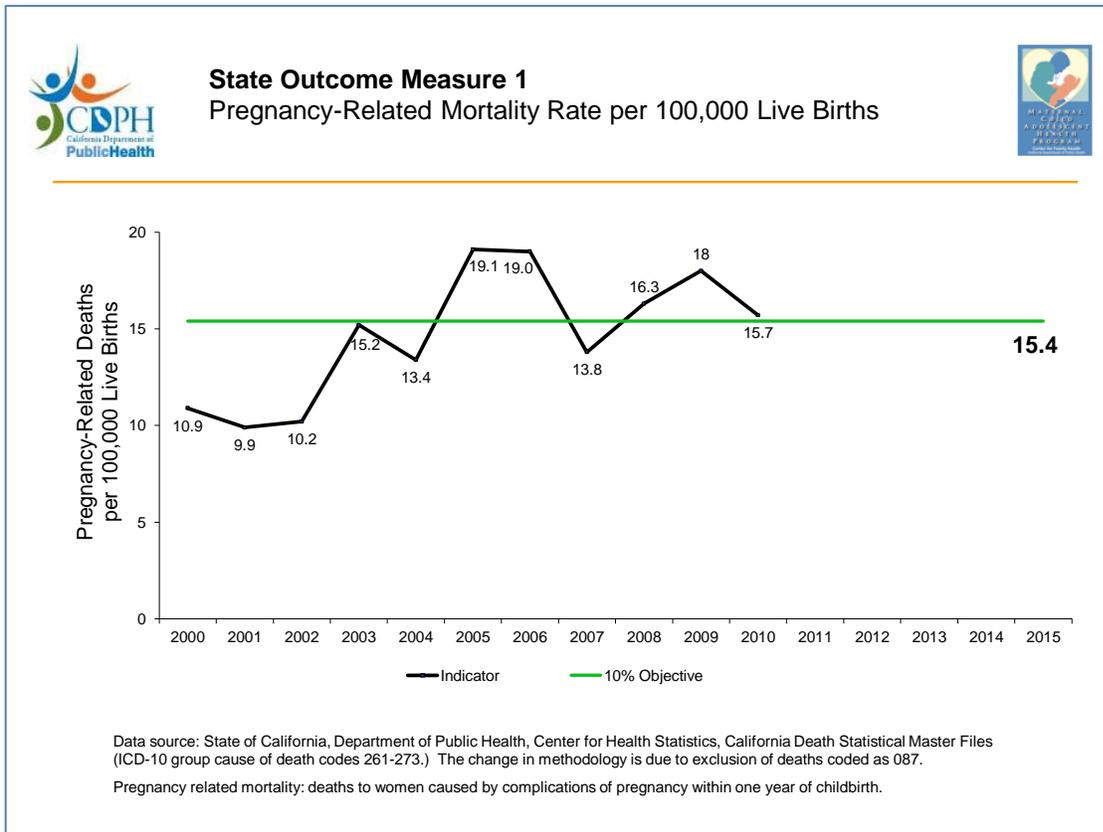


National Outcome Measure 6 Death Rate per 100,000 Children 1-14 Years of Age



Data source: State of California, Department of Public Health, Center for Health Statistics, California Death Statistical Master File by place of residence. State of California, Department of Finance, Race/Ethnic Population w/Age & sex Detail, 2000-2050, July 2007

State Outcome Measure

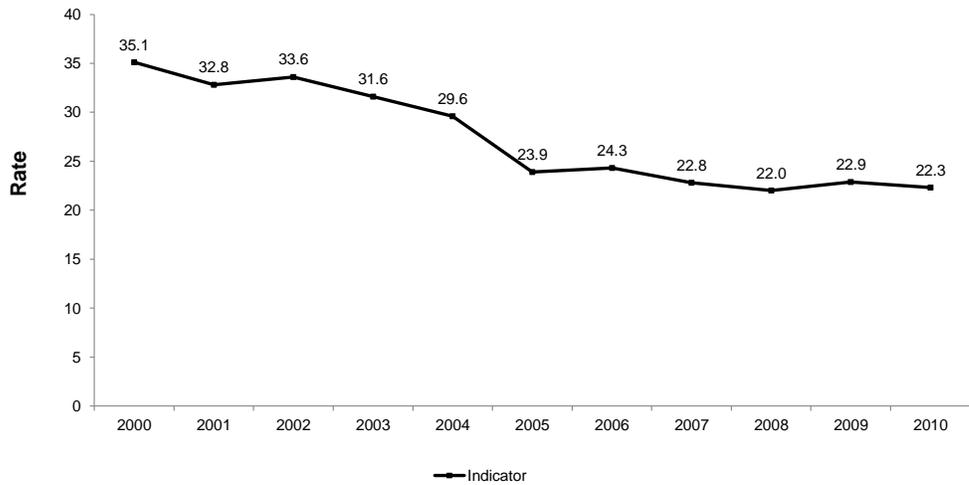


Health Systems Capacity Indicators



Health Systems Capacity Indicator 1

The asthma hospitalization rate for children <five years old per 10,000

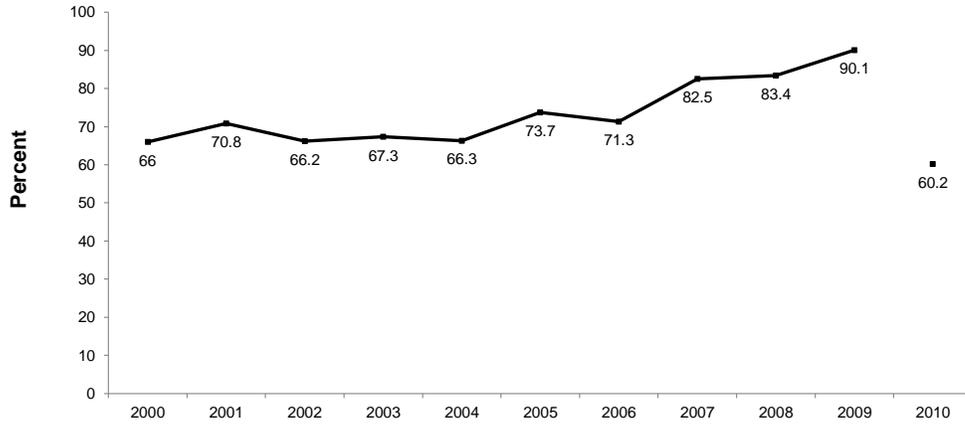


Data source: State of California, Office of Statewide Health Planning and Development



Health System Capacity Indicator 2

The percent of Medicaid enrollees < 1 year of age that received an initial periodic screen

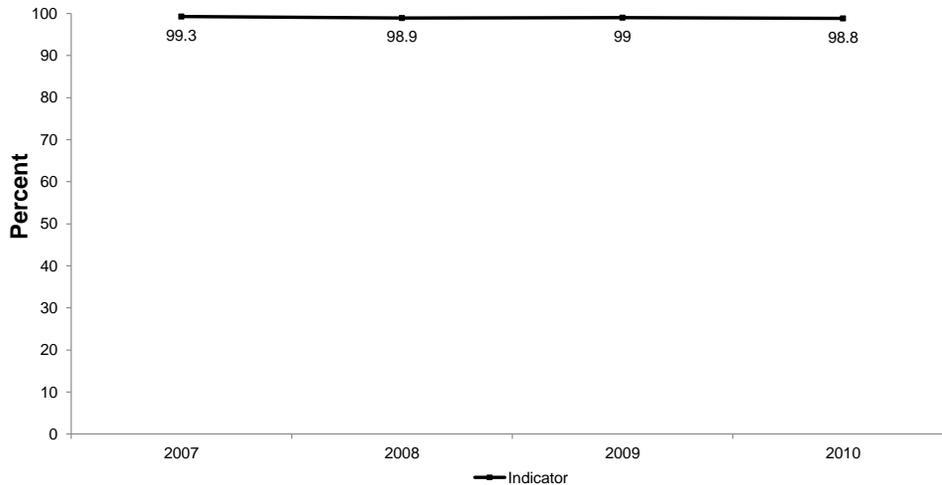


Data source: For 2010, Form CMS-416 Annual EPSDT Participation Report; for prior years, CHDP program data and Medi-Cal. Therefore, data reported for 2010 not comparable to previous years data for this indicator.



Health Systems Capacity Indicator 3

The percent State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen

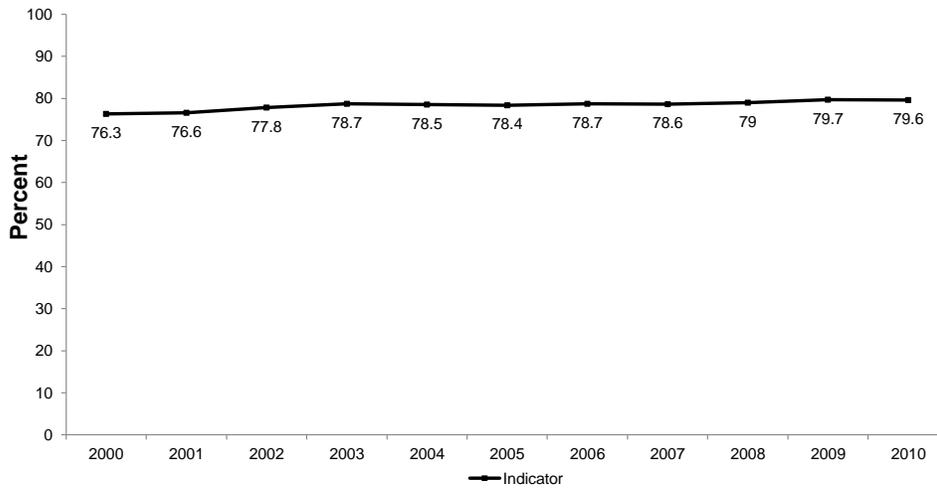


Data Source: Healthy Families, Healthcare Effectiveness Data and Information Set (HEDIS)
Data provided above is for children 15 months or less, continuously enrolled in managed care and received one well child visit



Health Systems Capacity Indicator 4

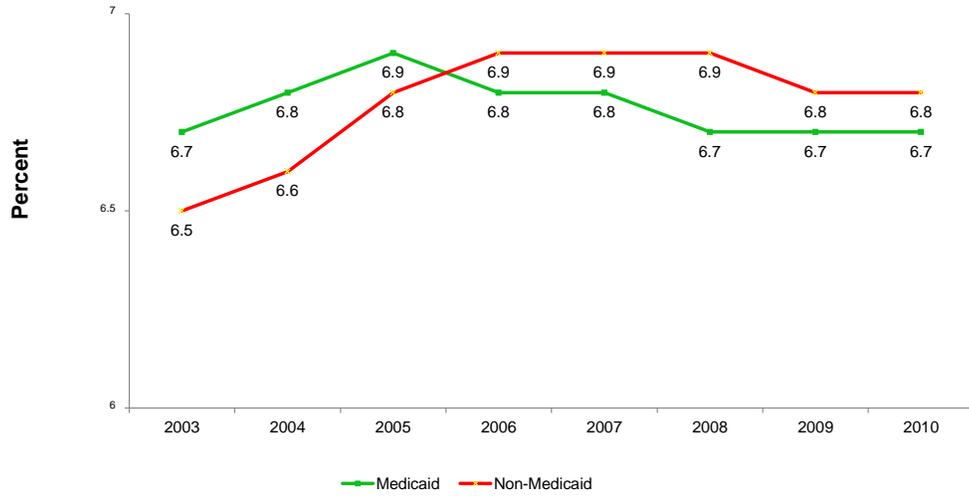
The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index



Data Source: Birth Statistical Master File



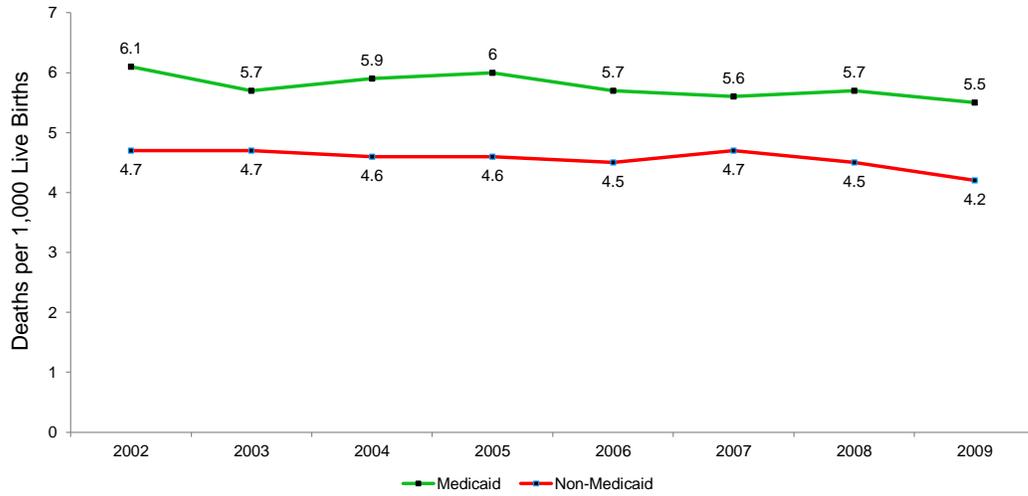
Health Systems Capacity Indicator 5A Percent of low birth weight <2500 grams



Data source: State of California Birth statistical Master File



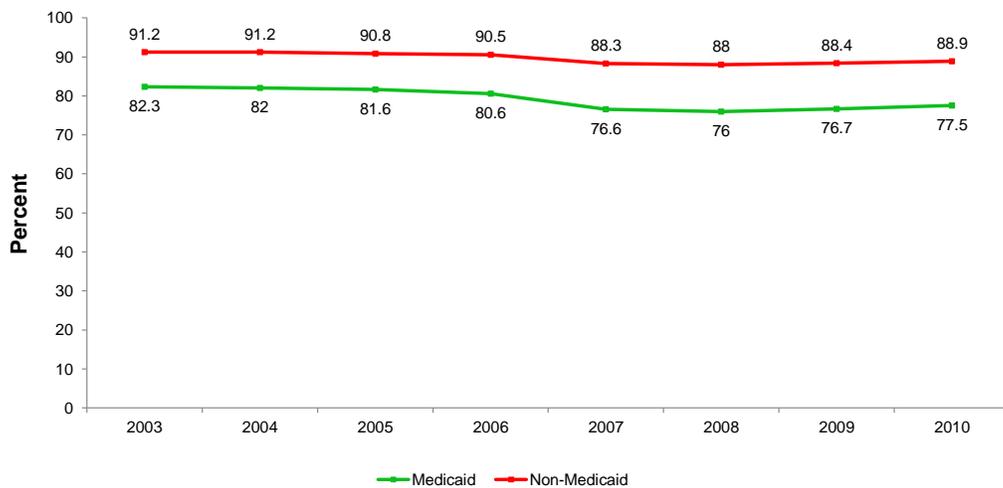
Health Systems Capacity Indicator 5B Infant deaths per 1,000 live births



Data source: State of California Birth Cohort File



Health Systems Capacity Indicator 5C Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

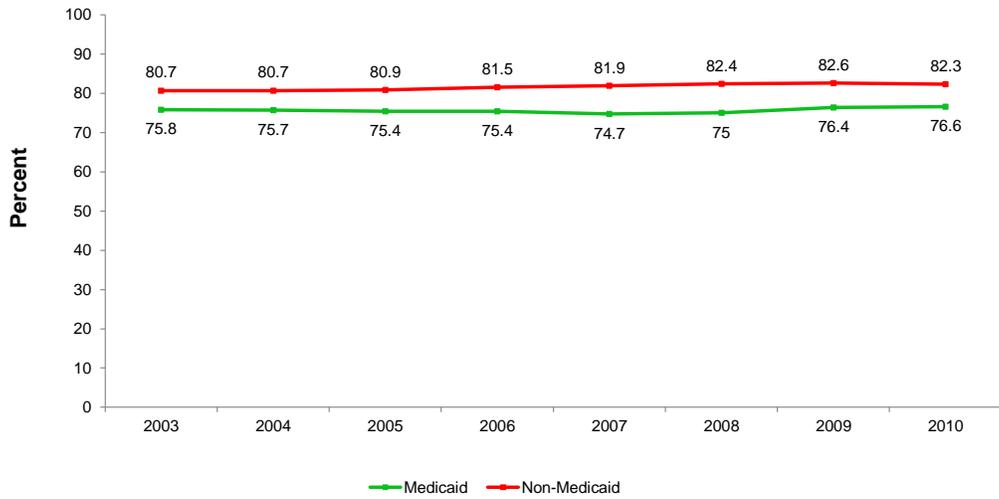


Data source: State of California Birth Statistical Master File



Health Systems Capacity Indicator 5D

Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])

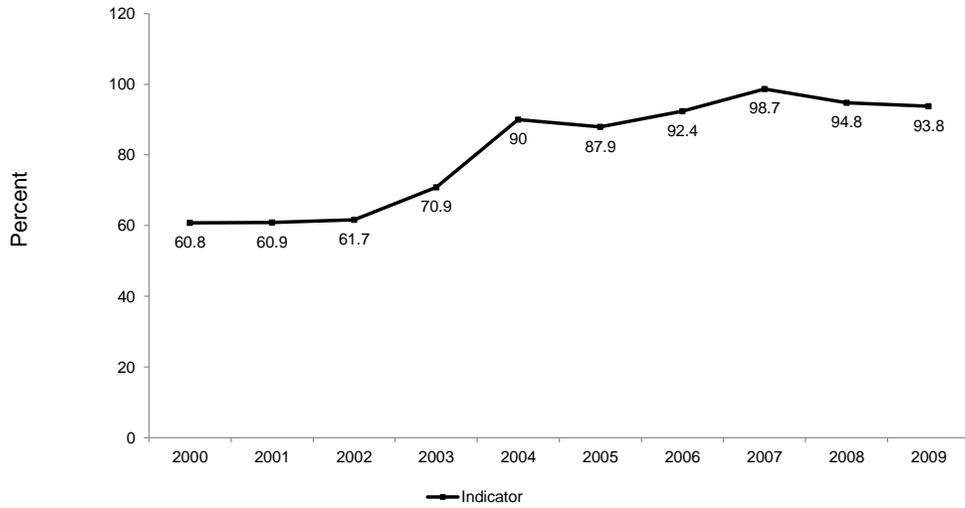


Data Source: State of California Birth Statistical Master File



Health Systems Capacity Indicator 7A

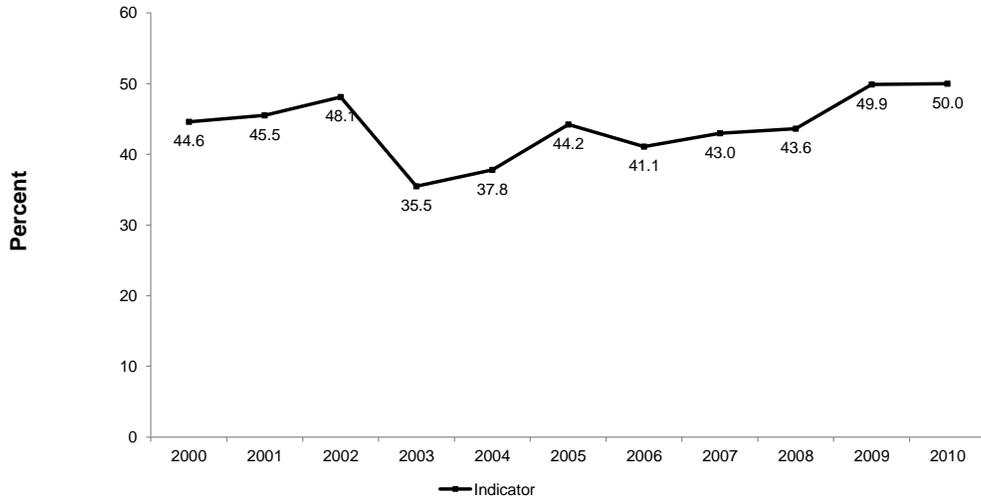
Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program



Data source: California Department of Health Care Services, Fiscal Forecasting and Data Management Branch

Health Systems Capacity Indicator 7B

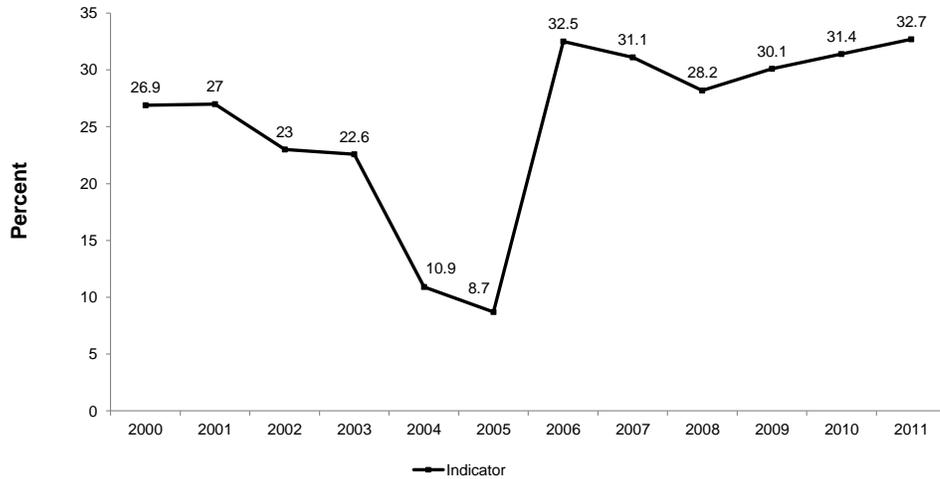
The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year



Data source: revised HCFA-416 Form

Health Systems Capacity Indicator 8

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program



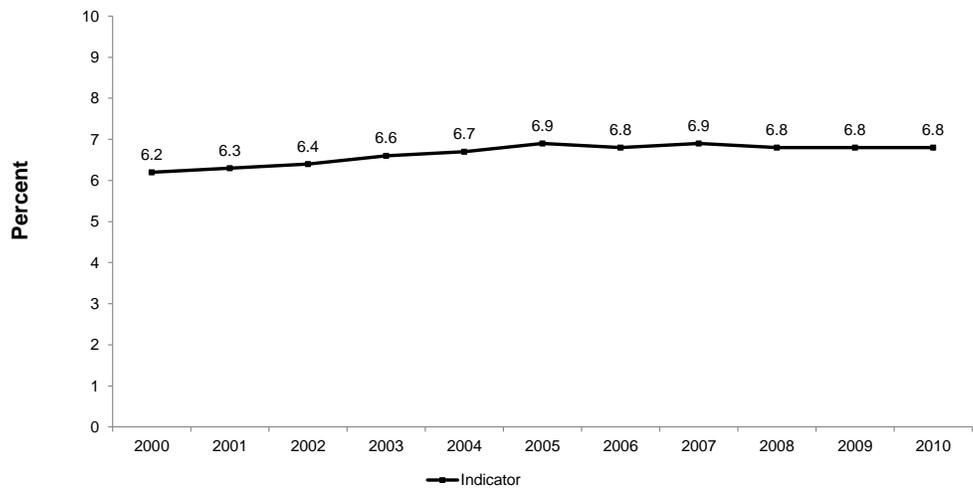
Data source: CMS Net and CCS program data

Health Status Indicators



Health Status Indicators 1A

The percent of live births weighing less than 2,500 grams

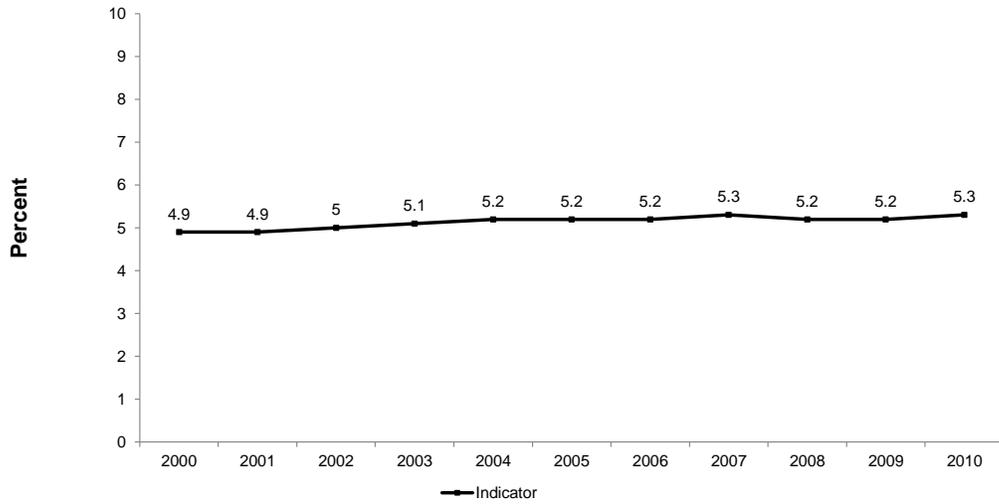


Date source: State of California Birth Statistical Master File



Health Status Indicators 1B

The percent of live singleton births weighing less than 2,500 grams

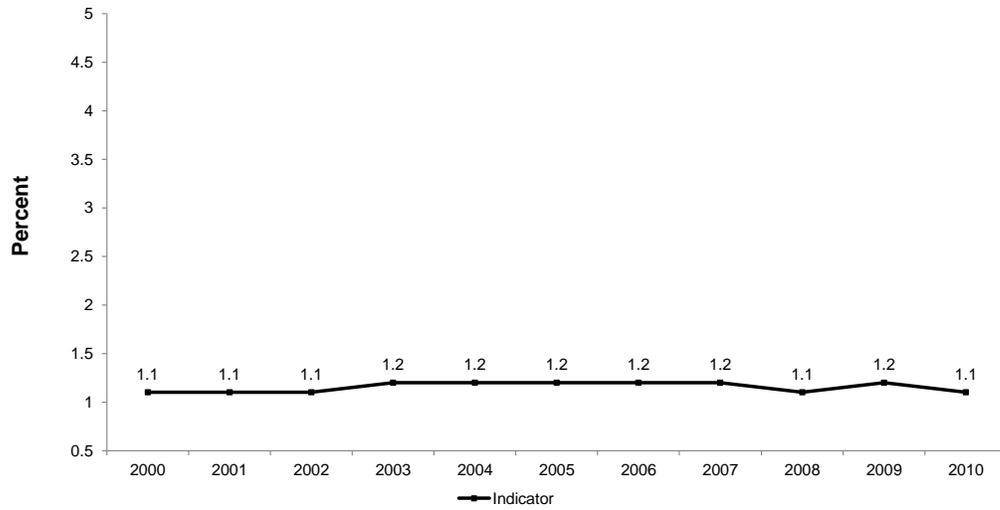


Data source: State of California Birth Statistical Master File



Health Status Indicators 2A

The percent of live births weighing less than 1,500 grams

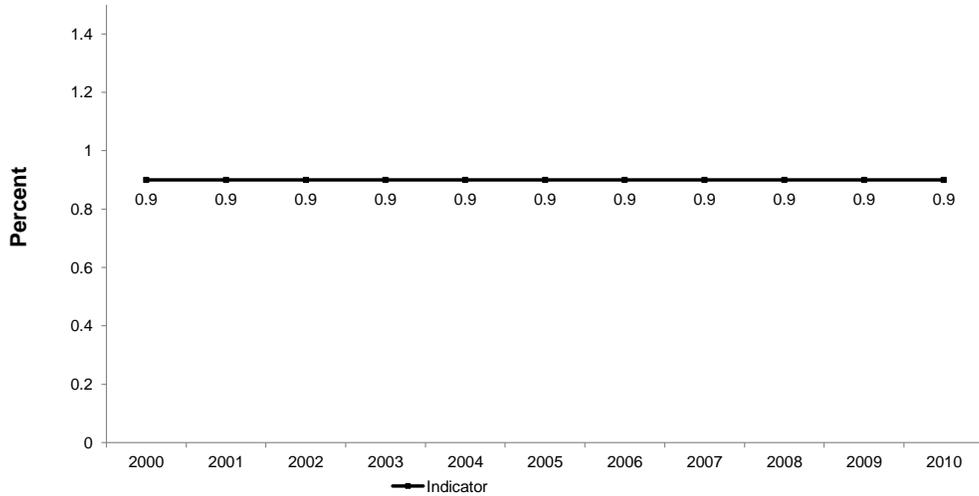


Data source: State of California Birth Statistical File



Health Status Indicators 2B

The percent of live singleton births weighing less than 1,500 grams

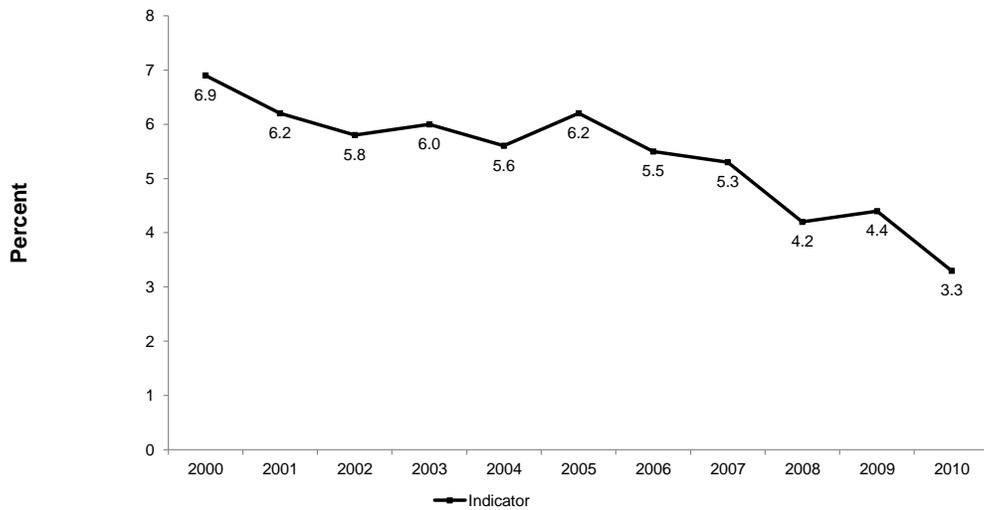


Data source: State of California Birth Statistical File



Health Status Indicators 3A

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger

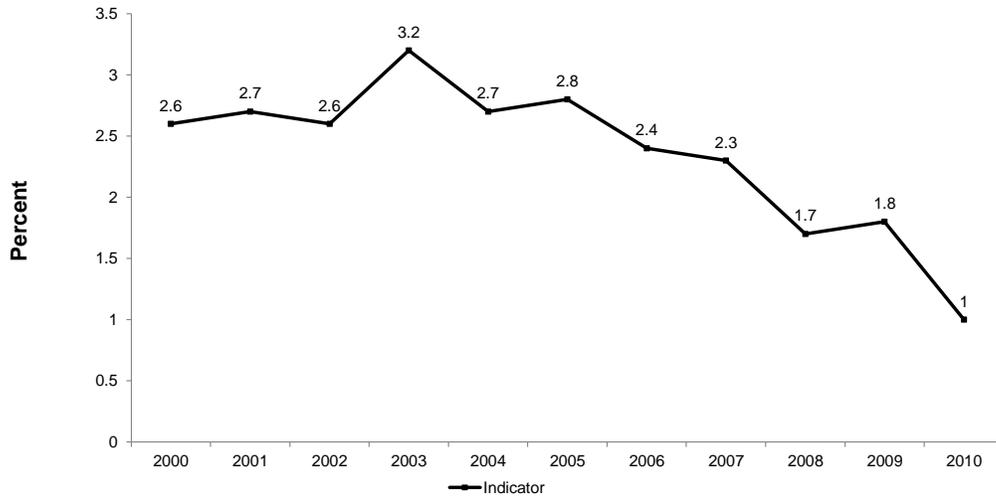


Data source: State of California Death Statistical Master Files



Health Status Indicator 3B

The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes

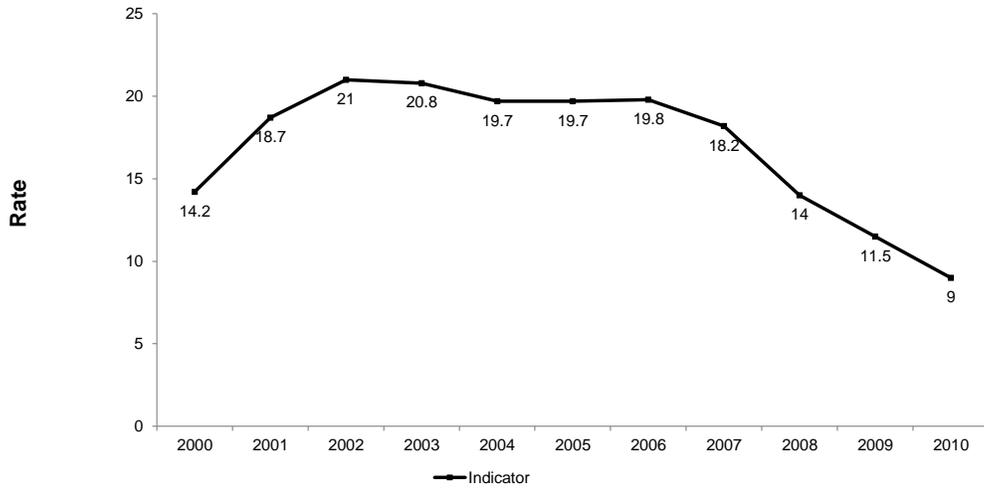


Data source: State of California Death Statistical Master Files



Health Status Indicators 3C

The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years

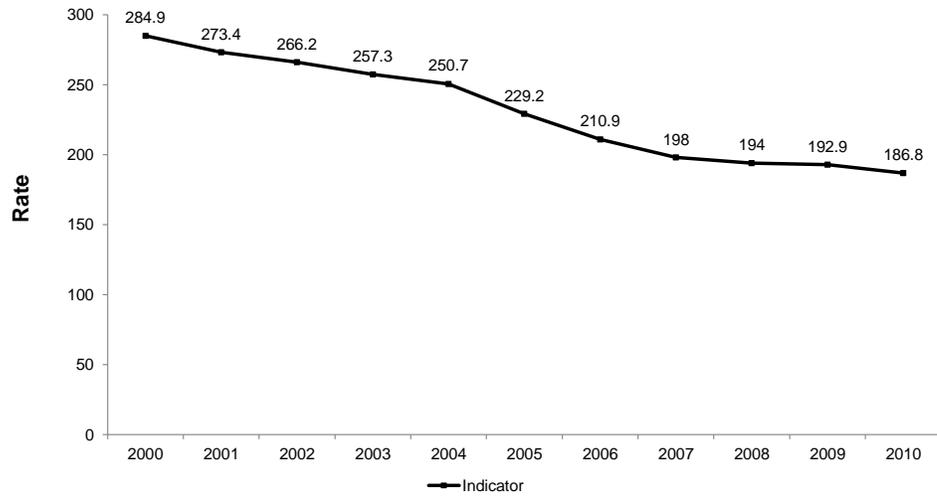


Data source: State of California Death statistical Master Files



Health Status Indicators 4A

The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger

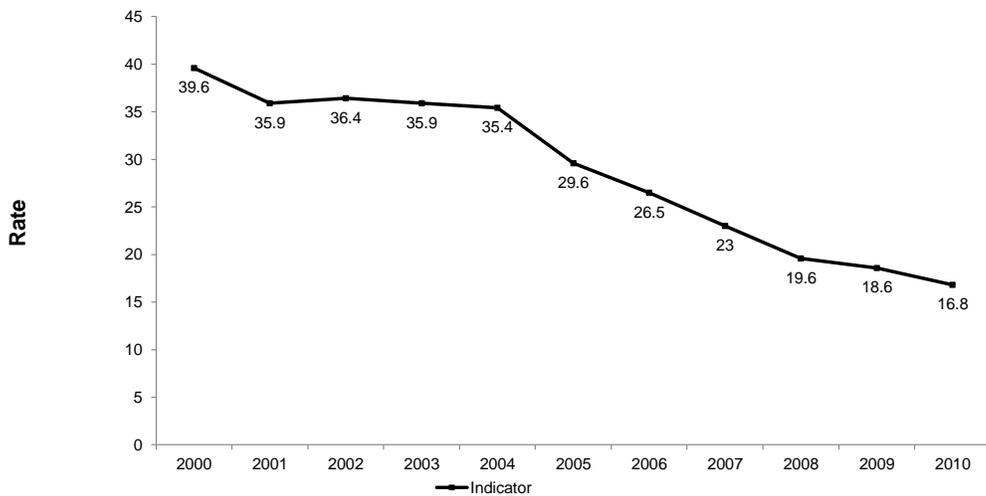


Data source: State of California Hospital Discharge Data



Health Status Indicators 4B

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger

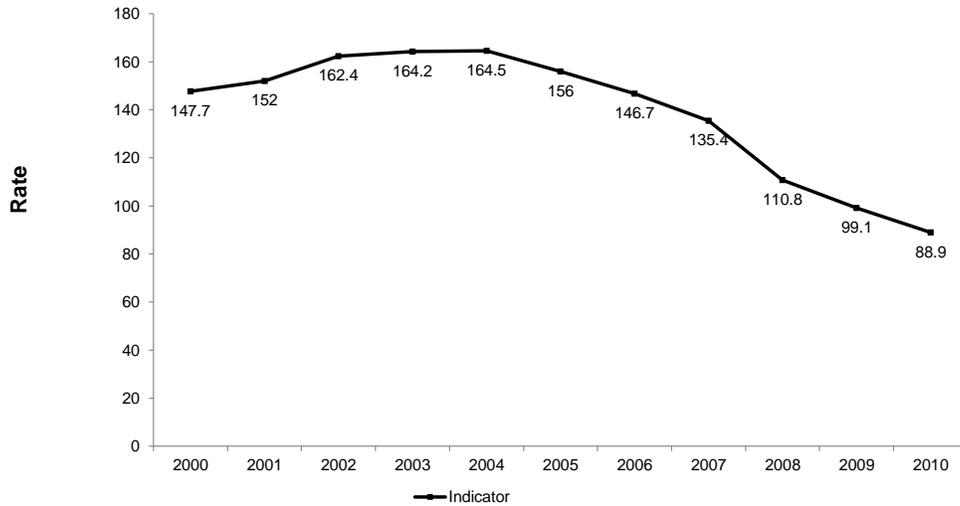


Data source: State of California Hospital Discharge Data



Health Status Indicators 4C

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years

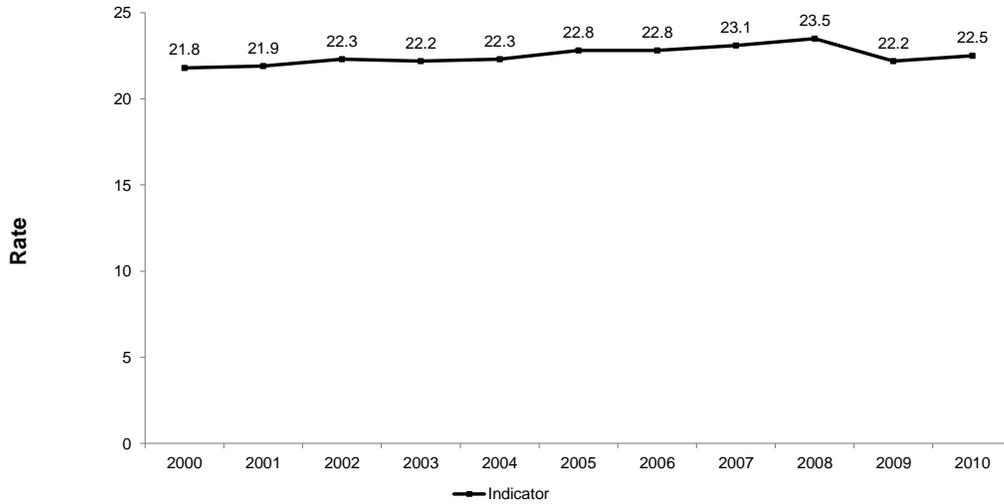


Data source: State of California Hospital Discharge Data



Health Status Indicators 5A

The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia

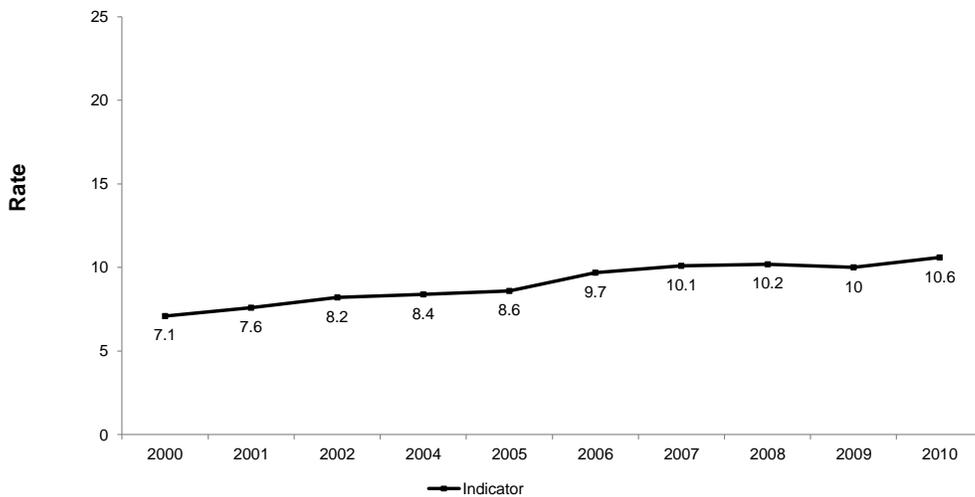


Data source: California Department of Public Health, STD Branch, Chlamydia, Cases and Rates by Race/Ethnicity, Gender and Age Group



Health Status Indicator 5B

The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia

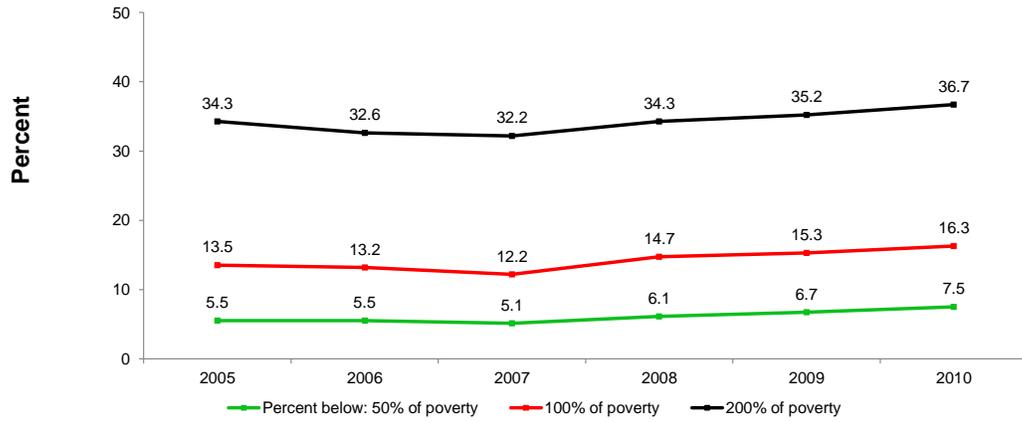


Data source: California Department of Public Health, STD Branch, Chlamydia, Cases and Rates by Race/Ethnicity, Gender and age group



Health Status Indicators 11

Percent of the State population at various levels of the federal poverty level

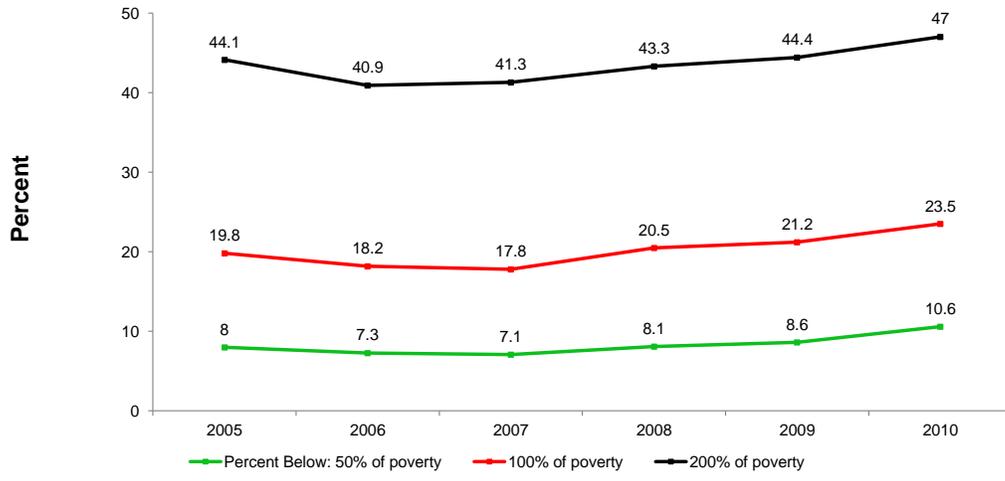


Data source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement



Health Status Indicators 12

Percent of the State population aged 0 through 19 at various levels of the federal poverty level



Data source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement

E. Glossary of Acronyms and Abbreviations

A	AAP-CA	California District of the American Academy of Pediatrics
	ABCD	Assuring Better Child Health and Development
	ACA	Affordable Care Act of 2010
	ACIP	Advisory Committee on Immunization Practices
	ACOG	American Congress of Obstetricians and Gynecologists
	ADP	Alcohol and Drug Program
	AFLP	Adolescent Family Life Program
	AI	American Indian
	AN	Alaskan Native
	AIDS	Acquired Immune Deficiency Syndrome
	AIIHI	American Indian Infant Health Initiative
	AIM	Access for Infants and Mothers
	ASHWG	Adolescent Sexual Health Work Group
	B	BBC
BIH		Black Infant Health
BMI		Body Mass Index
C	CA	State of California
	CAA	Certified Application Assistants (for Medi-Cal & Healthy Families)
	CAHC	California Adolescent Health Collaborative
	CalWorks	California's cash assistance program for children and families
	Cal-SAFE	California School Age Families Education
	CAN	California Association of Neonatologists
	CAPHI	California Asthma Public Health Initiative
	CLABSI	Central Line Associated Blood Stream Infection
	CBDMP	California Birth Defects Monitoring Program
	CBO	Community Based Organization
	CCDPPH	Center for Chronic Disease Prevention and Health Promotion
	CCG	Community Challenge Grant
	CCHA	California Children's Hospital Association
	CCLHO	California Conference of Local Health Officers
	CCS	California Children's Services
	CDAPP	California Diabetes and Pregnancy Program
	CDC	Centers for Disease Control and Prevention
	CDE	California Department of Education
	CDPH	California Department of Public Health
	CDRT	Child Death Review Team
	CFH	Center For Family Health
	CFHC	California Family Health Council
	CHDP	Child Health and Disability Prevention
CHHSA	California Health and Human Services Agency	
CHI	Children's Health Initiatives	
CHIIP	California Health Incentives Improvement Project	

	CHIS	California Health Interview Survey
	CIPPP	Center for Injury Prevention Policy and Practice
	CLABSI	Central Line Associated Blood Stream Infections
	CLPP	Childhood Lead Poisoning Prevention program
	CMQCC	California Maternal Quality Care Collaborative
	CMS	Children's Medical Services
	CPeTS	California Perinatal Transport Systems
	CPQCC	California Perinatal Quality Care Collaborative
	CPSP	Comprehensive Perinatal Services Program
	CPS	Child Passenger Safety
	CRISS	Children's Regional Integrated Service Systems
	CSCC	Children's Specialty Care Coalition
	CSHCN	Children with Special Health Care Needs
	CSS	California Student Survey
	CSTS	California Student Tobacco Survey
	CSUS	California State University, Sacramento
	CT	Chlamydia trachomatis
	CTCP	California Tobacco Control Program
	CYSHCN	Children and Youth with Special Health Care Needs
D	DDS	Department of Developmental Services
	DHCS	Department of Health Care Services
	DHF	Dental Health Foundation
	DMH	Department of Mental Health
	DMS	Data Management Service
	DSS	Department of Social Services
E	EAPD	Epidemiology, Assessment and Program Development
	ECCS	Early Childhood Comprehensive Systems
	EHB	
	EPSDT	Early and Periodic Screening, Diagnosis and Treatment
F	Family	Family Planning, Access, Care & Treatment
	PACT	
	FASD	Fetal Alcohol Spectrum Disorder
	FCC	Family Centered Care
	FFY	Federal Fiscal Year (October 1 - September 30)
	FHOP	Family Health Outcomes Project
	FIMR	Fetal Infant Mortality Review
	FISC	Functional Improvement Score
	FMCO	Fiscal Management and Contract Operations
	FPL	Federal Poverty Level
	FQHC	Federally Qualified Health Clinic
	FRC	Family Resource Center
	FVCA	Family Voices of California
	FY	State Fiscal Year (July 1 - June 30)

G	GDSP	Genetic Disease Screening Program
	GHPP	Genetically Handicapped Persons Program
	GIS	Geographic Information System
H	HBEX	Health Benefits Exchange
	HBV	Hepatitis B vaccine
	HCC	Hearing Coordination Center
	HCP	Hearing Conservation Program
	HCPCFC	Health Care Program for Children in Foster Care
	HF	Healthy Families -- California's State Children's Health Insurance Program
	HIV	Human Immunodeficiency Virus
	HRIF	High Risk Infant Follow-up
	HRSA	Health Resources and Services Administration
	HSCI	Health Status Capacity Indicator
	HSCR	Human Stem Cell Research
	HSI	Health Status Indicator
I	I&E	Information and Education Program
	ICD	International Classification of Diseases
	ICPC	Interconception Care Project of California
	IHI	Institute for Healthcare Improvement
	IPODR	Improved Perinatal Outcome Data Reports
	ITS	Information Technology Section
	IZB	Immunization Branch, CDPH
K	KASA	Kids as Self Advocates
L	L.A.	Los Angeles
	LAPSNC	Los Angeles Partnership for Special Health Care Needs Children
	LBW	Low Birth weight (<2500 grams)
	LHJ	Local Health Jurisdiction
M	MCAH	Maternal, Child, and Adolescent Health
	MCHB	Maternal and Child Health Bureau (Federal Agency)
	MCMC	Medi-Cal Managed Care
	MHF	Maternal Health Framework
	MHSA	Mental Health Services Act
	MIHA	Maternal and Infant Health Assessment
	MIS	Management Information Services
	MOD	March of Dimes
	MQI	Maternal Quality Improvement
	MRMIB	Managed Risk Medical Insurance Board
	MTP	Medical Therapy Program
N	NBS	Newborn Screening

	NCHS	National Center for Health Statistics
	NH/PI	Native Hawaiian or Other Pacific Islander
	NHSP	Newborn Hearing Screening Program
	NICU	Neonatal Intensive Care Unit
	NICHQ	National Initiative for Children’s Healthcare Quality
	NPM	National Performance Measure
	NQI	National Quality Improvement
	NTD	Neural Tube Defect
O	OFFP	Office of Family Planning
	OHAC	Oral Health Access Council
	OHC	Other Health Coverage
	OOH	Office of Oral Health
	OPG	Obesity Prevention Group
	OSHPD	Office of Statewide Health Planning and Development
	OTech	Office of Technology Services
	OTS	Office of Traffic Safety
	OVR	Office of Vital Records
P	PAF	Pregnancy Assistance Fund
	PAIS	Program Allocation, Integrity and Support
	PAMR	Pregnancy-Related and Pregnancy-Associated Mortality Review
	PAOPP	Physical Activity and Obesity Prevention Program
	PCP	Primary Care Physician
	PDD	Patient Discharge Data
	PDS	Program Development Section
	PedNSS	Pediatric Nutrition Surveillance System
	PHCC	Preconception Health Council of California
	PHHI	Preconception Health and Healthcare Initiative
	PHL	Parent Health Liaison
	PHN	Public Health Nurse
	PICU	Pediatric intensive care unit
	PKU	Phenylketonuria
	PQIP	Perinatal Quality Improvement Panel
	PRAMS	Pregnancy Risk Assessment Monitoring System
	PREP	Personal Responsibility Education Program
	PRHD	Primary and Rural Health Division
	PRISM	Pediatric Risk of Mortality
	PSA	Public Service Announcement
	PSS	Program Support Section
	PSU	Provider Services Unit
	PYD	Positive Youth Development
Q	QCI	Quality of Care Initiative
	QI	Quality Improvement

R	RCA	Regional Cooperative Agreements
	RFAs	Requests for Applications
	RFP	Request for Proposal
	RLP	Reproductive Life Planning
	ROS	Regional Operations Section
	RPPC	Regional Perinatal Programs of California
S	SAC	Safe and Active Communities
	SCCs	Special Care Centers
	SCD	Sickle Cell Disease
	SCHIP	State Children's Health Insurance Program
	SCOTS	Statewide Coalition on Traffic Safety
	SDSU	San Diego State University
	SIDS	Sudden Infant Death Syndrome
	SIT	State Interagency Team
	SPM	State Performance Measure
	SPS	Statewide Programs Section
	SSC	State Screening Collaborative
	SSI	Supplemental Security Income
	STD	Sexually Transmitted Disease
T	TA	Technical Assistance
	TANF	Temporary Assistance to Needy Families
	TWG	technical workgroups
U	UCB	University of California, Berkeley
	UCEDD	University Center for Excellence in Developmental Disabilities
	UCLA	University of California, Los Angeles
	UCSF	University of California, San Francisco
V	VFC	Vaccines for Children
	VLBW	Very Low Birth weight (<1500 grams)
W	WIC	Women, Infants, and Children Program
	WHO	World Health Organization
Y	YRBS	Youth Risk Behavior Survey
	YSHCN	Youth with Special Health Care Needs

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