CALIFORNIA GRANT APPLICATION
AND
ANNUAL REPORT
FOR THE MATERNAL AND CHILD HEALTH SERVICES
TITLE V BLOCK GRANT PROGRAM

MATERNAL, CHILD, AND ADOLESCENT HEALTH DIVISION
DEPARTMENT OF PUBLIC HEALTH
&
SYSTEMS OF CARE DIVISION
DEPARTMENT OF HEALTHCARE SERVICES

STATE OF CALIFORNIA

July 11, 2014 SUBMISSION
APPLICATION/ANNUAL REPORT

Maternal and Child Health Services Title V Block Grant

State Narrative for California

Application for 2015 Annual Report for 2013

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I. General Requirements

A. Letter of Transmittal

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

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

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

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

>Facilitating Comment on the Federal Fiscal Year (FFY) 2011 Title V Report
To generate awareness, stakeholders and partners were informed that public comment will be sought regarding the FFY 2011 Title V Report/Application and the 2011-2015 Needs Assessment Report. These announcements were made during meetings with stakeholder and advisory groups a few weeks prior to the reports were released. Since the full reports were long and extensive and too lengthy for the public, the Maternal Child and Adolescent Health Program (MCAH) developed abridged versions of both reports. Sections included in the 58-page draft FFY 2011 Title V Report/Application for public comment were a state overview, including major state initiatives; agency capacity; impact of the state budget cuts on programs; and, data on national and state performance measures and health capacity and status indicators. Included in the 126-page draft 2011-2015 Needs Assessment Report for public comment were, an overview of social determinants of health; data presenting the health status of the MCAH population; health insurance and healthcare utilization, a discussion on the impact of the state budget cuts to MCAH programs and the priority needs that were identified during the needs assessment process. Both reports were posted on the MCAH website (http://www.cdph.ca.gov/programs/mcah/Pages/MCAH-TitleVBlockGrantProgram.aspx)

The /2014/Systems of Care Division, (SCD), formerly//2014// Children's Medical Services (CMS) Branch added a link on the CMS website that connected to the MCAH website and the draft Application/Report, making it available to its partners. CMS posted the full version of the Children with Special Health Care Needs (CSHCN) Needs Assessment report online.

An e-mail was sent to agencies, organizations, and stakeholder groups targeted for comment or input. MCAH also sought comment from potential stakeholders including the Maternal Child Health Bureau (Federal Agency) (MCHB)-funded California principal investigators listed on the MCHB website (http://www.mchb.hrsa.gov/RESEARCH/projects.asp) A CMS Information Notice was placed on the CMS Website informing stakeholders, including the California Children's Services (CCS) administrators, local Child Health and Disability Prevention (CHDP) program directors, deputy directors and medical consultants, and CMS Branch staff, about accessing the draft Application/Report.

Stakeholders were given two weeks to provide comment either by phone or e-mail. A surge of comments were received when a reminder e-mail was sent out to targeted agencies, organizations and stakeholder groups to provide input. MCAH responded to each person/entity providing comment.

Comments were received from 27 professionals representing local MCAH programs, offices or programs from various state departments, academia, a health maintenance organization, a professional medical association, a parent and family advocacy organization and a health policy organization. Seventy percent of those who provided comment acknowledged the great amount of effort that was invested in creating the reports and/ or the high quality and thoroughness of the reports posted for public comment.

Themes that emerged from the comments received include constructive suggestions to elaborate on certain health issues or programs that address the needs of the MCAH population, barriers and opportunities for program enhancement, as well as technical edits. Input received in response to the draft reports will be considered and will have its greatest impact during MCAH's strategic planning process.
/2012/
>Facilitating Comment on the FFY 2012 Title V Report/Application
A similar method as described above was adopted to facilitate public comments on the FFY 2012 Title V report/application. A public document was circulated to more than a hundred stakeholders for comment, including those representing tribal organizations. Comments were received from 9 professionals representing local MCAH programs, and offices, academia and a professional medical association. //2012//

/2013/
>Facilitating Comment on the FFY 2013 Title V Report/ Application
A similar method as described above was adopted to facilitate public comments on the FFY 2013 Title V report/application. A public document was circulated to several hundred stakeholders for comment, including those representing tribal organizations. More than 30 comments were received from providers, program clients and local MCAH directors. //2013//

/2014/
>Facilitating Comment on the FFY 2014 Title V Report/ Application
A similar method as described above was adopted to facilitate public comments on the FFY 2014 Title V report/application. A public document was circulated to several hundred stakeholders for comment, including those representing tribal organizations. Comments were received from 18 individuals. The individuals include local MCAH directors and various stakeholders.//2014//

/2015/
>Facilitating Comment on the FFY 2015 Title V Report/ Application
A similar method as described above was adopted to facilitate public comments on the FFY 2013 Title V report/application. A public document was circulated to several hundred stakeholders for comment, including those representing tribal organizations. Comments were grouped by common themes and presented verbatim in the attachment. The attachment also includes responses to these comments.

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

public comments, as well as the number of public comments reviewed by news article are provided in the attachment. The comments provide insight of public awareness and perceptions on health issues confronting the MCAH population.

In addition, California's Title V program solicited for comment related to Dr. Lu's MCH Transformation 3.0 video. A compilation of the comments, together with the video transcript is available upon request. //2015//

>Facilitating Input on Programs
Public input is a valuable tool to increase program success and improve services. Input from community members and families have been sought through each of the 61 local needs assessments conducted by MCAH local health jurisdictions (LHJs). Activities related to the local needs assessment and capacity assessment is a form of soliciting public input. Most MCAH LHJs reported that they conducted community meetings, forums and focus groups. These provided the community an opportunity to voice concerns relevant to MCAH health and health care services currently available in the state.

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

All MCAH programs systematically and conscientiously make every effort to encourage consumers of program services to give voice to their concerns or provide suggestions on how the quality and effectiveness of MCAH Program can be improved. Most of these are conducted through satisfaction surveys. Results of these surveys are routinely reported in annual reports by local program agencies which are submitted to MCAH. MCAH staff invites input on an ongoing basis via phone, e-mails or through listservs. The MCAH webpages provide a mechanism for the public to e-mail inquiries and comments directly to MCAH.

MCAH stakeholders and partners are kept apprised of changes in federal legislation and the impact of these changes on MCHB Title V funding, recommendations and requirements. Updates are provided via conference calls, in-person meetings or program newsletters with all MCAH partners including but not limited to meetings for the Preconception Health Council of California (PHCC), the MCAH Action Committee, the Adolescent Sexual Health Workgroup (ASHWG), the California Perinatal Quality Care Collaborative (CPQCC) and California Maternal Quality Care Collaborative (CMQCC) Executive Committees and the Regional Perinatal Programs of California (RPPC).

/2015/ Attached are results of a survey of registered voters asking them what they think poses the greatest risk to California children. Numerous comments, suggestions and recommendations from stakeholders during meetings, conference calls, webinars, etc., were not quantified nor included in the attachment. //2015//

An attachment is included in this section. IE - Public Input

II. Needs Assessment

In application year 2015, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Reference to Children's Medical Services (CMS) is gradually being phased out and replaced by Systems of Care Division (SCD). Emerging issues and changes to SCD programs and system capacity as they relate to priority needs are described below.

Preparation for 2015 Needs Assessment has begun, with the Family Health Outcomes Project (FHOP) at the University of California, San Francisco (UCSF) contracted to facilitate the SCD needs assessment process. Preliminary data collection and preparation for stakeholder meeting, focus groups, and a family survey administered through the California Children's Services Program (CCS) has been initiated.

> Modify CCS with appropriate funding, to cover the whole child.
The 1115 Bridge to Reform waiver implementation has begun. Five project demonstration sites were selected with four different models of care through which CCS-enrolled children will have all their care needs met through a single coordinated health system. The Medi-Cal Managed Care (MCMC) Health Plan model was implemented on April 2013. Key milestones include establishment of a capitated monthly reimbursement rate, ensuring member/consumer rights, and maintaining the core functions of the CCS programs in counties where the CCS Demonstration will be implemented.

The CCS Demonstration pilot programs will be evaluated through the University of California at Los Angeles (UCLA), Center of Health Policy Research. This work is overseen by the 1115 Evaluation Oversight Committee, a team of key CCS leaders, Medical Consultants, and stakeholders representing facilities, providers and family advocacy groups.

> Expand the number of qualified providers of all types in the CCS program.
An on-going CCS Program challenge is to improve access to pediatric sub-specialty physicians and the number of CCS-approved hospitals and special care centers. SCD has reinvested in a concerted effort to increase production of processing applications from facilities to become CCS approved providers. Electronic submissions of provider applications began in XXX, with increased number of applications?

The passage of the Affordable Care Act (ACA) resulted in a significant increase in physician reimbursement for pediatric primary and subspecialty care. The State anticipates a significant increase in access to health care for all Children with Special Health Care Needs (CSHCN), including enrollees in CCS and Medi-Cal. The State is also examining the potential integration of nurse practitioners into the CCS Program.

In addition, CCS is implementing Assembly Bill (AB) 415, enacted in 2012 with the goal of removing barriers from Telehealth use and increasing access. CCS and Medi-Cal are actively developing policies to implement the provisions of AB 415, while maintaining CCS standards for proper multidisciplinary care, and integrating "best practice."

> CCS will work with appropriate partners to define, create, and implement standards for Medical Homes for CCS children.
CCS is obtaining information on the number of CCS children with a medical home through a performance measure that indicates whether each child in the CCS program has a medical home. In addition, CCS meets with stakeholders to gather consensus on essential elements of a medical

home and has a standardized definition of a medical home shared with all groups.

The CCS stakeholder group identified priority objectives where successful implementation can be assessed through a survey, assessing medical home status and family partnership in decision making. A client/family satisfaction survey specific to the CCS population including the 1115 waiver clients, is being developed with intent to administer statewide.

> Ongoing Needs Assessment Activities
The California Department of Public Health (CDPH), Maternal, Child and Adolescent Health Program (MCAH) conducts ongoing needs assessment activities to monitor and assess the health of the state's MCAH populations. Ongoing data collection and analysis related to our priority needs inform state level programs and policies. Dissemination of findings to local health jurisdictions (LHJs) and stakeholders supports their efforts to effectively address these priorities as well. Annual Scope of Work (SOW) revisions also provide an opportunity for local programs to address emerging health issues through their local MCAH programs.

As mentioned in last year's report, California has begun the needs assessment process. Assessment of the needs of mothers, women, infants and children is a two-stage process: an initial community assessment to be conducted by local health jurisdictions which will then be synthesized and inform the state-level needs assessment.

The goal of the community health assessment is to facilitate data-driven community planning to inform development of five-year local action plans that will address a specific list of health topics/subtopics using standardized objectives. Unlike previous community health assessments, local MCAH Directors were provided a list of health problems of unique concern to the MCAH population and not adequately addressed by other state partners. To support the local needs assessment effort, MCAH will provide each LHJ with a community health status report which include select health indicators, environmental and social determinants and local demographics to make comparison of local data with benchmarks (state average, Healthy People 2020 objectives, and local trend data) to help identify potential health issues in their communities. In addition, LHJs were provided logic models, problem analysis and five-year action plan examples to assist LHJs in developing their strategic plans to address their priorities in the next five years. Trainings via webinars are being conducted to orient LHJs with the community health assessment process, provide training on planning and implementing a comprehensive community assessment, use of data to identify health problems in the community and assist in developing local strategic plans to address priorities.

In Fall 2013, a survey was sent to LHJs to identify activities and partnerships to address the health needs of CSCHN and AI populations. With the implementation of ACA, the survey included questions to assess the impact and challenges of ACA implementation on local MCAH programs.

To enhance program communications, MCAH and SCD have initiated monthly face to face meetings starting in April 2013. Updates on state needs assessment plans have been provided regularly at these meetings.

MCAH in partnership with UCSF conducted a survey in Fall 2013 to create a centralized resource that includes essential information about adolescent sexual and reproductive health programs to help identify opportunities for collaboration as well as potential gaps in services. All local health jurisdictions were asked to complete the survey to help identify state, regional or county-specific programs addressing sexual health/ abstinence, support services for pregnant and parenting teens, HIV/ sexually transmitted infections, teen dating violence prevention/ healthy relationships and positive youth development.

MCAH is working with the UCSF, to identify Adolescent Sexual and Reproductive Health Programs (ASRH) throughout California. The goal of this project is to create a centralized

resource that includes essential information about these programs to help identify opportunities for collaboration as well as potential gaps in services.

III. State Overview

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, Filipino and Vietnamese. Within each Asian group is variation in language and culture. While the largest numbers of Asians reside in the large population centers of Southern California in Los Angeles (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//

/2013/ > Economy

For 2012-13, the State faces a $15.7 billion budget deficit. To restore fiscal balance, more cuts to state programs and the state workforce were proposed. //2013//

>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, proportion of children ages 0-5 who are Hispanic are expected to continue to increase through 2020, while the proportion that is White are 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 are expected to decline to 32%. Other groups are expected to remain somewhat stable. Of particular interest are the youngest women of reproductive age, who demonstrate increased risks and poorer birth outcomes compared to their older counterparts. [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 MCAH status 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.[11] In 2004, approximately 41% of California's undocumented immigrants resided in L.A. County. [10]

>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. [12]

>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 to18.9% in 2008. [13] 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%). [14] 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.[15] /2012 In 2009, the graduation rate increased to 70%.[13]

>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. [16] Among children under age 18 the rate is higher: 16% of the population is in poverty, or approximately 1.6 million children. [17] 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. [17] 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. [16] [18] 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. [18]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. [19] /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. [20] While employment grew in 2010, the unemployment rate also increased to 12.4%, the third highest rate in the U.S. [21] 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%. [22] //2012//

>Housing
California's high housing costs create a burden for families, resulting in less income available for other resources needed to maintain health. [23] 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. [23] It also exposes families to urban deserts, i.e., neighborhoods lacking sidewalks, grocery stores and parks. Even for working families, the high cost of fair market rent is out of reach. In 2010, the fair market rent in California ranged from $672 in Tulare County to $1,760 in San Francisco Bay Area counties. [24] 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. 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. [25] 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. [26] Homelessness in children has been linked to behavioral health problems, [23] and negatively impacts educational progress. [26]] /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. [25] //2012// /2013/ In December 2011, California had the second highest rate of foreclosures in the country. [27] //2013//

>Public Health System

CDPH is the lead state entity in California providing core public health functions and essential services. The Department has five centers to provide detection, treatment, prevention and surveillance of public health and environmental issues. The 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 provides 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 provides 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 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/ CCS addresses the health service needs of 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) was moved from CDPH to the Department of Health Care Services (DHCS) effective July 2012. The Teen Pregnancy Prevention Programs under OFP, including the 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.//2013// /2014/ The Office of Health Equity will play a key leadership role to reduce health and mental health disparities to vulnerable communities through the building of cross-sectoral partnerships.//2014//
/2013/The Governor established the Get Healthy California Task Force in May 2012 to improve the health of Californians.

> Access to Health Care
In California, 19 percent of the population did not have health insurance in 2009/10, and highest among Hispanics. [13]

> Healthcare Reform
The Patient Protection and Affordable Care Act of 2010 (ACA) created a new mechanism for purchasing health insurance coverage called a Health Benefit Exchange (HBEX). California was the first state to pass legislation to create a HBEX, a quasi-governmental body that follows the "active purchaser" model of benefits exchanges. [28] //2013// /2014/Starting October 2013, Covered California, the state-run health insurance market, will qualify low-income individuals and families for free health insurance through Medi-Cal and moderate-income families to premium subsidies to make private health coverage affordable. It provides consumer protections set forth by the ACA including the ten Essential Health Benefits. //2014//

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 (CSHCN)
California's Medicaid Section 1115 waiver for hospital financing and uninsured care expired on August 2010 and provides an opportunity to transform the delivery of health care to children enrolled in CCS 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 with a new waiver application.

Pursuant to (Assembly Bill (AB) x4 6, August 2009), DHCS submitted 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 slow the long-term rate of Medi-Cal program expenditures.

A Stakeholder Advisory Committee consists of individuals representing the populations for whom the delivery of care would be restructured through the waiver design. 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 (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 of the 1115 Waiver was approved in November 2010. In April 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.//2012// /2013/Five projects were selected with four different models of care through which CCS children will have all their health care needs met by a single coordinated health system. Projects have phased-in start dates from June 2012 to 2013 and an evaluation program is under development.//2013// /2014/MCMC, the 1115 Waiver Model, began April 2013 in San Mateo County while the Accountable Care Organization model will begin later in 2013.//2014//

>Child Health Insurance Coverage
State legislation AB 1422, along with funding from the First Five Commission and program savings enacted by the Managed Risk Medical Insurance Board (MRMIB) will allow the Healthy Families Program, (HF), 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 Child Health and Disability Prevention Program (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//

/2014/ The combined HF and Medi-Cal enrollment for fiscal year (FY) 2010 was 6,188,788. The California Health and Human Services Agency (CHHSA), MRMIB and DHCS developed a transition plan for HF enrollees to Medi-Cal. Medi-Cal established the Targeted Low Income Children's Program which expands child eligibility to 250% of FPL. The transition, implemented in phases, began in January 2013. HF will continue to serve families until they are transitioned to Medi-Cal, including Access for Infants and Mothers (AIM)-linked infants. In addition, children continue to be pre-enrolled into Medi-Cal through the CHDP Gateway.//2014// // ***/2015/In 2013, HF no longer enrolled new applicants. For details, see HSCI 3.//2015//***

> Obesity

See National Performance Measure 14 and State Performance Measure 6.//2013//

>Breastfeeding
Due to state budget cuts in August 2009, funds were reduced for the Birth and Beyond California (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 Regional Perinatal Programs of California (RPPC) in L.A. to develop a report on BBC pilot project findings and provide technical assistance (TA) for all other RPPC regions for 2 years. To date, 20 hospitals participated and two RPPC regions 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. BBC generated national interest and was highlighted at the first California Hospital Breastfeeding Summit held in January 2011.//2012// ***/2015/MCAH is an in-kind sponsor of the annual Breastfeeding Summit.//2015//***

/2013/MCAH released the "BBC: A Hospital Breastfeeding Quality Improvement and Staff Training Demonstration Project Report". Curricula, trainer notes, evaluation tools, and other materials for hospitals are posted at http://cdph.ca.gov/BBCProject.//2013// ***/2015/Vermont's Breastfeeding Quality Improvement Project adopted BBC to develop an online platform which is shared with the BBC website. //2015//***

MCAH is in the process of releasing 2008 in-hospital exclusive breastfeeding data and will be made available online with 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 (PAOPP) grant funded by the Centers for Disease Control and Prevention (CDC). MCAH is represented in 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 QI 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 2011. The goal of improving by 25% any breastfeeding at discharge for <1500gm infants was met.//2012//

/2013/ WIC and MCAH finalized a web-based hospital breastfeeding policy curriculum for hospital administrators. In 2011, the Infant Feeding Act was passed requiring that all maternity hospitals have an infant feeding policy that supports breastfeeding by 2014.//2013//

/2014/ MCAH ***/2015/ and SCD //2015//*** is collaborating with the Office of Emergency Preparedness to develop an infant feeding plan and with Chronic Disease Division to develop breastfeeding-supportive clinics.//2014//

/2015/ MCAH collaborated with the CA Obesity Prevention Program (COPP) on a statewide pilot project focused on increasing breastfeeding duration rates in low- income

communities of color. Working with 15 community health centers and an expert advisory committee, recommendations will be published on implementation of model "breastfeeding-friendly" environmental clinic policies/practices, and improved reimbursement policies.

SCD and MCAH provide assistance to the DHCS's Breastfeeding Task Force to increase breastfeeding rates among women receiving Medi-Cal as part of the DHCS Strategy for Quality Improvement. The task force is working with external stakeholders, including MCMC plans, to increase breastfeeding rates. //2015//

>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.

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,/2013/lessons learned from our previous model, staff and partner expertise//2013//and state and national best practices. The revised model is strength-based, ensures linkages to prenatal care, empowers women to make better health choices for themselves and their families, improves their ability to manage stress related to the social, cultural, and economic issues known to influence health, and encourages broader community engagement to address the problem of poor birth outcomes. Services are provided in a culturally competent manner.

The program starts with an assessment of clients' needs and strengths. There is primarily case management based on each client's 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 revised to assess the program's effectiveness and has program standards and quality assurance measures to ensure the revised model's fidelity. In June 2010, a panel of national experts that was convened 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, 8 of the 15 BIH sites implemented the revised model. Initial qualitative reports indicate that clients are well engaged and find the group intervention positive and empowering. An early assessment 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 addressing client recruitment. BIH sites will be required to complete a client recruitment plan. MCAH will be transitioning the remaining sites through TA and training, to begin implementation in November 2011.//2012//

/2013/ The revised model was implemented in November 2011. In March 2012, MCAH published the report entitled: Black Infant Health Program Pilot Implementation (Phase I) Preliminary Assessment Report. In 2012, MCAH will conduct site profiles of each LHJ and launch an upgraded management information system//2013// /2014/ (MIS). All profiles were completed and all sites have been trained to use the MIS. Data will be analyzed to generate information for program improvement and evaluation.//2014//

>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, Implicit in its Preconception Health and Health Care Initiative (PHHI) MCAH employs a life course perspective that promotes health for women and girls across their 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 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. 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. /2012/ /2013/It was updated in 2012 and features reproductive life planning (RLP) and new preconception health clinical resources and statewide initiatives.//2013//

MCAH worked to incorporate preconception health messaging by including interconception curriculum content in BIH and the trainer module for California Diabetes and Pregnancy Program (CDAPP)//2012//

Other preconception health activities include a folic acid awareness campaign implemented in early 2009 designed to address Latinas and women of lower education attainment. It 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. The campaign resulted in a 1200% increase in calls to referral line and 45,000 bottles of vitamins distributed.

MCAH received the First Time Motherhood grant funds from Health Resources and Services Administration (HRSA)/MCHB to implement a preconception health social marketing campaign. /2012/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// The project will test "preconception health" and RLP messages in a life course context and message delivery mechanisms, including web-based and mobile-based strategies, with different populations, especially African-American women, Latinas and youth of color. The campaign will also address broader societal influences on health. MCAH will be working on this campaign through early 2011. /2013/PHHI collaborated with AFLP PYD 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 CDC's preconception health consumer workgroup /2014/Show Your Love campaign.//2014//

PHCC is the coordinating hub for preconception health activities across the state such as the Interconception Care Project of California (ICPC), an American Congress of Obstetricians and Gynecologists (ACOG), District IX project funded by MOD that is charged with developing postpartum care visit guidelines for obstetric providers. The project aims to provide physicians

with tools to address issues at the postpartum 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/ICPC guidelines were completed and include English and Spanish provider algorithms and patient handouts on 21 common postpartum conditions//2013// /2014/, with diabetes offered in Vietnamese.//2014// /2013/Providers were informed of its availability and guideline trainings were offered.//2013//

MCAH LHJs have also undertaken activities related to preconception health. The L.A. Collaborative to Promote Preconception/Interconception Care 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 (CFHC) 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 developed preconception health scope of work objectives and provided technical assistance to MCAH LHJs. State and local MCAH are partnering to implement the federal Office of Minority Health Peer Preconception Health Program in community colleges and universities//2013// /2014/Together with local partners, MCAH trained about 200 Preconception Peer Educators (PPE) in the San Joaquin Valley and developed statewide training and outreach resources online.//2014// ***/2015/ The Preconception Health Initiative streamlined its focus on four priority areas: folic acid use, linkage to medical home/well-women visits, family planning and healthy relationships. MCAH developed the social media toolkit targeting year-long messages to young men and women. //2015//***

>High-Risk Infants
The High Risk Infant Follow-up Program (HRIF) 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 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 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 2012, 65 of 66 CCS-approved HRIF programs are reporting online, with 19,055 HRIF Program Referrals/Registrations and 17,079 HRIF Program Standard Core Visits. The HRIF Executive Committee established a QI workgroup in February 2012.//2013// /2014/As of February 2013, 67 of 69 HRIF programs are reporting online with 5170 HRIF Program Referrals/Registrations and 1550 HRIF Program Standard Core Visits for 2012. HRIF summary reports provide information on the follow-up status of enrollees, demographic/social risk information, status of medical and special service needs, neurological examination outcomes and developmental outcomes. Feedback and reports from HRIF Program staff are obtained in the annual quality audit report.//2014// ***/2015/In 2013, 70 of 115 CCS NICUs had HRIF and used a web-based data reporting system. The number of infant referrals to a CCS HRIF exceed 33,000. By January 2014, HRIF QCI finalized data reporting system improvements. Each HRIF ensures there is a system in place to follow-up with families to improve adherence to HRIF diagnostic assessments and evaluations. Recent and planned ongoing CPQCC/CCS research includes assessment of site-specific NICU and HRIF clinic challenges and successes.//2015//***

>Neonatal Quality Improvement Initiative
CMS and the California Children's Hospital 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 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 January 2008. After the grant extension ended in June 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/By mid-2011, CLABSI rate decreased another 70% from 2009; for all birth weights combined it has declined to 0.65 infections/1000 central line-days. Participating NICUs are implementing practice policies. To comply with Section 2701 of the ACA, elements of the NICU CLABSI collaborative will be brought to all CCS approved NICUs and Pediatric Intensive Care Units (PICUs) beginning July 2012.//2013// /2014/The collaborative ends mid-2013. It has sustained gains with an overall CLABSI rate of 0.65/1000 central line-days.

CCS began a new NICU CLABSI prevention collaborative that integrates QI routinely. This new collaborative funded by the American Hospital Association is linked to a NICU CLABSI prevention collaborative in 14 other states, Of the 180 NICUs in this national collaborative, 68 are CA NICUs. The ultimate goal is to enroll all 132 CA NICUs in ongoing QI projects led by CCS.//2014//

/2015/The multi-year collaborative ended in 2013 with an overall CLABSI rate of about 1 per 1000 central line-days. CCS is working with neonatology and hospital organizations to develop core curriculum on safety, reliability, and process improvements to eliminate NICU CLABSI.

>Critical Congenital Heart Disease (CCHD) Screening
SCD released a policy stating that an in-patient CCHD Screening Provider shall be any general acute care hospital with licensed perinatal services, any intermediate, community and regional-level NICUs. NICUs are encouraged to develop policies to screen admitted neonates whose clinical course and care would be unlikely to detect CCHD before discharge.//2015//

>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; Pediatric Risk of Mortality 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 (PCC) 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/In February 2012, there were 23 CCS-approved PICUs. Annual PICU reports are stratified by PRISM III scores or data through the Virtual Performance System (VPS) which exports 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 is under development.//2013// /2014//In 2013, two CCS Community PICUs were approved, while the RCA is being developed. The VPS California PICU database was developed to be the standard for all PICUs in California. This dataset will be representative of nearly all CSHCN in California.//2014// ***/2015/ PICUs increased to 25. The PICU Database is required for all 25 PICU data gathering and reporting.//2015//***

>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 two 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 for 11 of the original 13 counties participating. 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 the next year, who would benefit from the supportive palliative services offered by Partners for Children (PFC). The five year waiver renewal application has been submitted.//2013// /2014/The Pediatric Palliative Care Waiver (PPCW) was renewed effective through March 2017 with UCLA conducting the program evaluation. Preliminary results show high levels of program satisfaction and significant program savings. As of December, 2012, there were 84 children enrolled in the program in nine counties, served by one of ten participating agencies.//2014// ***/2015/ The PFC PPCW enrolled 85 clients. //2015//***

>Maternal Health
Maternal mortality doubled in California since 1998 to 16.9 deaths per 100,000 live births in 2006, well above the Healthy People 2010 benchmark. 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.//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. MCAH conducts the PAMR which is the first statewide fatality review of maternal deaths. 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 which describes the methods, the key findings, and recommendations from the Committee. Findings have 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/ MQI has found significant change in maternal morbidity with increased rates of diabetes, maternal hypertension, and asthma.//2012// //2014/MQI created a composite indicator and compared ways to track elective delivery.//2014// ***/2015/ MQI published the results of the maternal morbidity analysis in the American Journal of Public Health. MQI composed and submitted***

manuscripts for the comparative methodology manuscript on tracking elective deliveries in the Journal of Obstetric, Gynecologic and Neonatal Nursing and the Composite Childbirth Morbidity Indicators to the American Journal of Obstetrics and Gynecology. A draft of the statewide Maternal Health Report is in progress and data are being obtained to quantify the cost of maternal morbidity among Medi-Cal patients. //2015//

Secondly, MCAH promotes creation of regionalized 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 and uses current statewide and hospital-specific outcomes data to implement strategies to improve risk-appropriate care for mothers and their babies and collaborates with perinatalogists for high-risk mothers and their infants. /2012/RPPC works 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// ***/2015/ The elective delivery toolkit has been implemented nationally and has been determined to be responsible for a substantial decline in elective delivery in six states where it has been implemented. //2015//*** The California Perinatal Transport System (CPeTS) facilitates transport of mothers with high-risk conditions and critically ill infants to regional intensive care units and collects transport data for regional planning and outcome analysis. MCAH also provides 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 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/Several LHJs are promoting preconception health.//2013// /2014/Due to funding cuts, the Local Assistance for Maternal Health (LAMH) project was reduced to only providing technical assistance through the RPPC program.//2014//

Thirdly, MCAH has developed a Maternal Health Framework (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 three phases of the life course: prior to, during, and following pregnancy to restore a mother to health should a health complication arise during pregnancy. /2012/The MHF is being shared with all MCAH 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. 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//2013// /2014/"Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age"//2014// /2013/ to reduce elective inductions prior to 39 weeks gestation was licensed to the MOD for national dissemination. It 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.//2013// /2014/It includes elimination of elective inductions and elective C-sections before 39 weeks gestation and was relicensed in 2013. The Spanish translation of the OB Hemorrhage Toolkit has been delayed.//2014// /2013/A third toolkit to improve the quality of care for preeclampsia is now in development.//2013// /2014/The toolkit to Improve the Health Care Response to Preeclampsia was released in April 2013.//2014//

WIC contributes to optimizing health outcomes throughout all three phases 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.

/2015/>Transition

CCS adjudicates the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Service requests for skilled nursing services, Private Duty Nursing (PDN) and Pediatric Day Health Care (PDHC) services which are supplemental nursing services under the EPSDT benefit.

DHCS has implemented the EPSDT Age-Out Program to assist young adults who are currently receiving PDN and/or PDHC services and who will age out of the EPSDT service category when they reach their 21st birthday. SCD will identify these young adults at age 18 to develop an appropriate care and resource plan. //2015//

>Data and Surveillance
In 2010, MCAH began collaborating with WIC on public health research projects. The goal of the first project is to create data linkages between WIC program data, the Birth Statistical Master File, and MCAH program data in order to identify areas in California where there is a need for WIC services and opportunities to better target WIC services to MCAH populations, and to evaluate outcomes associated with the receipt of WIC services. Geographic information systems (GIS) and 21 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 linked and will get analyzed in 2011 for similar resource allocation and planning purposes. MCAH also provided training and TA to State WIC staff as well as local WIC providers and agencies on how to interpret and use choropleth maps.//2012// /2013/In 2012, WIC program data were linked to the 2010 birth file. MCAH has begun to develop maps using the 2010 data, and a detailed report on WIC participation around the time of pregnancy.//2013// /2014/A detailed report was provided to WIC on 2010 WIC participation around the time of pregnancy. In 2013, WIC program data were linked to the 2011 birth file. MCAH has also started to examine the association between WIC and MCAH outcomes, such as pre-term birth.//2014// ***/2015/ WIC program data will be linked with the 2012 birth file to examine WIC impact on birth outcomes.//2015//***

Second, California's Maternal and Infant Health Assessment (MIHA) Survey will be expanded in 2010. /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. 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/County-level data tables and charts were published.//2013// /2014/Updated

tables, maps, charts and reports using 2011 data will be posted online. The sample design has been revised to allow county-level estimates for the 35 counties with the most births.//2014// ***/2015/ MIHA 2011 data tables, maps, charts and reports were disseminated including statewide snapshots of key MCAH indicators stratified by maternal race/ethnicity, income, age, education, and prenatal health insurance. The MIHA website has an easy-to-use searchable format. Unmet need for WIC services and reasons for not enrolling in WIC during pregnancy was assessed; an update was provided to WIC and release of a summary report is planned. MCAH provided technical assistance to DHCS and to the CDPH Office of Health Equity to assess several indicators of women's health, including disparities in breastfeeding outcomes, barriers to accessing oral health care among Medi-Cal recipients, and use of MIHA data.//2015//***

Over the past year, MCAH 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. 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 (HP 2020) measures have been accepted as part of the Maternal, Infant, and Child Health topic area to provide baseline data for each HP 2020 objective. Additionally, MCAH collaborated with researchers at UCSF and CDC to submit an abstract to the 3rd National Preconception Health Conference in June 2011, highlighting 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//

/2014/ In 2013, MCAH collaborated with CDC and UCSF on a Morbidity and Mortality Weekly Reports that used combined MIHA-PRAMS data to estimate how many women were eligible but not enrolled in WIC during pregnancy across 27 states and New York City. Out of all eligible women in California, 83.3% participated in WIC, the highest coverage rate in any state examined. Characteristics of WIC participants and eligible non- participants were also presented.//2014//

/2012/Since 2004, the Office of Vital Records and MCAH have collaborated to plan Birth Data Quality Workshops across California annually. Joint meetings target area hospitals with missing data and RPPC assist with presentations to birth clerks 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. Local and state birth registrars, county MCAH Directors, local hospital administration, perinatal nursing staff, medical records and birth data collection staff are brought together, and hospitals are recognized for improvement and high achievement. In 2010, more than 530 participants attended a workshop. /2013/ 2012 is the 8th year for these workshops to improve birth data quality.//2013// /2014/ Eight workshops to improve birth data quality are scheduled for 2013.//2014// ***/2015/ Birth data quality workshops will continue annually. //2015//***

MCAH is making a concerted effort to increase surveillance capacity with 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 to locate clusters of women in need of WIC services, or could benefit from home visiting program services.

Specialized spider diagram maps were developed to analyze 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.

/2015/ MCAH increased capacity for analyzing area-based measures of poverty and program participation from the American Community Survey to identify areas in need of MCAH services and targeted outreach efforts.//2015//

MCAH LHJ data books, used for local surveillance and needs assessment activities, are being revised by the Family Health Outcomes Project (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. Data books will be updated each year to support regular community-level monitoring, as is required by the new LHJ scopes of work.

/2014/With the support of RPPC,//2014//MCAH disseminates breastfeeding initiation rates annually to all maternity hospitals and provides them with TA to implement evidence-based policies and practices that support breastfeeding. The California WIC Association (CWA) has used these data to publish an annual report that ranks hospitals based on breastfeeding rates, generating media attention. California breastfeeding data are available at: http://cdph.ca.gov/breastfeedingdata.

/2013/MCAH continues to post hospital breastfeeding initiation data. These data were used by the CWA to publish their reports.

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%. ***/2015//A state CCS work group updated CCS performance measures including county compliance with designating a primary care medical home physician or nurse practitioner provider; timeliness of eligibility determination; referral to appropriate CCS-approved outpatient Special Care Center (SCC)/provider; evidence of interdisciplinary SCC team visit; CCS and/or Medical Therapy Program transition planning; and family participation.//2015//***

>California's Primary and Secondary Teen Pregnancy Prevention Initiatives
Incorporation of teen pregnancy prevention programs into MCAH affords an opportunity for coordinated service delivery across primary and secondary teen pregnancy prevention efforts.//2013//. /2014/Two cross-cutting areas of focus include positive youth development and healthy relationships.//2014// ***/2015/MCAH convened its first adolescent sexual health annual meeting in 2013.//2015//***

>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. /2014/MCAH re-applied for funding for four years, beginning 2013-2014. //2014// 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 School-Age 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.//2012// /2013/MCAH awarded 11 local sites for piloting the new positive youth development case management intervention with integrated life planning to promote reproductive life planning and build youth resiliency.

/2013/>California Personal Responsibility Education Program (CA PREP)
PREP educates adolescents on abstinence and contraception to prevent pregnancy and sexually transmitted infections (STIs), through evidence-based program models and adulthood preparation

subjects. /2014/Twenty-one local sub-awardees began activities in July 2012.//2014//

>Information and Education (I&E)
I&E provides adolescents with pregnancy and STI prevention information and linkages to health care. Funded through state general funds and matching Title XIX funds, the most recent request for application (RFA) for this program was released in 2010, and made funding available from Summer 2012 to Fall 2016.//2013//

> Home Visiting Program
The Maternal, Infant and Early Childhood Home Visiting Program was established on March 23, 2010 by the ACA of 2010, which amended Title V of the Social Security Act by adding Section 511. CDPH is designated as the single State entity to oversee and administer home visiting funds on behalf of California. To receive funding from HRSA and the Administration of Children and Families (ACF), MCAH began working in partnership with DSS, ADP, the California Head Start State Collaboration Office (CHSSCO) of 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, 2011/3)./2013/MCAH was awarded the Expansion Grant to increase the number of communities served. This effort targets particularly high risk and difficult to enroll populations and evaluates individual, program and community factors affecting enrollment and retention. MCAH anticipates implementation of home visiting programs by mid- year 2012. /2014/Client enrollment began in 2012.//2014//

Two evidence-based models, Nurse-Family Partnership (NFP) and Healthy Families America, were selected to meet the needs of the 22 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.

>Health Communications and Public Health Successes
MCAH continues its strong partnership with key cohorts including local MCAH programs. MCAH helped develop news releases on teen births and infant mortality. MCAH developed fact sheets on multiple MCAH-related health issues.//2013// /2014/ Since April 2014, MCAH and DHCS have been meeting monthly to improve information exchange between the programs.//2014// ***/2015/ MCAH developed a news release on infant mortality.//2015//***

>Strategic Map
/2013/CDPH developed, and will implement the Strategic Map, a graphic representation of CDPH's strategy. MCAH provided input in its development and will participate in CDPH strategic priorities and objectives.//2013// /2014/In Winter 2013, the Office of Quality Performance and Accreditation was created to provide leadership and coordinate department initiatives that seek to improve the quality and performance of programs and processes within CDPH, including public health accreditation.//2014//

/2015/ CDPH's Strategic Map implementation is focused on activities, interventions and tactics identified within the six priority objectives on a department-wide basis and at the program level. MCAH is the lead on reducing the infant mortality rate ratio between Medi-Cal vs. non-Medi-Cal covered births.

CDPH submitted documentation for public health accreditation in February 2014 to the Public Health Accreditation Board.//2015//

An attachment is included in this section. IIIA - Overview

B. 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.

/2014/Reference to Children's Medical Services and/or CMS Branch is gradually being phased out and replaced by Systems of Care Division (SCD).//2014//

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 Cal Works as it is known in California. AFLP targets services to pregnant and parenting teens and is providing services to approximately 6000 adolescents in 38 /2014/33//2014// 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/ MCAH awarded 11 local agencies to increase program capacity and professional development in the area of positive youth development.//2013/ ***/2015/MCAH was re-awarded a second Pregnancy Assistance Grant to fund 17 agencies implementing the Positive Youth Development initiative.//2015//***

>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 /2014/2009//2014// ***/2015/2010 //2015//*** birth year information was recently linked to vital statistics live birth and fetal death information, creating a database of more than 129,000 /2014/135,323//2014// pregnancies affected with birth defects from a base population of 6.25 million births. Birth year 2007 /2014/2010//2014// linkage will be completed soon. /2013/Birth year information is linked to vital statistics data for eight counties. The CBDMP Registry has data for more than 140,000//2013// /2014/144,650//2014// ***/2015/147,379//2015//*** babies with birth defects 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, /2014/ and 222,032 in SFY 11-12//2014// 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.

>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/CDAPP funding for regional services was eliminated; however, a resource and training Center will be maintained//2013// /2014/to provide webinar trainings and resources to CDAPP Sweet Success Affiliates.//2014//

>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.

/2014/Plans were developed to implement Help Me Grow whose core components complement the developmental screening activities of the California Home Visiting Program and California's Race-to-the-Top Early Learning Challenge.//2014//

ECCS is partnering with Alameda County to develop early childhood programs of care for children 0 to 8 years of age called the 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// /2014/Systems change resulted in introducing evidence-based practices; improved social-emotional services; new partnerships; a shift toward a more comprehensive early childhood view (ages 0-8); promoting improved screening tools, curricula, and referral protocols; and working toward a common framework for providing child and family services.//2014//

/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// ***/2015/ ECCS focused on strengthening its partnerships. California will develop a mutually designed cross-agency agenda for change.//2015//***

>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.

/2015/In 2013, children were transitioned from Medi-Cal fee-for-service to Medi-Cal Managed Care health plans (MCMC). MCMC expansion increased the number of CHDP beneficiaries receiving health assessments. ACA implementation, and adoption of the Modified Adjusted Gross Income guidelines increased the number of eligible children and families for full scope Medi-Cal services. CHDP continues to provide, care coordination, referral support, and assistance with scheduling and transportation to non-managed care enrolled children, foster care and uninsured children.//2015//

>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. /2014/A Case Review Team examines fetal and infant death cases, and identifies factors, including systems issues associated with these deaths.//2014// 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 database 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.//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/For 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. /2014/As of May 2012, the foster care children caseload was 57,459.//2014// ***/2015/Funds for HCPCFC were redirected to county welfare agencies but an alternative funding structure is maintained until transition occurs in FY 2015-16.//2015//***

>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 /2014/ and additional visits as determined medically necessary//2014// 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. /2014/Statewide data trainings were held. By March 2013, 67 of 69 HRIF programs are reporting online.//2014//

/2015/The State Systems Development Initiative grant supports a web-based HRIF Data Reporting System. HRIF QCI developed a provider resource directory to motivate communication between the NICU and HRIF Programs. The HRIF QCI data system update reported >33,100 total referrals/registrations for birth years 2009-2013.//2015//

/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 focus will be on the implementation of two evidence-based home visiting models: Nurse Family Partnership (NFP) and HF America,//2013// ***/2015/early childhood system integration and continuous QI //2015//***

>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.

/2014/
>Information & Education (I&E) Program
The I&E Program funds local agencies to implement sexual and reproductive health education programs that equip teens at high risk for pregnancy with the knowledge, and skills in partner communication, sexual negotiation and refusal skills to make responsible decisions regarding risky sexual behaviors, and to access reproductive health services.//2014//

>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// /2014/ Client enrollment is below 1999 levels.//2014// ***/2015/ The program has implemented use of outcome measure tools to assist therapists to determine effectiveness of therapy services.//2015//***

>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/Five hospitals were pending certification and 253 hospitals certified as Inpatient Infant Hearing Screening Providers.//2013// /2014/All hospitals with licensed perinatal services are certified and participating in the NHSP.//2014//

>Pediatric Palliative Care Waiver Program (PPCWP)
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 nine active hospice or home health agency providers.//2013//

//2015//As of March 2014 three hospice agencies, three home health agencies, and one congregate living health facility participate in PPCW program.//2015//

/2014/
>California Personal Responsibility Education Program (CA PREP)
CA PREP educates high-risk adolescents on both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, through replication of evidence-based programs to delay sexual activity, increase contraceptive use or reduce pregnancy. CA PREP also implements activities to prepare young people for adulthood and are also referred to family planning related health care services.//2014//

>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 newsletter was terminated.//2013// /2014/ A mid-year report including updates to

steps toward reduction of early elective deliveries <39 weeks by hospitals was implemented.//2014//

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 QI 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. /2014/ All CCS-approved NICUs are included. QI activities are focused on in-transit operational and therapeutic management issues.//2014//

>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.//2014//

>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 Medi-Cal, WIC and the CA Breastfeeding Coalition to improve hospital support for breastfeeding.

/2013/

> Nutrition and Physical Activity Technical Assistance Initiative

This integrates healthy eating and physical activity promotion within MCAH and its local programs. Strategies include providing technical assistance, development of healthcare policies, training and guidelines; supporting partners in coalition building; and using epidemiological information 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.//2013// /2014/MCAH partnered with the Office of Minority Health to trained support preconception peer educators in colleges and universities.//2014//

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 CSHCN 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 /2014/positive//2014// 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 hospitals representing over 90% of all neonates cared for in 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 four sub-committees.//2012// /2013/The goal is to support benchmarking and performance improvement activities http://www.cpqcc.org/quality_improvement/collaborative_3_delivery_room_management_qi_collaborative_and_nicu_qi. //2013// /2014/ PQIP defines indicators and benchmarks, recommends QI objectives, provides models for performance improvement, and assists providers in a multi-step transformation of data into improved patient care.//2014//

/2015/CPQCC members include 116 CCS-approved NICUs and 132 NICUs . There are 25 NICUs participating in the PQIP-sponsored quality improvement collaborative which aims to optimize length of NICU hospital stay. //2015//

> 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 maternity care quality improvement efforts.//2013// /2014/The Preeclampsia Prevention Toolkit was released and a multi-hospital collaborative was initiated. MCAH participates in an advisory

committee to develop risk appropriate maternal levels of care and the California Maternal Data Center.//2014// ***/2015/ The next QI toolkit for release will address cardiovascular disease in pregnancy targeting family medicine and ER staff.//2015//***

Family Voices of California (FVCA)
FVCA helps CSHCN 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, /2014/changes in Medi-Cal, the difference between occupational therapy (OT) and physical therapy (PT) and medically related OT and PT; autism; and insurance.//2014//

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. /2014/FVCA will evaluate CSHCN's timely access to appropriate care providers during the HF client transition into Medi-Cal.//2014//

/2012/
>Maternal Quality Indicator (MQI) workgroup
The MQI workgroup conducts trend analysis of maternal morbidity rates, chronic conditions that compromise maternal health//2012// /2013/ analyzes composite healthcare costs maternal morbidities//2013// /2012/and suggests strategies for monitoring quality benchmarks for obstetric hospitals//2012// ***/2015/ MQI developed a composite morbidity indicator to combine reporting maternal and neonatal morbidity.//2015//***

>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 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 (PHCC)
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 were developed through the PHCC.//2013// ***/2015/PHCC developed clinical guidelines for preconception care.//2015//***

>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 was 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 is funded by the Medicaid Infrastructure Grant (MIG) from the Centers for Medicare and Medicaid Services. As staffing allows, CMS will participate on the CHIIP Youth Transition Advisory Committee. /2014/ The Youth Transition Advisory Committee was defunded and terminated.//2014//

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

/2012/
> 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 meet 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 was also contracted to develop and maintain BIH Management Information Services (MIS), a software package for BIH agencies conducting case management. /2013/Branagh Information Group provides Help Desk support and training for the BIH MCAH MIS, a new database for BIH.//2013// ***/2015/ Branagh Information Group no longer provides services to BIH agencies.//2015//***

>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// ***/2015/ The Internet Sexuality Information Services was suspended due to funding reallocation.//2015//***

>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 /2014/from journals and reports from more than 30

professional disciplines.//2014// ***/2015/Funding to San Diego State University/Center for Injury Prevention Policy and Practice (CIPPP) was cut in 2013.//2015//***

>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 five years.//2012// ***/2015/SCD is working with FHOP to conduct the 2015 statewide needs assessment. //2015//***

>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 /2014/20-year//2014// trend. Information is available at the state, county, and zip code levels.

/2015/
>Los Angeles Partnership for Special Needs Children (LAPSNC)
LAPSNC is a group of community providers, payers, community based organizations and parents that works with LA CCS and LA Family Resource Centers on improving the system of care for children with special health care needs in Los Angeles County.//2015//

>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. /2014/The report provides information about birth certificate data completeness and quality.//2014// ***/2015/Due to funding cuts, the Perinatal Profiles Report is no longer being produced.//2015//***

/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.

/2014/
>Center for Health Policy at University of California, Los Angeles (UCLA)
The Center for Health Policy was contracted to develop cost savings estimates of early management of preeclampsia, eclampsia and obstetric hemorrhage.//2014// ***/2015/The October 2013 reports [30] show that 5.6% (27,580) of 2011 CA births were complicated by gestational hypertensive disorders while 4.6% (22,730) had maternal hemorrhage complications and $106 million, respectively to treat these conditions.//2015//***

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 at 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 at 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 (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//

/2014/ State law required the transition of children enrolled in HF to Medi-Cal. HF continues to serve children that have not yet transitioned to Medi-Cal, including AIM -linked infants.//2014// ***/2015/In 2013, HF no longer enrolled new applicants -- see HCSI 3.//2015//***

>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. ***/2015/CCS provides medical eligibility evaluation trainings. The Department of Rehabilitation (DOR) was awarded a Promoting Readiness of Minors in Supplemental Security Income grant in October 2013 to benefit families of CSCHN/YSHCN who receive Supplemental Security Income which may include CCS-enrolled CSHCN.//2015//***

>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// ***/2015/ CRISS brings together CCS programs, family support organizations, and pediatric providers and hospitals in a cohesive regional coalition for collaboration, planning and action.//2015//***

The CRISS National Initiative for Children's Healthcare Quality 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. ***/2015/This project ended but Sonoma CCS continues medical home activities with a managed care plan.//2015//***

Additionally, CRISS makes available the parent health notebook and other medical home materials on its website www.criss-ca.org. /2013/CCS is partnering with CRISS to provide local medical home projects. The Alameda Medical Home Project is implemented through provider training in medical home concepts, resources, and referral pathways with pediatric practices and clinics.//2013// ***/2015/CRISS continues the FCC workgroup. FVCA and 15 FRCs participate in CRISS.. Parent health notebooks are available to family resource networks, and on the CRISS website. //2015//***

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 legislation; 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 and CCS hold monthly webinars with families of CSHCN.//2013// /2014/

CCS leadership presents program updates at the annual FVCA summit.//2014//

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 that 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, teaching aids and a food guide in various 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.

>***/2015/Telehealth***
CCS Telehealth policies were clarified through stakeholder meetings and a CCS policy letter. SCD works with CSHCN stakeholders to expand Telehealth care access.//2015//

An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

Arnold Schwarzenegger is the Governor of California, a position he has held since November 2003. S. Kimberly Belshé is the Secretary for CHHSA, which is a cabinet-level position that reports directly to the Governor. Mark B. Horton, MD, MSPH is the Director of the CDPH, which is one of thirteen departments in CHHSA together with the DHCS. David Maxwell-Jolly, Ph.D. is the Director of DHCS.

/2012/ In November 2011, Edmund "Jerry" G. Brown, Jr. was elected to replace Arnold Schwarzenegger as the Governor of California. Shortly thereafter, Diana Dooley was appointed to replace S. Kimberly Belshé as the Secretary for CHHSA. In March 2011, Howard Backer, MD, MPH replaced Mark B. Horton, MD, MPH as the Interim Director of the CDPH. Toby Douglas replaced David Maxwell-Jolly, Ph.D. as the Director of DHCS.//2012//

/2013/ On June 13, 2011, Ron Chapman, MD, MPH, was sworn in as director of CDPH by CHHSA Secretary Diana S. Dooley.//2013//

The State of California designates CDPH to administer the MCAH Program. [31], [32] MCAH has the primary responsibility for carrying out Title V functions, the MCAH program, and other similar programs that include the HSCR and Cord Blood Banking Program and CBDMP. MCAH reports directly to CDPH's CFH, which is one of five centers responsible for carrying out CDPH's core

activities. [26] Catherine Camacho is the Deputy Director of CFH, a position she's held since CDPH was established in July 2007. [31] Vickie Orlich is the Assistant Deputy Director for CFH. /2014/ As of February 2013, Dan Kim is acting Deputy Director for CFH. As of July 2012, Christine Nelson is serving as the Assistant Deputy Director for CFH.//2014//

/2012/ In response to the United States' Patient Protection and ACA of 2010, which President Obama signed into law in March 2010, the MCAH Program created the California Home Visiting Program (CHVP), which manages the ACA's Maternal, Infant, and Early Childhood Home Visiting Program in California.//2012//

MCAH coordinates with DHCS' CMS Branch to handle Title V activities related to CSHCN. /2014/ Reference to CMS Branch is gradually being phased out and replaced by Systems of Care Division (SCD).//2014//

Information about MCAH is provided in the sub-sections below. Information about CMS Branch is available in Section III D. For updated organizational charts for MCAH and CMS Branch, see the attachments to Sections III C and III D, respectively.

>Maternal Child and Adolescent Health Program (MCAH)
Shabbir Ahmad, PhD, has acted as Chief of MCAH since June 2007. Les Newman is the Assistant Chief, a position he has held since February 2001. MCAH includes professionals from various clinical, public health, and scientific disciplines.

MCAH consists of six branches:
- Epidemiology, Assessment and Program Development
- Fiscal Management and Contract Operations
- Program Allocations, Integrity and Support
- Program Standards
- Policy Development
- California Birth Defects Monitoring Program

/2013/As of January 2012, Christine Nelson, replaced Les Newman as the Assistant Chief.//2013// /2014/ Addie Aguirre is Assistant Division Chief for MCAH. MCAH now consists of seven branches with the addition of the California Home Visiting Program. MCAH is also awaiting upcoming changes to some of its branch names: Fiscal Management and Contract Operations will change to Federal Monitoring and Compliance; and Program Allocations, Integrity and Support will change to Title V Integrity and Support.//2014//

> Epidemiology, Assessment and Program Development (EAPD) Branch
EAPD Branch analyzes and assesses program and population-based data and information that allow MCAH to monitor program implementation, evaluate program effectiveness, develop policies, and allocate appropriate resources. EAPD Branch also oversees the compilation of all Federal Title V reporting requirements for the annual block grant application/report and statewide five-year needs assessment.

Mike Curtis, Ph.D., is the Acting Chief of EAPD Branch, a position he held since June 2007. EAPD Branch consists of two sections with a total of 19 staff positions:
- Epidemiology, Evaluation and Data Operations
- Surveillance, Assessment and Program Development

/2014/Mark Damesyn, Dr. P.H. joined EAPD as Chief of the Epidemiology, Evaluation, and Data Operations Section in April 2012.//2014//

EAPD Branch also houses the Human Stem Cell Research and Cord Blood (HSCRCB) Program, which is responsible for implementing legislation mandating the monitoring of stem cell research in California.[28]

> Fiscal Management and Contract Operations (FMCO) Branch
FMCO Branch assumes the contract monitoring functions for MCAH, including fiscal forecasting, budget-related work, management of over 400 contracts, and working with Department of Finance and other control agencies. Jo Miglas is the Chief of the FMCO Branch, a position she's held since 2007.

FMCO Branch consists of three units with a total of 23 staff positions:
- Accounting and Business Operations
- Maternal, Child and Adolescent Health Contracts and Grants.
- Office of Family Planning Allocation and Matched Funding

/2014/FMCO Branch consists of a total of 16 staff positions. MCAH is awaiting upcoming name change for the FMCO Branch, which is to be called the Federal Monitoring and Compliance Branch: the Accounting and Business Operations Section would be called Federal Monitoring and Reporting Section; the Maternal, Child and Adolescent Health Contracts and Grants Section would be called the Technical Assistance and Compliance Section; and the Office of Family Planning Allocation and Matched Funding Section would be absorbed by the Technical Assistance and Compliance Section.//2014//

> Program Allocation, Integrity and Support (PAIS) Branch
PAIS Branch undertakes activities associated with allocation and matched funding of MCAH programs; program integrity; special projects and administrative activities associated with more than fifteen MCAH programs, including bill analysis and regulation development; policies and procedure development; administrative activities related to management analysis, personnel, training, and procurement; and information technology management, including website maintenance, local area network support, and management of servers, hardware, software, and inventory. Fred Chow is the Chief of the PAIS Branch, a position he has held since 2007. ***/2015/ As of December 2013, Fred Chow has retired. //2015//***

PAIS Branch consists of three units with a total of 18 positions:
- Allocation and Matched Funding
- Special Projects and Administrative Support Unit
- Information Technology Unit

/2014/MCAH is awaiting upcoming name change for the PAIS, which is to be called the Title V Integrity and Support Branch: the Allocation and Matched Funding Section would be called the Title V Fiscal and Program Oversight Section; the Special Projects and Administrative Support Unit would be called Program Services Section; and the Information Technology Unit would be absorbed by CDPH Information Technology Services Division, which will continue to serve MCAH.

Title V Integrity and Support Branch consists of a total of 19 staff positions.//2014// ***/2015/As part of the CDPH's IT consolidation efforts, MCAH's Information Technology Unit was absorbed by the CDPH's Information Technology Services Division (ITSD). //2015//***

> Program Standards Branch (PS)
The Program Standards Branch coordinates the implementation of standards of care for pregnant women, children, and infants in the AFLP, Advanced Practice Nursing program, BIH, CPSP, and local MCAH programs. PS program consultants provide consultation and technical assistance to LHJs and other organizations. Anita Mitchell, MD is the Chief of PS Branch, a position she has held since July 2005. Dr. Mitchell is board-certified in Pediatrics. The PS Branch consists of a total of 11 staff positions.

/2012/In August 2010, Karen Ramstrom, DO, MSPH, replaced Anita Mitchell, MD as the Chief of the PS Branch. //2012// /2014/ PS Branch consists of a total of 24 staff positions. In January

2013, I&E and CA PREP were moved under the administration of the PS Branch.//2014// ***/2015/ As of September 2013, Karen Ramstrom has accepted a position outside of MCAH. Laurel Cima , MPA is the Chief of the PS Branch.//2015//***

> Policy Development (PD) Branch
PD Branch develops policies and procedures in support of all MCAH programs and collaborates on Federal, State, and local levels, providing expertise on multiple health priorities including nutrition, obesity, breastfeeding, physical activity, oral health, ECCS, preconception health, FIMR, SIDS, RPPC, CPeTS, CDAPP, CMQCC, CPQCC and BIH program development. PD Branch identifies relevant data points for annual reporting to ensure that LHJs address state priorities and program requirements.

Karen Ramstrom, DO, MSPH, is the Chief of PD Branch, a position she has held since May 2006. Dr. Ramstrom is board-certified in Preventive Medicine and Family Medicine. PD Branch consists of eleven staff positions.

/2012/In August 2010, Connie Mitchell, MD, MPH, replaced Karen Ramstrom, DO, MSPH as the Chief of the PD Branch.//2012// /2014/As of July 2012, Sandra Bahn is the acting Branch Chief for PD.//2014//

> California Birth Defects Monitoring Program (CBDMP)
CBDMP is legislatively mandated to provide surveillance of birth defects and maintains a birth defect registry. CBDMP joined MCAH in January 2007. [31] Marcia Ehinger, MD, board-certified in pediatrics and clinical genetics, is the Chief of CBDMP, a position she has held since July 2007. /2014/ As of August 2012, Barbara Warmerdam is the Section Chief over CBDMP.

>California Home Visiting Program (CHVP)
CHVP was created as a result of the Patient Protection and Affordable Care Act of 2010. CHVP's focus is to provide comprehensive, coordinated in-home services to support positive parenting and to improve outcomes for families residing in identified at-risk communities. Christopher Krawczyk, Ph.D., is the Branch Chief of CHVP, a position he has held since March 2012. CHVP Branch consists of a total of 26 staff positions.//2014//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Information about the MCAH Program is provided in Section III C (Organizational Structure) above. Information about the CMS Branch is provided below. /2014/The CMS Branch was reorganized in 2007. Reference to Children's Medical Services (CMS) and/or CMS Branch is gradually being phased out and replaced by Systems of Care Division (SCD).//2014//

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

Louis Rico, Chief, Systems of Care Division is Acting Chief for the CMS Branch until a replacement can be recruited for the position. The CMS Branch was reorganized in 2005. The Branch is composed of the following five sections: Program Development, Regional Operations, Statewide Programs, Program Support, and Information Technology. /2012/Louis Rico, is no longer Acting Chief for the CMS program, but continues as Chief of the Systems of Care Division

with its oversight of the CMS program. On November 1, 2010, Dr. Robert Dimand, under a new organizational structure, became the Chief Medical Officer for CMS with responsibilities for medical oversight and direction including policy development and revision. Dr. Dimand comes to CMS from his previous position as Professor and Chair of the Dept. of Pediatrics at UCSF Fresno and Chief of Pediatrics at Children's Hospital of Central California. He is fellowship trained in Pediatric Critical Care (PCC) Medicine and Pediatric Gastroenterology.

There are currently seven sections: Program Development, Dependent County Operations, Independent County Operations, Statewide Programs, Program Support, Information Technology, and Waiver and Research.

On November 1, 2010, under a new organizational structure, Stephen Halley became the Chief Operations Officer for CMS with responsibilities for operational oversight and direction as well as operations and administrative policy. Mr. Halley joined CMS in July 2010 as Assistant Branch Chief replacing Harvey Fry who held the position from January 2005 through 2008. Mr. Halley had been in private consulting and had worked with a number of state departments. He was also a former hospital administrator.//2012// /2014/The Chief Operations Officer position is currently vacant.//2014//

/2013/ In the new organizational structure, the Chief Medical Officer oversees the Statewide Medical Services Branch, which is comprised of seven medical consultants, three nurses, and the Medical Policy and Consultation Section. Dr. Joseph Schulman, MD, a nationally recognized leader in Neonatal Medicine and Quality Outcomes, and the lead author on a manuscript describing the optimal approach to CLABSI in New York has joined CCS. He is coordinating the multidisciplinary efforts around CLABSI, Health Care Associated Complications, and "never events" in the NICU.//2013// /2014/ Dr. Marcia Ehinger, a board certified geneticist and pediatrician, joined SCD in 2012.//2014//

> Program Development Section (PDS)
PDS is responsible for the development and implementation of program policy, regulations, and procedures for the programs administered by the Branch and for provision of statewide consultation in a variety of professional health disciplines. Jill M Abramson MD, MPH is the Chief of the Program Development Section. She is a board certified pediatrician and is board eligible in Preventive Medicine. PDS has 15 positions./2012/ PDS has 13 positions.//2012// /2013/The section was renamed Medical Policy and Consultation Section (MPAC) and now has eight positions. The new section is responsible for program policy, statewide consultation and medical consultation//2013// /2014/to CCS county programs and providers.//2014//

The PDS Section consists of three units: the Program Policy and Analysis Unit, the Research Unit and the State Consultation Unit. The Program Policy and Analysis Unit is responsible for development and implementation of program policy, regulations, and procedures for all programs administered by the Branch. Unit staff develop provider standards for CCS; develop policies and procedures to assist in the implementation of HRIF and Pediatric Palliative Care programs; review and approve/deny all requests for organ transplants for children covered by CCS and Medi-Cal; and provide pediatric consultation to Medi-Cal and other DHCS programs. The unit is also responsible for research and program analysis functions and development, implementation of a pharmaceutical rebate program for CCS and GHPP, and execution of a new delivery system that enhances access to medical foods and improved clinical management for metabolic patients. /2012/The unit facilitates negotiations and claims processing for out-of-state providers when a child enrolled in CCS is treated in another state either emergently or electively.//2012//

The Research Unit consists of three research staff responsible for program data retrieval, aggregation and analysis for the CCS and CHDP programs. /2012/In 2010, a new Research and Waiver Section was created. The Research Unit, which was under the Program Development Section, was transferred and merged with the Waiver unit to form the Research and Waiver Section.//2012//

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

/2012/
>Waiver and Research Section
Don Fields is Chief of the Waiver and Research Section. This Section is comprised of two units the Waiver Unit and the Research Unit.

The Waiver Unit, with 14 positions, has the responsibility for implementing the CCS portion of the Federal 1115 Waiver. The Waiver Unit will implement the CCS pilot programs that will redesign the CCS Program in certain geographic areas to provide the full-range of health care benefits to children with CCS eligible medical conditions, including primary and preventative services. The new system of care will maintain CCS provider standards and will require delivery of services to eligible children by facilities and individual providers who meet these standards. The implementation will include contract development, a readiness review, enrollment, and contract management of the pilots.//2012// /2014/Reference to the Waiver Unit is appropriately referenced as the Waiver and Research Section. The California 1115 Waiver is also known as the "Bridge to Reform Waiver".//2014//

/2012/The Research Unit consists of six research staff responsible for program data retrieval, aggregation, and analysis for the CCS and CHDP programs. The research staff will also design and implement the enrollment process for the CCS pilots.//2012// /2014/The Research Unit staff are responsible for program data retrieval, aggregation, and analysis for CCS, CHDP, and other SCD programs.//2014//

/2013/The Waiver and Research Section is also responsible for two Disease Management Programs for Seniors and Persons with Disabilities (SPDs) with chronic conditions or major medical conditions. These programs provide coordinated care to SPDs in designated counties.//2013// /2014/The Waiver and Research Section is comprised of 13 positions.//2014//

> Regional Operations Section (ROS)
ROS is composed of three CMS regional offices located in Sacramento, San Francisco, and L.A. This section provides case management services for CCS-eligible clients residing in dependent counties (those with populations of less than 200,000). Case management services include, but are not limited to, determination of medical eligibility and authorizations for services, including review and approval of EPSDT Supplemental Services requests, resolution of financial appeals, determination of eligibility for MTU services, and program consultation/TA. /2014/SCD, formerly known as CMS, maintains a statewide presence with offices located in Sacramento, the San Francisco Bay Area, and in Los Angeles. The CCS Program provides administrative case management services as noted in previous narrative.//2014//

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

Staff in the regional offices are responsible for coordinating and facilitating on-site reviews of

hospitals, special care centers, neonatal and pediatric intensive care units, and medical therapy units for compliance with established program standards, policies, and procedures and for certifying outpatient rehabilitation centers located within CCS medical therapy units. /2014/Staff in all geographical locations are involved in CCS program operations.//2014//

V. David Banda is the ROS Section Chief, a position he has held since December 2008. He was manager of the CMS Hearing & Audiology Services Unit/NHSP for 10 years and has more than 30 years of experience in the Department. In 2009, the Governor's budget eliminated 12 positions. ROS now has 40 positions. /2012/ROS is currently identified as Dependent County Operations Section and Independent County Operations Section. /2014/V. David Banda now serves as a program consultant to the Chief, SCD, and is responsible for handling the most complex and sensitive programmatic issues as directed by the Division Chief. David is well versed in child related programs, including the CCS program, and has held a number of mid-level manager positions in SCD.//2014//

James Delgado is the Acting Section Chief for the Dependent County Operations and has held that position since November 1, 2010. Prior to this position, Mr. Delgado was a manager in the DHCS Medical Case Management Program for approximately ten years. There are 44 positions in this Section.//2012//

/2013/As of June 2, 2011, James Delgado was appointed as the Section Chief for the Dependent County Operations Section (DCOS) formerly known as the Sacramento Regional Operations Section. Mr. Delgado has 25 years of state service. Of the 44 positions within DCOS, 34 positions are in Sacramento and 10 positions in L.A.//2013// ***/2015/Provider and CCS County trainings conducted statewide.//2015//***

/2012/The Section Chief for the Independent County Operations is currently vacant. V. David Banda is the Section Chief for Independent County Operations. There are 41 positions in this Section.//2012// /2013/The Section Chief for the Independent County Operations is Janis Fong. There are 38 positions in this Section.//2013// ***/2015/Of the 38 positions, five positions are in Sacramento and 33 positions are in Los Angeles.//2015//***

> Statewide Programs Section (SPS)
The Statewide Programs Section is responsible for administration of specialty programs with statewide responsibilities. Joleen Heider-Freeman is the Section Chief of SPS as of May 2005. The SPS currently has 24 filled positions. The SPS vacant positions have been cut due to the Governor's Balanced Budget Reduction Act. /2012/The SPS currently has 27 filled positions and 1 vacant position. Joleen Heider-Freeman retired as of April 8, 2011. V. David Banda is the Section Chief of SPS since April 11, 2011.//2012// /2013/The SPS currently has 14 filled positions and 6 vacant positions//2013// /2014/The SPS is comprised of 20 positions.//2014// ***/2015/Thomas Bone is the Section Chief of SPS as of May 2013. The SPS has 31 positions, with 3 vacancies.//2015//***

There are three units within the section: Specialty Programs, Hearing and Audiology Services, and GHPP. The Specialty Programs Unit is responsible for the monitoring of the HCPCFC, identifying CHDP administrative needs and priorities and initiates efforts to accomplish CHDP objectives, and offers TA with the Transition Planning Statewide Guidelines. /2013/SPS is offering TA with CCS Transition Planning.//2013// /2014//SPS does not provide transition planning TA.//2014//

The Hearing and Audiology Services Unit is responsible for the maintenance and monitoring of NHSP and for providing consultation/TA to providers and local programs regarding program benefits. The Unit is also responsible for the development and implementation of the NHSP Data Management Service (DMS). Staff in the unit monitor contracts with NHSP Hearing Coordination Centers (HCCs) providing follow-up testing and treatment services to infants with suspected hearing loss; evaluate and certify school audiometrists; and provide TA for the CHDP providers

on the audiometric testing of hearing for children in the school setting. ***/2015/The Hearing and Audiology Services Unit consists of three contract managers having oversight of three NHSP HCC designated regions: Northern California Regions A & B, South Eastern California Region C, and Southern California Region D. Total participating NHSP hospitals are as follows: Region A & B -- 118 hospitals, Region C -- 43 hospitals, and Region D -- 99 hospitals. There are over 555,000 births per year in California. All families of infants delivered in California hospitals will have their newborn's hearing tested.//2015//***

The Hearing and Audiology Services Unit develops and implements NHSP and CCS policy relating to hearing services. Monitoring and quality assurance activities are conducted with NHSP contractors and CCS providers. ***/2015/It is anticipated that there will be an estimated 1,275 infants born each year with significant hearing loss that will be identified and linked with ongoing services. In addition to improving the life of a child with hearing loss, early detection and intervention will produce long term savings as a result of improved integration and performance in school and society.//2015//***

GHPP provides all medical and administrative case management services for approximately 1750 clients statewide with serious, often life threatening, genetic conditions (e.g., hemophilia, cystic fibrosis, sickle cell anemia). /2012/GHPP has 1800 clients.//2012// /2013/GHPP has 1540 clients.//2013// /2014/ For GHPP enrollment data, see Agency Capacity.//2014// ***/2015/GHPP employs ten RN's for medical review of Service Authorization Requests (SARs), clinical certifications for applicants, and care management of GHPP members. Six of the ten nurses are located in our Oakland office and four in Sacramento and serve approximately 1,750 GHPP members. Staff handle approximately 700 calls per month and adjudicate approximately 300 SARs each week.//2015//***

> Program Support Section (PSS)
PSS is composed of three units and has responsibility for a variety of activities in support of Branch operations. The Section Chief is Erin M. Whitsell. She has held the position since 2003. There are currently 17 positions in PSS. /2012/Since Fall 2010, PSS is composed of two units: Administrative and PSU.//2012// /2013/Effective November 2011, Joseph De La Torre became the Section Chief of PSS.//2013// /2014/ PSS supports Division operations. //2014// The Administration Unit is responsible for fiscal, personnel, contracting, purchasing, and business services for CMS. Staff in the unit review, approve, and process CCS county and CHDP county/city invoices; resolve invoicing/payment issues; develop and implement administrative and fiscal procedures for new programs administered by the Branch; develop and manage contracts and interagency agreements; process contract and county expenditure invoices; and maintain personnel and business services transactions for all CMS Branch staff. /2012/These activities are for all Systems of Care Division (SCD) staff.//2012//

The Provider Services Unit (PSU) is responsible for enrolling providers for the CCS, CHDP, and GHPP programs and acts as a liaison between CMS Branch programs, their providers, the Medi-Cal Payment Systems Division, and the State fiscal intermediary. Staff in PSU also process hospital approval updates and all special care center directory updates and works with Information Technology staff in posting updates to various sites. Staff also develop and conduct provider training to individual and group health care providers, hospitals, special care centers, clinics, etc. in statewide formal training seminars. /2014/PSU acts as a liaison between all Division programs, their providers, the Medi-Cal Payment Systems Division, and the State fiscal intermediary.//2014//

The Clerical Support Unit provides general clerical support to the CMS Branch management and staff. The unit is responsible for completion of complex typing assignments; assists in organizing and filing all program documents; respond to telephone calls, faxes, and e-mails; disseminates program information to State staff, local agencies, the general public, and various other organizations; coordinates meetings; and, makes travel arrangements for staff. /2012/Clerical Support Unit has merged with PSU. PSU also provides general clerical support to the SCD

management and staff. The clerical support staff assists in organizing and filing all program documents; responds to telephone calls, faxes, and e-mails; and disseminates program information to State staff, local agencies, the general public, and various organizations.//2012// /2014/ SCD no longer has a separate clerical unit.//2014//

> Information Technology Section (ITS)
ITS is responsible for all aspects of information technology support for the CMS Branch and CMS Net, the Branch's automated case management system. This includes CMS Branch office products, CMS Net network support, CMS Net operations, and CMS Net Help Desk operation. The section provides consultation to the CHHSA's Data Center regarding county LAN/WAN connectivity and is responsible for corrections and modifications to CMS Net application. /2012/This is hosted at the Office of Technology Services'(OTech) Data Center.//2012// Brian Kentera was appointed Chief in February 2008. The CMS Net system is used by the county and State Regional CCS offices to manage the health care of approximately 170,000 children. /2012/The CMS Net system is used for managing the cases of 185,000 CCS and 1800 GHPP clients.//2012// /2013/The CMS Net system is used for managing the cases of 177,000 CCS and 1500 GHPP clients.//2013// /2014/ Reference to Children's Medical Services (CMS) Branch is gradually being phased out and replaced by Systems of Care Division (SCD). Brian Kentera serves as the ITS Chief. The CMS Net system is used by all State CCS offices. The CMS Net system is used to manage 180,200 active CCS cases and 1,630 active GHPP cases.//2014// ***/2015/ Recent CMS Net system enhancements include a new client referral tracking module, expanded case registration features and CCS demonstration pilot health care plan enrollment. Client referral tracking improves eligibility determination in the local CCS County offices and integrates with Case Registration for more efficient CCS client enrollment. Manual CCS Demonstration Pilot enrollment allows County eligibility case workers to designate optimal plan membership for those eligible in San Mateo County. These newly added efficiencies support children and families of those with special health care needs.//2015//***

This section is divided into two units: Information Systems and Information Technology. This section provides consultation to OTech, a division within the Office of the State Chief Information Officer, formerly the California Department of Technology Services. ITS currently consists of 11 State staff and 9 contractors. /2014/ITS has 12 staff. The Office of the State Chief Information Officer was re-named California Technology Agency.//2014// ***/2015/ The CMS Net system currently hosts 173,809 active California Children's Services (CCS) cases and is supported by 11.75 full-time equivalent (FTE) State IT Staff and 9 FTE Contractors in two organizational units.//2015//***

E. State Agency Coordination

MCAH and CMS are the primary entities in California that provide core public health and essential health care services for mothers, infants, children, and CSHCN through its Title V programs. This requires involvement at the community, local, and state level and seeking out of community based organizations (CBOs), building intra and inter-agency collaboration, partnering with universities, health foundations, hospitals, and health professional organizations and working with individuals we serve. Both MCAH and CMS provide leadership in working with these various stakeholders to identify and focus our priorities, establish a process, and create a plan to address these priorities and demonstrate progress in meeting these priorities.

Both MCAH and CMS actively foster statewide collaboratives and partnerships. A detailed discussion of our major collaboratives and partnerships was included in Section III-B, Agency Capacity.

> Department of Education (CDE)

MCAH collaborates with CDE on the ECCS grant to coordinate early childhood health programs for California's children .

CMS and CDE work collaboratively to assure all infants with hearing loss identified through the NHSP, are referred to Early Start. The MCHB grant supports improvement of services for early identification and intervention of hearing loss.

The CCS MTP provides physical therapy and occupational therapy services to program eligible children in the public school setting. The local education agency provides the space and equipment for the MTU, and the county CCS program provides the administrative and clinical staff. /2013/The State Interagency Cooperative Agreement between the CDE and DHCS, CMS, CCS MTP, was revised last year by CCS.//2013// ***/2015/County CCS programs, with State consultation, develop interagency agreements with local education agencies. //2015//***

The CMS Liaison to CDE participates on the Improving Special Education Services Stakeholders Group to achieve objectives of the State Improvement Grant.

MCAH is a part of the ASHWG collaborative comprised of representatives from CDPH, CDE and non-governmental organizations to address sexual and reproductive health issues of California adolescents.

/2015/ CDE is the lead agency for California's Race-to-the-Top Early Learning Challenge grant and a partner in ECCS.//2015// MCAH collaborates with CDE on the ECCS grant to coordinate early childhood health programs for California's children. In addition, The ECCS Coordinator is working with CDE on two early childhood grants: 1) to train early childhood child care educators on evidence-based practices for identifying and working with autistic children in their environments, and 2) to train the trainers at pilot sites to work with early childhood care and education staff on how to promote the social emotional wellness of young children. The goal is to create a statewide, sustainable system that is based on a common approach developed by Vanderbilt University Center on the Social Emotional Foundations for Early Learning. /2014/This collaboration ended.//2014//

> Department of Developmental Services (DDS)
CCS and Medi-Cal provide medical services to eligible infants and toddlers receiving services through the Early Start Program. Through participation on the Interagency Coordinating Council and Health Services Committee, CMS maintains ongoing communication with DDS. Some CCS clients also receive Regional Center Services and care coordination between CCS and DDS. CMS executed a Data Use Agreement with DDS to obtain outcome data on Early Start program enrollment of infants identified with hearing loss through the Newborn Hearing Screening Program.

MCAH collaborates with the Early Start program at DDS on planning and implementation activities of the ECCS grant. The ECCS coordinator has been appointed by Dr. Mark Horton, to represent CDPH on the DDS Early Start Interagency Coordinating Council, as mandated by the Individuals with Disabilities Education Act. CDPH also participates on the Data Committee. ***/2015/ MCAH no longer participates in this activity.//2015//***

DDS has expressed interest in the potential for disease prevention through MCAH preconception health activities and was invited to participate on the PHCC. /2014/ DDS is participating on the PHCC//2014//

> Department of Social Services (DSS)/Children in Foster Care
HCPCFC is collaboration between DSS and CMS to improve oversight of health care for children in foster care. CMS initiated a performance measure to evaluate the effectiveness of the HCPCFC administrative case management. A data collection system is being developed. /2013/Revised performance measures will be implemented on July 1, 2013.//2013//

With the passage of AB X4 4 in July of 2009, the HCPCFC became a mandated program statewide. The role of the Public Health Nurse (PHN) remains that of administrative case manager working collaboratively with the Social Worker and/or Probation Officer.

Five regional committees as well as a statewide subcommittee of the CHDP Program Executive Committee meet on a quarterly basis. /2013/Four regional committees as well as a statewide subcommittee of the CHDP Program Executive Committee meet on a quarterly basis.//2013//

AFLP continues to collaborate with the DSS/Cal-Learn as part of case management oversight for pregnant and parenting teens.

/2015/The Office of Child Abuse Prevention (OCAP) is a partner in strengthening CHVP's focus on developing an integrated early childhood development system.//2015// Under the ECCS grant the Statewide Screening Collaborative (SSC) continues to provide technical assistance to DSS to implement developmental screening at the county level for foster children as part of the federal law, Child Abuse Prevention and Treatment Act, which requires that any child under the age of two with substantiated abuse or neglect be referred to early intervention services. /2014/The SSC has developed the Help Me Grow model as a way to develop local systems of early identification and referral. The Help Me Grow Learning Community comprises 18 counties who are implementing Help Me Grow.//2014//

/2012/Assembly Bill 12 (AB 12), California's Fostering Connections Act was signed into law on September 30, 2010 bringing numerous changes to the Foster Care system, most notable the extension of foster care benefits to age 21.//2012// /2013/CMS continues to collaborate with DSS and local program PHNs in the development of AB 12 related policies and procedures.//2013//

> Managed Risk Medical Insurance Board (MRMIB)
CMS and MRMIB coordinate quarterly meetings throughout the state for medical plans, and separate meetings for dental plans. Ad hoc subcommittees comprised of members from CCS and MRMIB work together to train providers and resolve program issues. ***/2015/MRMIB provide health coverage through commercial health plans, local initiatives and county organized health systems to eligible but uninsured individuals. See HSCI 3 for more information.//2015//***

Under ECCS grant, the SCC is working with MRMIB to identify ways to incentivize the use of standardized developmental screening tools in their plans. A survey was conducted in 2009 that showed only 1.26% of their children under the age of five were being screened with a validated tool. ***/2015/MCAH no longer participates in this activity.//2015//***

> Childhood Lead Poisoning Prevention Branch (CLPP)
CMS, through CHDP, provides lead screenings for children. The CCS program covers the cost of evaluation and treatment of serious lead poisoning cases. The CHDP program and CLPP developed new approaches to screening that consider all low income children to be at risk and require blood lead screening.

The Health Assessment Guidelines section on management of elevated blood lead levels has been revised as recommended in the November 2007 Morbidity and Mortality Weekly Report.

CHDP and CLPP released a joint letter in December 2008 outlining the updated UCSD recommendations on childhood lead poisoning prevention. /2012/CHDP and CLPP are reviewing blood lead referral and screening rates to ensure that blood lead testing is done at the appropriate intervals of 12 and 24 months.//2012//

MCAH and CMS participate in the statewide planning process led by CLPP to eliminate childhood lead poisoning and meet the HP 2010 goal. A federal interagency strategy and objectives have

been developed. /2012/MCAH is no longer involved in this project.//2012// ***/2015/SCD and CLPP coordinate the revision of the lead screening health assessment guidelines to incorporate in the CDC guideline guidance.//2015//***

> Immunization Branch (IZB)
The CMS and IZ Branches collaborate with the Vaccines for Children (VFC) program by providing vaccination coverage and modifications through the CHDP program, including: tetanus, diphtheria and acellular pertussis vaccine; FluMist; meningococcal conjugate; measles, mumps, rubella, and varicella; hepatitis A, hepatitis B, Haemophilus influenzae type B vaccine, rotavirus, influenza, human papillomavirus, and meningitis vaccines./2013/Pneumococcal vaccine (PCV13 and Pneumovax23 when appropriate) are provided by the CHDP program.//2013//

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

MCAH has partnered with the IZ Branch to provide immunization updates to the MCAH Perinatal Services coordinators, review immunization brochures on immunization during pregnancy, development of educational materials on H1N1 in pregnancy, and the importance of influenza vaccination. /2012/MCAH worked closely with the IZ Branch to provide information on pertussis to MCAH providers.//2012// /2014/MCAH coordinated with the IZ branch to partner with Text4Baby to remind mothers to immunize their babies and educate parents about the new requirement, that all students entering, advancing or transferring into 7th grade will need proof of an adolescent whooping cough booster immunization.//2014//

> California Nutrition, Physical Activity and Obesity Prevention Program/ Champions for Change
MCAH and CMS collaborate with the California Nutrition, Physical Activity and Obesity Prevention Program and the Champions for Change to promote healthy lifestyles to reduce the prevalence of obesity. MCAH and CMS participated on the 2009 Childhood Obesity Conference committee, which showcased evidence-based prevention, interventions, and community efforts. MCAH featured their BBC project, working with hospitals to integrate Q I efforts within the maternity care setting to ensure policies and practices are supportive of breastfeeding, as well as the work they are doing to promote healthy weight before, during, and after pregnancy and "Tracking Childhood Obesity Trends Using Geographic Information System (GIS) Mapping, California: 1996-2006."

MCAH was also on the planning committee for the 2009 Weight of the Nation, a national forum to highlight progress in the prevention and control of obesity through policy and environmental strategies. MCAH was instrumental in including a life course perspective and a presentation on BBC.

/2012/MCAH is working on the next Childhood Obesity Conference scheduled for 2011 in San Diego, partnering with CDE, UC Berkeley's Atkins Center for Weight and Health, CA Endowment, and Kaiser Permanente.//2012// /2014/MCAH is working with the same partners on the 2013 Childhood Obesity Conference in the Long Beach Convention Center.

MCAH is providing expert consultation for the California Obesity Prevention Program to 15 clinics to become "Breast Feeding Friendly. //2014//

/2012/MCAH participated in a multi-agency workgroup to develop the Health in All Policies Task Force report which has specific nutrition and physical activity recommended policies, programs, and strategies that State agencies can implement to advance health.//2012// /2014/MCAH has been an active partner in developing and implementing the strategies in the Coordinated Chronic Disease Plan.//2014/ ***/2015/ MCAH provided input into the 2014 California Wellness Plan and Health in All Policies nutrition guidance for the Department of Corrections.//2015//***
/2012/PHCC Interconception Care Project of CA, in coordination with ACOG District IX and

funded by MOD, is finishing provider guidelines for post-partum visits, which include management of women who developed gestational diabetes during their prior pregnancy.//2012//

> Medi-Cal Managed Care Division (MCMC)
California WIC Association, WIC, and MCAH meet monthly with MCMC Division to clarify and simplify access to breastfeeding supportive benefits. ***/2015/MCAH collaborates with MCMC to share issues identified by stakeholders related to access to perinatal care services through managed care and fee-for-service. MCMC contracts with established networks of organized systems of care. CCS provides administrative case management and specialty care coordination to CSHCN enrolled in the Medi-Cal program.//2015//***

> Safe and Active Communities Branch (SAC)
The Safe and Active Communities (SAC) Branch is the lead agency within CDPH responsible for coordinating statewide injury and violence prevention efforts. This includes the prevention of intentional and unintentional injuries as well as surveillance and epidemiology. Current intervention efforts focus on child passenger safety (CPS), violence prevention (ranging from child maltreatment, violence against women, including sexual assaults, homicide and suicide), elder maltreatment, fall prevention, pedestrian safety, and creating safe and active communities conducive to walking and bicycling. SAC's injury surveillance and epidemiology program includes the California Injury Data Online, a web-based do-it-yourself injury surveillance table builder (www.dhs.ca.gov/EPICenter).

MCAH collaborates with SAC on injury prevention activities, including local training programs, SIDS and the Child Death Review Team (CDRT), SAFE-KIDS California Advisory Committee, and the Strategic Coalition on Traffic Safety. MCAH Title V support data collection and prevention work of the local CDRTs. MCAH and SAC are also working together to address Electronic Death Recording System data issues related to Shaken Baby Syndrome and SIDS. /2013/MCAH and SAC will also be collaborating to analyze trauma related maternal deaths.//2013//
> Office of Audits and Investigations
MCAH works closely with DHCS Audits and Investigations to ensure the integrity of MCAH programs.

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

CCS provides services for conditions identified on (NBS) tests, develops standards, and approves Metabolic, Endocrine, and Sickle Cell Special Care Centers (SCCs) for treatment.

/2012/MCAH collaborated with GDSP to revise "Your Future Together," a preconception and prenatal health information booklet for women obtaining marriage licenses.//2012//
/2013/Newborn screening now also includes screening for Severe Combined Immunodeficiency.//2013// ***/2015/CCS and GDSP will continue to work together to impact of the various genetic mutations found in the NBS for cystic fibrosis.//2015//***

> Women, Infants & Children (WIC) Supplemental Nutrition Division
MCAH and CMS collaborate with WIC in a variety of areas, including improvement of prenatal care, linkages between MCAH and WIC data files, obesity prevention, oral health, childhood injury prevention, and breastfeeding. In 2010, MCAH began collaborating with WIC on several applied, public health research projects (as described in Section III-A). /2014/WIC and MCAH are in discussions regarding how they could collaborate to increase enrollment in WIC, especially among high risk and hard to reach eligible women, infants, and children.//2014//

MCAH collaborated with WIC on updating WIC food packages to ensure foods address the

nutritional needs of women, infants, and children and are consistent with the 2005 Dietary Guidelines for Americans. The modifications enhance the nutritional quality of foods available to WIC families, improve health outcomes, and expand the cultural food options and overall food choices for WIC's diverse populations. CMS also collaborated on the regulations for medical providers. MCAH partnered with WIC to facilitate dissemination of the new information.

WIC, MCAH, California WIC Association, and the Nutrition, Physical Activity and Obesity Prevention Program developed a California Breastfeeding Roundtable to develop and implement a breastfeeding strategic plan.

CMS collaborates with WIC regarding CHDP provider relations, relevant health assessment guidelines, and communications. For example, when WIC's food package changes, a new pediatric referral form is generated. This change is communicated to CHDP providers via Provider Information Notices. CHDP Health Assessment Guidelines promote the use of WIC nutrition education materials for providers to use for anticipatory guidance. Additionally, CMS assists WIC with using the Pediatric Nutrition Surveillance System (PedNSS) prevalence data for local program nutrition education plans.

CMS also coordinates with WIC regarding the provision of specialty enteral nutrition products for the Special Needs Population in WIC and CCS.

CMS, WIC, and MCAH meet quarterly for program updates /2012/coordinate projects and develop relevant policies/guidelines.

MCAH coordinated with WIC, CA WIC Association, the CA Obesity Grant and the CA Breastfeeding Coalition to coordinate National Breastfeeding Week activities, and hosted the 2011 Hospital Breastfeeding Summit. MCAH also partnered with WIC to develop and disseminate a teen cookbook.//2012// /2013/This collaboration continued for the 2012 2nd Annual Breastfeeding Summit.//2013// /2014/This collaboration continued in the third Annual Breastfeeding Summit, including PAC-LAC. ***/2015/In 2014, MCAH supported the 4th Breastfeeding Summit. //2015//***

MCAH is working closely with the Office of Emergency Preparedness, as well as WIC and other partners to develop a policy supporting lactating mothers and their infants in a disaster. MCAH and WIC are sending a letter to hospital executives to provide direction for implementation of the Infant Feeding Act that requires hospitals to have an infant feeding policy by 2014.

MCAH produced prenatal weight gain grids for pregnant women with twins. The grids were developed with input from WIC and continue to be based on the 2009 Institute of Medicine's Weight Gain During Pregnancy: Reexamining the Guidelines. WIC's website provides a link to the MCAH posted grids.//2014// ***/2015/MCAH revised the CDPH breastfeeding webpage with input from WIC and the California Obesity Program. //2015//***

>CDPH Center for Health Care Quality
Collaboration between CDPH and CMS: CLABSI reporting. CDPH issued its first public report on hospital CLABSI in 2012. CMS and CDPH have begun to collaborate to help ensure benchmarking data accuracy because neonatal reporting entails data elements unique to this age group and evaluation of inconsistent/anomalous values requires specialized knowledge of NICU care processes.//2013// ***/2015/CDPH Center for Health Care Quality sends all CLABSI data to CCS to explore new improvement methods for CLABSI prevention.//2015//***

> Universities
MCAH and CMS work closely with the University of California and other universities in the state. Partnerships include the National Adolescent Health Information Center and the Bixby Center for Reproductive Health Research & Policy at UCSF, Stanford University (on CMQCC and CPQCC issues), and the Center for Injury Prevention Policy and Practice at San Diego State University

(SDSU). UCSF FHOP provides consultation and training to local MCAH jurisdictions in monitoring and updating local five-year plans, data collection, identification of data sources, data analysis, and survey development. FHOP also provides consultation, data analysis, attends stakeholder meetings, and conducts interviews for the Title V Needs Assessment. /2014/MCAH worked with UCSF FHOP to develop an introductory webinar on addressing the built environment and its influence on nutrition and physical activity.//2014//

UCLA's Center for Healthy Children, Families and Communities participates in the Statewide Screening Collaborative as well as collaborate with the maternal QI project. /2012/ UCLA was contracted to conduct an analysis of maternal morbidity and improve data collection at hospitals needed to report on Joint Commission obstetrical measures for quality improvement.//2012// /2013/Additionally, the UCLA Center for Health Policy Research has been contracted to provide the 1115 Bridge to Reform Evaluation, as well as the evaluation of the Pediatric Palliative Care Waiver Program.//2013// ***/2015/UCLA's Center for Healthy Children, Families and Communities participates in the SSC. MCAH contracted with UCLA Center for Health Policy Research to provide the 1115 Bridge to Reform Evaluation and to estimate costs savings of earlier treatment of maternal hemorrhage and hypertensive disease for Medi-Cal births. UCLA Cedars Sinai participates in the Maternal Quality Indicator Workgroup.//2015//***

MCAH provides MPH student internships, and mentoring for students and physicians in training.

In collaboration with MCAH, UCSF Center on Social Disparities in Health conducts, analyzes, and reports on MIHA. MCAH contracted with the UCSF Center on Social Disparities in Health to assess BIH program services. UCSF's recommendations have served as a foundation to develop a standardized intervention and evaluation plan. /2012/UCSF partners with MCAH in the development and implementation of the evaluation of BIH.//2012//

Through a contract with SDSU Institute of Public Health and CCHA, the Catheter Associated Bloodstream Infection Prevention Neonatal Quality Improvement Initiative (NQI) using the IHI model was initiated in 2007 with 13 regional NICUs. CLABSIs were reduced by 29% in all weight groups. The collaborative expanded in 2008 to include all 22 CCS-approved regional NICUs. And in July 2009, the collaborative has continued on with 14 regional NICUs and expansion to all hospital associated bloodstream infections. /2012/The bloodstream infection (BSI) prevention Collaborative is continuing through 2012.//2012//

> California District of the American Academy of Pediatrics (AAP-CA)
Under the leadership of MCAH ECCS, the SSC is working with the AAP-CA. AAP-CA has designated Dr. Renee Wachtel, a developmental pediatrician, to represent the AAP-CA on the SSC. She has been leading a subcommittee for the Collaborative to work with Medi-Cal Fee-For-Service on identifying issues with developmental screening reimbursement. Recommendations to be provided to Medi-Cal in spring 2010. ***/2015/This activity ended.//2015//***

/2013/Conference calls between the AAP-CA Chapter Champions, the state NHSP staff, and the HCC directors occur every other month. An article on the NHSP was published in the District magazine. A podcast is being developed to educate pediatricians about the NHSP and their role in coordinating care during and after the identification process. Two of the Chapter Champions will be attending the national Early Hearing Detection and Intervention meeting in 2012. No Chapter Champion from Chapter 3 has been designated.//2013//

The CMS Branch collaborates with AAP-CA on many initiatives such as the 1115 Waiver, the CCS Needs Assessment, and the Palliative care Initiative.

/2012/> American Congress of Obstetricians & Gynecologists California (ACOG) District IX
ACOG supported the toolkit to eliminate non-medically indicated deliveries prior to 39 weeks gestation and developed a Speaker's Bureau for the statewide effort. ACOG has representation

at PHCC and CMQCC Executive Committee. /2014/ ACOG works closely with MCAH and MOD on promoting the use of the toolkit to eliminate non-medically indicated deliveries <39 weeks gestation.//2014//

>March of Dimes (MOD)
MCAH partners with MOD in the PHCC ***/2015/and now MOD assumes PHCC's full funding//2015//***. MOD and ACOG, with input from the Preconception Council, is developing an Interconception Health Care Toolkit for use in California. MCAH provided a toolkit to eliminate non-medically indicated deliveries before 39 weeks gestation to the MOD for national dissemination. MOD funds 8 California obstetrical hospitals in a national collaborative to reduce elective early term deliveries. MOD provided CPeTS with a grant to develop regionalized, risk appropriate maternal care. MCAH previously collaborated with MOD on the Preterm Labor Assessment Toolkit and a Folic Acid Promotion Campaign. //2012// /2013/ MCAH will be collaborating with MOD as well as the Association of State and Territorial Health Officers to meet their national challenge to reduce preterm births by 8% from 2009 levels by 2014.//2013// ***/2015/California received a 2014 MOD Franklin D. Roosevelt Prematurity Campaign Leadership award for achieving the HP 2020 objective for preterm births.//2015//*** /2014/ In partnership with the CDC Preconception Health Initiative and PPE, MCAH and PHCC implemented the Show Your Love public awareness campaign.//2014/ ***/2015/ RPPCs encourage hospitals to participate in the MOD Antenatal Corticosteroid Utilization Practices Survey.//2015//***

> California Association of Neonatologists (CAN) and Stanford University
CMS and MCAH work with these groups on a perinatal and neonatal morbidity and mortality reporting system that provides information on quality of care, and serves as a basis for quality improvement in participating hospitals. CMS participates in CAN/District IX Board Meetings and annual conferences and in 2009-10 has provided progress reports on the Federal 1115 Waiver Renewal and the CCS Technical Workgroup which will be making recommendations for CCS redesign http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx . Collaboration with Stanford and CPQCC continues with NICU and HRIF data collection and the breast milk nutrition QI /2014/ Length of Stay//2014// Collaborative. CMS has worked with the Packard Foundation as they assess a service system for Children and Youth with Special Health Care Needs (CYSHCN) in CA. /2012/ CMS is working with CAN on NICU Z code conversions to national codes and looking at NICU models of provider reimbursement.//2012//

> Children's Specialty Care Coalition (CSCC)
CSCC is an organization of pediatric specialty and subspecialty providers practicing at CCS-approved tertiary hospitals and Special Care Centers. CSCC has participated in the Title V Needs Assessment process and is also an active participant in the 1115 Waiver Redesign process. /2012/CSCC is working with CCS and Medi-Cal on Z code conversions to national codes for NICUs and PICUs.//2012// ***/2015/CSCC is assisting in implementing the ACA primary care MD payment increase, and CCS PICU VPS database.//2015//***

> California Conference of Local Health Officers (CCLHO)
CMS works with CCLHO on issues related to county program operations for CSHCN, preventive health services for children, and the CMS Net Data system.

> California Children's Hospital Association (CCHA)
The Children's Hospitals are vital providers of services to children in the CCS program. CMS works closely with hospitals in the Title V Strategic Planning Process; develops quality improvement initiatives; and advocates for children's services.

In collaboration with CCHA, CMS is sponsoring a Neonatal Quality Improvement Initiative. CMS collaborates with CCHA in the NQI Initiative, which includes all 22 Regional NICUs. /2012/This collaboration ended in 2009.//2012//

> Other Professional Organizations
CMS collaborates with the California Dental Association, the California Association of Orthodontists, the Oral Health Access Council, the California Orthopedic Surgeons Association, the California Association of Home Health Agencies, California Association of Ophthalmologists, California Association of Medical Products Suppliers and the Hemophilia Council and Foundations to improve working relationships, recruit providers, and address barriers to access to services. CMS works with Medi-Cal to improve reimburse processes for providers.

A number of professional organizations are actively involved in the Title V Needs Assessment process and participating in the 1115 Waiver Redesign process.

CMS collaborates with the Children's Hospice and Palliative Care Coalition to develop a federal Medicaid waiver to allow CCS clients to access 'hospice-like' services while still receiving treatment services for their eligible conditions. There are 60 members of the stakeholder group providing input into the waiver design and development, including representatives from the Children's' Hospitals, University of California hospitals, CSCC, hospices and home health agencies.

The Palliative Care Waiver was approved by Federal Centers for Medicare and Medicaid Services with a start date of July 1, 2009. /2012/Start date was April1, 2009.//2012//

ECCS partners with many others through the SSC including First 5, the California Academy of Family Physicians, the California Association of Health Plans, the Advancement Project,***/2015/ and Help Me Grow, in 18 counties statewide will be used as a referral source through ECCS.//2015//***

MCAH contracts with the CAHC to support LHJs' efforts on adolescent health.

MCAH collaborated with the Network for a Healthy California to develop a proposal for a preconception health social marketing campaign, funded by a HRSA/MCHB First Time Motherhood grant.

MCAH and CMS are involved in strategic planning for California's CDC-five year funded Nutrition, Physical Activity and Obesity Prevention Program. CMS conducted statewide webinars with local CHDP program staff to identify health care strategies for the health care sector of the Obesity Prevention Plan. ***/2015//MCAH consulted on a 2013 CDC grant to improve breastfeeding duration rates in high-risk communities by implementing a breastfeeding- friendly healthcare provider certification program at 15-safety net clinics and enhancing systems to provide professional breastfeeding support services and pumps as required by the ACA.//2015//***

CMS coordinated with MCMC Health Plans: Kaiser, Cal Optima, Anthem Blue Cross and Health Plan of San Joaquin to provide training workshops, "Pediatric Obesity: Provider Skill Sets for Improved Care" to accelerate provider practice changes regarding childhood obesity. CMS is collaborating with Head Start on childhood obesity intervention since the majority of Head Start children receive health assessments through CHDP.

/2012/MCAH collaborates with the ARC of CA in the Fetal Alcohol Spectrum Disorders Task Force, an independent, public-private partnership of parents and professionals from various disciplines committed to improving the lives affected by FASD and eliminating alcohol use during pregnancy.

MCAH has representation on the US Breastfeeding Promotion Committee and on the MCH Nutrition Council of the Association of State and Territorial Public Health Nutrition Directors (ASTPHND). ***/2015/The MCAH Nutrition and Physical Activity Coordinator serves as the President of the Association of State Public Health Nutritionists (ASPHN).//2015//*** The

Council addresses policy, programs and services that promote nutrition wellbeing across a woman's lifespan for women including breastfeeding. The MCAH Nutrition and Physical Activity Coordinator served as Chair of the ASTHPND MCH Nutrition Council. The Council's goal is to achieve optimal health through healthy eating and active living and provide members with networking, educational and advocacy opportunities.

CMS is coordinating with MCAH to present at the 6th Biennial Childhood Obesity Conference during the Healthcare Prevention Strategies Track. The workshop will address the efforts made by the CHDP program related to pediatric obesity. Also, CMS is collaborating with MCAH and WIC to develop strategies to implement the new WHO Growth Charts. The CHDP Nutrition Subcommittee has been charged with the task of developing CHDP provider trainings on the use of the new WHO Growth Charts.

>Multiple Collaborations through Home Visiting Program
MCAH joined with DSS, ADP, and CA Head Start State Collaboration Office of CDE to develop the state's Home Visiting Program application and Needs Assessment. /2014/This collaboration is continuing in the State Interagency Team California Home Visiting Workgroup. Additional collaborating agencies include DDS and Race to the Top in the CDE//2014// ***/2015/ First 5 California and the California Head Start Association.//2015//***

Additional input was obtained from the CA Emergency Management Agency; the Safe and Active Communities Branch of the CDPH; the STOP Violence Against Women regional coordinator for CA; CA Partnership to End Domestic Violence; and the Domestic Violence Assistance Program and local MCAH directors.//2012//

F. Health Systems Capacity Indicators

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

Health Systems Capacity Indicators Forms for HSCI 01 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	22.9	22.3	21.9	22.0	22
Numerator	6290	6187	5511	5539	
Denominator	2745856	2771815	2514468	2514271	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
A manual indicator is reported for 2013 based on 2012

Notes - 2012
Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2012. Primary diagnoses of each discharge abstract were tabulated, secondary diagnoses were not included.

Denominator:
State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2011-2012 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010 using these updated population projections was 24.5.

Notes - 2011
Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2011. Primary diagnoses of each discharge abstract were tabulated, secondary diagnoses were not included.

Denominator:
State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2011 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010, using these updated population projections, was 24.5.

Narrative:
HSCI 01 is the rate per 10,000 for asthma hospitalizations among children less than five years old. The rate of children hospitalized for asthma was 22.0 per 10,000 in 2012. Hospitalization rates for asthma were highest among African American children (62.3 per 10,000) compared to Hispanics and Whites (20.8 per 10,000 and 18.1 per 10,000, respectively. Nationally, asthma prevalence increased between 1980 and 2002 for children and adults. Since 2005, California has consistently achieved the Healthy People 2010 objective of 25 hospitalizations per 10,000 children under age 5.

The role of air pollution and second-hand smoke in the severity of asthma attacks is well documented in literature. Unlike second hand smoke which can trigger an asthma attack, the role of air pollution in initiating asthma is still under investigation and may involve a very complex set of interactions between indoor and outdoor environmental conditions and genetic susceptibility. The California's Air Resources Board (ARB) has been a leader in developing and supporting research to understand the relationship between air pollution and asthma. In the Central Valley the ARB F.A.C.E.S. project is examining the role of particulate matter pollution in the exacerbation of childhood asthma.

America's Health Rankings accounted for air pollution as a health determinant in ranking the over-all health of states [33] Since 2003, the annual America's Health Rankings reports listed California with the highest level of air pollution among all states. The U.S. had an average of 1.59 days of ozone levels exceeding 75 parts per billion in 2008; California had an average of 8.45 days. [34] Although air pollution in California dropped significantly over the last decade, about a third of the population live in communities where the air quality does not meet federal health standards.

Based on the 2010 local needs assessments conducted, San Joaquin County expressed concern about air pollution in their region and also of having the greatest asthma burden in adults 18-64 years of age in California. An emerging issue in Fresno County was air pollution and its link to increased asthma especially in young children and in African Americans. The Kern County MCAH System of Care planned to develop closer working relationships among its community partners to raise the awareness level among partners about health and environmental issues affecting the MCAH population.

To raise awareness of the links between air quality and health, MCAH, in collaboration with FHOP, released for the first time, data on the annual number of days that ozone levels are above regulatory standard by region and the local rate of smoking in households with children less than five enrolled in CHDP as part of a compilation of local health indicators for the current local needs assessment process underway.

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

Health Systems Capacity Indicators Forms for HSCI 02 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	90.1	88.5	87.3	80.7	76.1
Numerator	589251	557757	538894	510203	469920
Denominator	653829	630326	617510	632310	617445
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Manual Indicator for 2012 based on 2011.

Notes - 2011
Source: CHDP data and CMS 416 EPSDT report

Narrative:
Health Systems Capacity Indicator 02 (HSCI-02) is the percent of Medi-Cal enrolled children less than one year of age who received at least one CHDP health assessment in the reporting year.

The Memoranda of Understanding between MCMC plans and local CHDP programs continue. Each local CHDP program coordinates with MCMC plans to develop a procedure for working together. DHCS provides TA and program consultation to local CHDP programs and MCMC plans to resolve problem areas. The CHDP program at the local level provides outreach to providers and children and their families (such as health fairs and other community events). SCD collaborated with the California Medical Home Project and the LA Medical Home Project. LA County CCS also works with LA Care MCMC Plan for better coordination of care by the medical home.

Quarterly meetings between CHDP programs and MCMC plans are occurring in some counties and less frequently in other counties. SCD continues to collaborate with MCMC plans on statewide operational problems that occur with the carve-out of CCS services in Medi-Cal and HF managed care plans.

Local CHDP programs continue to provide education, training and outreach to CHDP provider office staff and the community. The CHDP Gateway pre-enrollment process and infant deeming appear to be having the greatest effect on this performance measure.

California has made a strong commitment to reducing the number of uninsured children and ensuring access to healthcare services for children. MCAH Division programs, such as the AFLP, BIH and CPSP screen and assess children and adolescents for Medi-Cal eligibility and assist them in obtaining services.

SCD continues to collaborate with MCMC management staff on statewide operational issues that affect local CHDP programs, including provider office site visits and sharing of information between program site reviewers in MCMC and CHDP.

To increase access to care, infants born to women eligible for and receiving Medi-Cal at the time of birth are automatically deemed Medi-Cal eligible for one year without a separate Medi-Cal application or SSN. This includes continued Medi-Cal eligibility for infants up to age one, which provides that the infants shall remain eligible, regardless of any increases in the family's income.

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

Health Systems Capacity Indicators Forms for HSCI 03 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2013
Data available from the state's SCHIP is an aggregate of the percent of children with six or more well-child visits in the first 15 months of life. State data describing the percent of children whose age is less than one year who received at least one periodic screen is not available.

Notes - 2012
Data available from the state's SCHIP is an aggregate of the percent of children with six or more well-child visits in the first 15 months of life . State data describing the percent of children whose age is less than one year who received at least one periodic screen is not available.

Notes - 2011
Data available from the state's SCHIP is an aggregate of the percent of children with six or more well-child visits in the first 15 months of life . State data describing the percent of children whose age is less than one year who received at least one periodic screen is not available.

Narrative:
Health Systems Capacity Indicator 03 (HSCI-3) is the percent of Healthy Families (HF) enrollees under one year of age who received at least one CHDP health assessment. HF plans did not conduct CHDP health assessments, but instead covered preventive examinations based on the AAP guidelines. The HF Program relied on HEDIS to evaluate the performance of the health plans. While HEDIS data is available on the MRMIB website, the specific data for HSCI-3 is not collected by MRMIB.

Pursuant to Assembly Bill 1494, the 2012-13 State Budget required the transition of children enrolled in HF to the Medi-Cal Program (except for AIM linked infants and children) and transitioned eligible subscribers to the Medi-Cal Program in four Phases throughout 2013. In November 2013, infants enrolled into the HFP as a result of being born to a mother who was on the AIM program with an income above 250 percent and up to 300 percent of the FPL were transitioned to DHCS and integrated into the new DHCS AIM-Linked Infants Program. As of February 1, 2014, DHCS fully implemented the ALIP health plan. In addition, DHCS has established a monitoring and reporting system to assure its health plans are fulfilling their obligation to provide covered Medi-Cal health services to their members in accordance with State and federal requirements. Infants in the ALIP with CCS-eligible medical conditions will continue to receive case management and care coordination from the CCS Program.

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

Health Systems Capacity Indicators Forms for HSCI 07B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	50.0	47.6	60.3	52.6	53.3
Numerator	440212	423316	553478	502486	620775
Denominator	880094	889036	918078	955716	1164862
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2013
This measure is the percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year. Source is the Form CMS-416: Annual EPSDT Participation report
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html

Notes - 2012
This measure is the percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year. Source is the Form CMS-416: Annual EPSDT Participation report
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html

Notes - 2011
Source: MIS/DSS Medi-Cal claims data

Narrative:
Health Systems Capacity Indicator 07b (HSCI-7b) is the percent of EPSDT eligible children (CHDP in California) aged 6 through 9 years who received any dental services during the year. The goal of this indicator is to increase dental health services to Medi-Cal eligible children at an important stage of dental development.

Current activities related to this indicator include: The CHDP Gateway covers dental services for pre-enrolled children up to 60 days after a CHDP health assessment and has increased access to dental services. CHDP Gateway offers the opportunity to apply for permanent enrollment in Medi-Cal or HF which includes dental benefits. Most Denti-Cal providers accept the pre-enrollment receipts and many children receive dental services through the Gateway. CHDP Gateway offers the opportunity to apply for permanent enrollment in Medi-Cal which includes dental benefits through Denti-Cal or dental managed care plans. Healthy Families is no longer in existence and therefore not an option. Those children are now eligible for Medi-Cal.

CHDP tools such as the revised two-sided full color "PM 160 Dental Guide" will continue to improve the quality of dental screenings and more acceptable annual referrals to a dentist beginning at age one. A provider notice, under development, will encourage CHDP providers to discuss the importance of dental sealants with families of 6 and 12 year old children. Fluoride varnish applications (3/year) became a benefit of the Medi-Cal program. CHDP providers were informed of this benefit, asked to apply fluoride varnish, and be reimbursed through Medi-Cal. A Power Point dental training has been developed and released on the State CHDP website for CHDP Providers and local program staff which includes resources and oral health topics specific to screening and referring children to a dentist by age one. The main purpose of the training is to encourage appropriate dental referrals using a four category classification system. Providers, as well as CHDP offices, will be able to make emergency and urgent dental referrals sooner, if not immediately, once trained. A condensed dental training has also been developed and will be placed on the CHDP website shortly. Fluoride varnish applications, 3 per year, became a benefit of the Medi-Cal program for children age 0 to 6. There will soon be a power point fluoride varnish training for CHDP providers to be placed on the CHDP website. The condensed version of the dental training as well as the fluoride varnish power point training are now available on the CHDP website.

Brochures entitled, "Fluoride Varnish-- Helping Smiles Stay Strong" and "Every Child Needs a Dental Home" have been released to local CHDP programs. These can be downloaded from local CHDP websites. They are currently available in three languages with three more languages planned. A resource guide has been developed and distributed to local programs.

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2013	250
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2013	100

Notes - 2015
: California Department of Health Care Services, Medi-Cal Eligibility Division (internal communications).

Notes - 2015
Source: California Department of Health Care Services, Medi-Cal Eligibility Division (internal communications. sCHIP (aka Healthy Families) was transitioned to Medicaid (Medi-Cal), as part of the Affordable Care Act's Medicaid expansion plan in the state and no longer enrolls new clients starting in 2013

Narrative:
Medi-Cal, California's Medicaid program has been covering low-income Californians since 1966. As of 2013, there were 8.5 million people enrolled. Beginning January 1, 2013, pursuant to Assembly Bill (AB) 1494, (Committee on Budget, Chapter 28, Statutes of 2012), Healthy Families Program (HFP) no longer enrolled new applicants (except for AIM linked infants and children). Through four phases in 2013, all HFP enrollees were transitioned to Medi-Cal, as allowed under federal law. By December 31, 2013, 751,293 children successfully transitioned to Medi-Cal. This transition resulted in 286,679 new cases added to Medi-Cal's new Optional Targeted Low Income Children's Program.

Effective November 1, 2013, 531 HF AIM linked infants above 250% and up to 300% FPL were transitioned into the new DHCS AIM Linked Infants Program (ALIP). The AIM-linked infants, covered under the authority of the Children's Health Insurance Program, will maintain their current income eligibility based on the income standards of their mother for up to their first two years of life and, if they meet income eligibility requirements for Medi-Cal, they will subsequently be transitioned into the Medi-Cal program. As February 1, 2014, DHCS fully implemented the transition of the ALIP under DHCS, similar to processes when the program was operated by MRMIB.

The state completed the expansion of Medi-Cal managed care services to all of California's 58 counties. Under the Affordable Care Act, Medi-Cal coverage will expand in 2014, making 1 million to 2 million new people eligible. Children who need health coverage but do not qualify for Medi-Cal may be eligible for the state's County Children's Health Initiative Program (C-CHIP). The C-CHIP provides federal funding for low cost health coverage to uninsured children through age 19, who are not eligible for the no-cost Medi-Cal Program, and whose household income falls within 251% to 300% of the federal poverty level (FPL).

IV. Priorities, Performance and Program Activities

A. Background and Overview

California's Title V performance reporting will include a total of twenty five to twenty eight measures: eighteen national performances measures (NPM) mandated by HRSA and seven to ten additional measures chosen by the state. /2012/ Sensible performance measures help our partners and stakeholders understand what is important , establish expectations in measurable terms, collect data on progress, make decisions with the collected information and adjust course when necessary. //2012// The three SPM in this report include the following:

SPM 01: The percent of children birth to 21 years enrolled in the CCS program who have a designated medical home; /2013/ This was revised to: 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.//2013//

SPM 02: The percent of primary care physicians, approved to participate in the CCS program, who are receiving authorizations for care; /2013/ This was inactivated and replaced by a newly created SPM 10.//2013//

SPM 03: The percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey;

The seven other state performance measures under consideration may include some of the measures reported in the 2006-2010 Five Year Needs Assessment. /2012/ The additional SPMs in this report include:

SPM 04: The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy

SPM 05: The percent of cesarean births among low risk women giving birth for the first time.

SPM 06: The percent of women of reproductive age who are obese.

SPM 07: The percent of women whose live birth occurred less than 24 months after a prior birth.

SPM 08: The percent of adolescents reporting a high level of school connectedness.

/2013/SPM 09: Low-income infant mortality rate.

SPM 10: The percent of CCS clients who have a designated primary care physician and/or a specialist physician who provides a medical home.//2013//

Careful consideration of incorporating the life course approach was used in selecting the MCAH-specific SPMs. Beyond measuring disease risk or conditions, these new SPMs include protective factors, cut across critical periods of development over the life course and may influence the capacity of the population to reach its full developmental potential. The detail sheets (Form 16) further emphasizes the influence of these SPMs on health pathways or trajectories, its impact on individual health within and across generations and its impact at specific sensitive periods of development.

Selection criteria for SPMs included availability of accurate data available, sufficient sample size, consistent data collection methodology over time, comparability to national data or benchmarks, , relevance to program planning and monitoring, and stakeholder buy-in. //2012// Data on performance measures are included in two parts of this report - on the data forms and in the narrative.

The three priorities currently identified targeting the CSCHN population were a result of the needs assessment conducted by CMS. The 2011-2015 CMS Five-year Needs Assessment process identified several priorities with the top three priorities included as part of this report. Following key informant interviews, focus group discussions, online-surveys, review of the 2005 CMS Needs Assessment priorities, consultation with CMS Branch state staff, and data analysis, 13 CMS priorities were identified and ranked. Stakeholders individually used the weighted criteria they had developed together and a tool provided by FHOP to rate each of the priority objectives. The individual rating scores were then aggregated to rank the priority objectives. The top 3 CMS priorities are listed as 1 to 3 below. /2014/ Reference to Children's Medical Services (CMS) is being gradually phased out and replaced by Systems of Care Division (SCD).//2014//

All ten of California's priorities have one or more related national or state performance measures. /2012/For NPMs, new SPMs and outcome measures that will be monitored for the 2011 to 2015 period, several meetings were held to discuss objective setting processes and methods. This included assessing program-related activities that impact each measure,

/2012/ In addition, the relationship between the seven MCAH priority needs with health systems capacity indicators and health status indicators were included as MCAH moves toward incorporating the Social Determinants of Health and Life Course approach to its health planning and decision framework .incorporating knowledge of effective interventions, identifying time frames for objective setting and determining a value for each performance objective that is challenging yet realistic. MCAH conducted a literature search on target setting methods that have been used including the rationale for its use, the advantages and disadvantages for each method and what compromises should be made when there is no existing evidence, or if evidence is weak or its relevance is limited. After an extensive review of multiple target setting methods, MCAH identified a straightforward approach that would be transparent for partners. Following the lead set by Healthy People 2020 in establishing standardized 10% improvement objectives, MCAH established 5% improvement over the 2008-2009 aggregate rate as the standard for California Title V Objectives. To ensure appropriate objectives were set for Title V measures with rates that have fluctuated from year to year, a 10% improvement objective was selected if the measure met or exceeded the 5% improvement objective since 2000. Likewise, a 15% or a 20% improvement objective was selected for measures with fluctuating rates that exceeded the 10% or 15% improvement objectives since 2000. For those measures that demonstrate worsening trends, a 0% improvement objective was established (or maintenance of current rate). In this way, State and Local MCAH Programs and stakeholders have an easily identifiable and reasonably attainable objective to strive towards over the next five years for each measure. //2012//

B. State Priorities

The ten priorities for Title V activities in California and the associated performance measures and health indicators are:

>Priority 1: Modify the CCS program, with appropriate funding, to cover the whole child.
SPM 1 (new): 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. /2013/ This was revised to: 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.//2013//

SPM 3(new): 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.
NPM 4: CSHCN age 0 to 18 whose families have adequate private and/or public insurance.
NPM 5: CSHCN whose families report the community-based service systems are organized so they can use them easily.

NPM 6: Youth with special health care needs who received the services necessary to make transition to all aspects of adult life.

>Priority 2: Expand the number of qualified providers of all types in the CCS program.
SPM 2 (new): The percent of primary care physicians, approved to participate in the CCS program, who are receiving authorizations for care. /2013/ This was inactivated and replaced by SPM 10: The percent of CCS clients who have a designated primary care physician and/or a specialist physician who provides a medical home.//2013//

NPM 3: CSHCN who receive coordinated, ongoing, comprehensive care within a medical home.
NPM 4: CSHCN age 0 to 18 whose families have adequate private and/or public insurance.
NPM 5: CSHCN whose families report the community-based service systems are organized so they can use them easily.
NPM 6: Youth with special health care needs who received the services necessary to make transition to all aspects of adult life.

>Priority 3: CCS will work with appropriate partners to define and create and implement standards for Medical Homes for CCS children.
SPM 3 (new): 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.
/2014/ SPM 10 The percent of CCS clients who have a designated primary care physician and/or a specialist physician who provides a medical home.//2014//
NPM 2: CSHCN whose family's partner in decision making at all levels and are satisfied with the services they receive.
NPM 3: CSHCN who receive coordinated, ongoing, comprehensive care within a medical home.

>Priority 4: Improve maternal health by optimizing the health of girls and women across the life course.
NPM 15: Percentage of women who smoke in the last three months of pregnancy.
SPM 3 (old): The percent of women, aged 18-44 years, who reported 14 or more "not good" mental health days in the past 30 days (frequent mental distress").
SPM 4 (old): The percent of women who reported drinking any alcohol in the first or last trimester of pregnancy.
SPM 8 (old): The percent of births resulting from an unintended pregnancy.
SPM 10 (old): The percent of women, aged 18 years or older, reporting intimate partner physical, sexual or psychological abuse in the past 12 months.
/2012/ SPM 4 (new): The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.
SPM 6 (new): The percent of women of reproductive age who are obese.
SPM 7 (new): The percent of women whose live birth occurred less than 24 months after a prior birth.
SOM 1 (new): The pregnancy-related mortality rate per 100,000 live births.
HSI 5a: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia
HSI 5b: The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.
HSI 9a (2): Percent in household headed by a single parent.
HSI 9a (3): Percent in TANF (Grant) families. //2012//

>Priority 5: Promote healthy nutrition and physical activity among MCAH populations throughout the lifespan beginning with exclusive breastfeeding of infants to six months of age.
NPM 11: The percent of mothers who breastfeed their infants at 6 months of age.
NPM 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.
/2012/SPM 6 (new): The percent of women of reproductive age who are obese. //2012//

>Priority 6: Reduce maternal morbidity and mortality and the increasing disparity in maternal health outcomes.
NPM 15: Percentage of women who smoke in the last three months of pregnancy.
NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates
NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
SPM 10 (old): The percent of women, aged 18 years or older, reporting intimate partner physical, sexual or psychological abuse in the past 12 months.
NOM1: The maternal mortality rate per 100,000 live births.
/2012/ SPM 4 (new): The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.
SPM 5 (new): The percent of cesarean births among low risk women giving birth for the first time.
SPM 6 (new): The percent of women of reproductive age who are obese.
SPM 7 (new): The percent of women whose live birth occurred less than 24 months after a prior birth.
SOM 1: The pregnancy-related mortality rate per 100,000 live births.
HSCI 4: The percent of women (15 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.
HSCI 5c: Percent of women entering care in the first trimester: Payment source from birth certificate (Medicaid and non-Medicaid comparison).
HSCI 5d: Percent of women with adequate (observed to expected prenatal visits is greater or equal to 80% (Kotelchuck Index) prenatal care (Medicaid and non-Medicaid comparison).
HSCI 6c: The percent of poverty for eligibility in the State's Medicaid and SCHIP programs for pregnant women (Medicaid and SCHIP eligibility levels). //2012//

>Priority 7: Reduce infant mortality and address disparities by promoting preconception health and health care and by preventing causes such as birth defects, low birth weight/prematurity, SIDS, and maternal complications in pregnancy.
NPM 15: Percentage of women who smoke in the last three months of pregnancy.
NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
SPM 4 (old): The percent of women who reported drinking any alcohol in the first or last trimester of pregnancy.
SPM 6 (old): The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System
/2012/ SPM 4 (new): The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.
SPM 6 (new): The percent of women of reproductive age who are obese.
SPM 7 (new): The percent of women whose live birth occurred less than 24 months after a prior birth.
NOM 1: The infant mortality rate per 1,000 live births.
NOM 2: The ratio of the black infant mortality rate to the white infant mortality rate.
NOM 3: The neonatal mortality rate per 1,000 live births.
NOM 4: The post-neonatal mortality rate per 1,000 live births.
NOM 5: The perinatal mortality rate.
HSCI 4: The percent of women (15 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.
HSCI 5a: Percent at low birth weight (<2,500 grams): Payment source from birth certificate (Medicaid and non-Medicaid comparison).
HSCI 5b: Infant deaths per 1,000 live births: matching data files (Medicaid and non-Medicaid comparison).
HSCI 5c: Percent of women entering care in the first trimester: Payment source from birth

certificate (Medicaid and non-Medicaid comparison).
HSCI 5d: Percent of women with adequate (observed to expected prenatal visits is greater or equal to 80% (Kotelchuck Index) prenatal care (Medicaid and non-Medicaid comparison).
HSCI 6a: The percent of poverty for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1) (Medicaid and SCHIP eligibility levels).
HSI 1a: The percent of live births weighing less than 2,500 grams.
HSI 1b: The percent of live singleton births weighing less than 2,500 grams.
HSI 2a: The percent of live births weighing less than 1,500 grams.
HSI 2b: The percent of live singleton births weighing less than 1,500 grams. //2012//
/2013/ SPM 9 (new): Low income infant mortality rate.//2013//

>Priority 8: Support the physical, socio-emotional, and cognitive development of children, including the prevention of injuries, through the implementation of prevention, early identification and intervention strategies.
NPM 1: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored NBS programs.
NPM 2: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.
NPM 3: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.
NPM 4: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.
NPM 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.
NPM 6: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
NPM 7: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
NPM 9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
NPM 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.
NPM 12: Percentage of newborns who have been screened for hearing before hospital discharge.
NPM 13: Percent of children without health insurance.
NPM 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.
/2012/ NOM 6: The child death rate per 100,000 children aged 1-14.
HSCI 1: The rate per 10,000 for asthma hospitalizations among children less than five years old.
HSCI 2: The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.
HSCI 3: The percent of Children's Health Insurance Program (SCHIP) enrollees' age is less than one year during the reporting year who received at least on periodic screen.
HSCI 6a: The percent of poverty for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1) (Medicaid and SCHIP eligibility levels).
HSCI 6b: The percent of poverty for eligibility in the State's Medicaid SCHIP programs for children (age ranges: 1 through 5 and 6 to 19) (Medicaid and SCHIP eligibility levels).
HSCI 7a: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.
HSCI 7b: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental service during the year.
HSI 3a: The death rate per 100,000 due to unintentional injuries among children aged 14 years &

younger.
HSI 3b: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.
HSI 4a: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.
HSI 4b: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.
HSI 9a(2): Percent in household headed by a single parent.
HSI 9a(3): Percent in TANF (Grant) families //2012//

>Priority 9: Promote positive youth development strategies to support the physical, mental, sexual and reproductive health of adolescents.
NPM 8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
NPM 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19.
SPM 5 (old): The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries.
SPM 9 (old): The percent of 9th grade students who are not within the Healthy Fitness Zone for Body Composition.
/2012/ SPM 7 (new): The percent of women whose live birth occurred less than 24 months after a prior birth.
SPM 8 (old): The percent of women whose live birth occurred less than 24 months after a prior birth.
/2015/ SPM 08 (new): The percent of adolescents reporting a high level of school connectedness.//2015//
HSCI 6b: The percent of poverty for eligibility in the State's Medicaid SCHIP programs for children (age ranges: 1 through 5 and 6 to 19) (Medicaid and SCHIP eligibility levels).
HSCI 9b: Data Capacity - Adolescent Tobacco Use (data capacity information).
HSI 3c: The death rate per 100,000 from unintentional violence due to motor vehicle crashes among youth aged 15 through 24 years.
HSI 4c: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.
HSI 5a: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.
HSI 9a(9): Rate per 100,000 juvenile crime arrest
HSI 9a(10): Percent of high school drop-outs grades 9 through 12. //2012//

>Priority 10: Link the MCAH population to needed medical, mental, social, dental, and community services to promote equity in access to quality services.
NPM 1: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored NBS programs.
NPM 2: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.
NPM 3: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.
NPM 4: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.
NPM 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.
NPM 6: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
NPM 7: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
NPM 9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
NPM 12: Percentage of newborns who have been screened for hearing before hospital

discharge.
NPM 13: Percent of children without health insurance.
NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
/2012/ SPM 4 (new): The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.
SPM 6 (new): The percent of women of reproductive age who are obese.
SPM 7 (new): The percent of women whose live birth occurred less than 24 months after a prior birth.
HSCI 2: The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.
HSCI 3: The percent of Children's Health Insurance Program (SCHIP) enrollees' age is less than one year during the reporting year who received at least on periodic screen.
HSCI 4: The percent of women (15 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.
HSCI 5: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State (a) Percent of low birth weight (<2,500 grams), (c) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester and (d) Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]
HSCI 6: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women.
HSCI7a: The percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program
HSCI 7b: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year. //2012//

C. National Performance Measures

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	574	561	663	602	
Denominator	574	561	663	602	
Data Source	Genetic Disease Screening Program	Genetic Disease Screening Program	Genetic Disease Screening Program	Genetic Disease Screening Program	Genetic Disease Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	100	100	100	100	100

Notes - 2013
A provisional indicator is reported for 2013.

Notes - 2012
NBS includes screening for the following conditions: Phenylketonuria (PKU), congenital hypothyroidism, galactosemia, sickle cell disease (Hb S/S, Hb S/+Thalassemia, and Hb S/B0 Thalassemia only), congenital adrenal hyperplasia, over 40 non-PKU inborn errors of metabolism tested by tandem mass spectrometry, cystic fibrosis, biotidinase deficiency, and severe combined immunodeficiency disorders (SCID).

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

Notes - 2011
NBS includes screening for the following conditions: Phenylketonuria (PKU), congenital hypothyroidism, galactosemia, sickle cell disease (Hb S/S, Hb S/+Thalassemia, and Hb S/B0 Thalassemia only), congenital adrenal hyperplasia, over 40 non-PKU inborn errors of metabolism tested by tandem mass spectrometry, cystic fibrosis, biotidinase deficiency, , and pilot testing for severe combined immunodeficiency disorders (SCID).

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

a. Last Year's Accomplishments
In 2012, GDSP detected and confirmed over 850 genetic and congenital abnormalities as a result of its NBS Program. California has effectively achieved universal coverage for NBS for genetic, metabolic and hematological disorders, with nearly 100 percent of newborns screened for all conditions for which screening was mandated.

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

The pilot study for SCID began in August 2010 and has proved that SCID is far more common than first thought. Prior to the inception of SCID screening in California, the incidence of classical

SCID was thought to be 1 in 100,000. Screening nearly 1.2 million newborns (through December 2012), has identified 20 babies with SCID requiring bone marrow transplants (1:60,000) and another 48 babies with immune disorders that required monitoring and/or treatment. The total incidence of SCID and other significant immune disorders is 1 in 17,500.

Pregnant women in California can participate in the California Prenatal Screening Program in several different ways:

1. Patients who only submit a blood specimen in the 2nd trimester (15 to 20 weeks) get Quad Marker Screening [risk assessment made based on 4 analytes: AFP, human chorionic gonadotropin (HCG), uE3, and Inhibin]
2. Patients who submit a blood specimen in the 1st trimester (10 to 13 weeks, 6 days) and another blood specimen in the 2nd trimester (15 to 20 weeks) get Serum Integrated Screening: [risk assessment made based on Pregnancy Associated Plasma Protein and HCG in the first trimester, plus the Quad Marker Screening analytes in the second trimester]
3. Patients who submit both 1st and 2nd trimester specimens as well as have a Nuchal Translucency (NT) Ultrasound measurement taken, get Sequential Integrated Screening [risk assessment made based on all analytes from the Serum Integrated Screening plus the NT measurement].

Sequential Integrated Screening identifies over 90% of fetuses with Down syndrome. Participation in the California Prenatal Screening Program includes diagnostic follow-up services for those with risks assessments above the cut-off.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. GDSP screens for genetic and congenital disorders, including testing, follow-up and early diagnosis of disorders to prevent adverse outcomes or minimize clinical effects.			X	
2. GDSP ensures quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance with them.				X
3. GDSP fosters informed participation in its programs through a combination of patient, professional, and public education, and accurate and up-to-date information and counseling.			X	
4. GDSP and SCD collaborate to ensure that infants identified with abnormal screening results receive prompt diagnostic evaluations at one of the CCS-approved Metabolic Special Care Centers (SCC) in the state.		X		

b. Current Activities

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

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

c. Plan for the Coming Year

GDSP will continue to screen for genetic and congenital disorders, including testing, follow-up and early diagnosis, in order to prevent adverse outcomes and minimize clinical effects. GDSP ensures the quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance with them. GDSP fosters informed participation in its programs through a combination of patient, professional, and public education, as well as accurate, up-to-date information and counseling (e.g., Hemoglobin Trait Carrier Follow-up Program, Maternal PKU Program, Gene HELP Resource Center and the Sickle cell Counselor Training and Certification Program).

GDSP will continue to work collaboratively with state and local agencies, including SCD, CCS-approved SCCs, GDSP NBS Contract Liaisons and other NBS Program staff, local County CCS programs, and Area Service Center Project Directors and Medical Consultants to ensure that newborns identified with positive screening reports are quickly evaluated, diagnosed, and appropriately treated, and that families are informed and supported throughout the process.

GDSP will continue to administer and evaluate the Prenatal Screening Program. Non-Invasive Prenatal Testing (NIPT) has been added to the list of covered follow-up services for those with elevated risk for having a baby with Down syndrome. NIPT would be offered as a choice for women alternative to amniocentesis and chorionic villus sampling (CVS). GDSP is exploring ways of offering NIPT as a first-tier prenatal screening test.

SCD and GDSP will continue to work together to address issues as they arise and update literature as needed. Despite the decreased staff, CCS will attempt to expedite authorizations appropriate for diagnosis and treatment of babies with positive results from newborn screening NBS.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**503788**					
Reporting Year:	**2012**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	496919	98.6	287	22	22	100.0
Congenital Hypothyroidism	496919	98.6	463	273	273	100.0

(Classical)						
Galactosemia (Classical)	496919	98.6	100	6	6	100.0
Sickle Cell Disease	496919	98.6	4848	61	61	100.0
Cystic Fibrosis	496919	98.6	176	59	59	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	496919	98.6	781	19	19	100.0
Tandem Mass Spectrometry (MS/MS) screening for non-PKU inborn errors of metabolism	496919	98.6	2277	136	136	100.0
Severe Combined Immunodeficiency	496919	98.6	74	6	6	100.0
Biotinidase Deficiency (BD+ Partials)	496919	98.6	200	20	20	100.0
HIV Oraquick	8258		3	20	17	85.0
HIV Enzyme	3319		10	10	8	80.0
Expanded Alpha Fetoprotein (Prenatal Screening)	391480		22761	846	846	100.0

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	47	47.5	48	48	48
Annual Indicator	46.6	46.6	61.8	61.8	61.8
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey	National Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2014	2015	2016	2017	2018
Annual Performance Objective	48	48	48	48	48

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

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

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

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

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

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

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

a. Last Year's Accomplishments
NPM 02 is one of five measures taken from the National Survey of CSHCN. Based on the 2009-2010 survey, 61.8 percent of CSHCN age 0 to 18 have families partnering in decision making at all levels and are satisfied with the services they receive.

1) County CCS programs collaborated with families to plan conferences on family participation in the CCS program.

2) The CRISS-FCC Work Group met several times to share ideas and resources; plan and coordinate conferences, trainings and activities; and monitor and promote transition activities,

parent liaison services, and medical home projects.

3) FVCA Council Member Agencies held monthly meetings to address parent and community involvement and monthly Brown Bag Lunch webinars statewide on issues affecting CSHCN.

4) FVCA Council Member Agencies provided workshops, presentations, and trainings to professionals and family members on C/YSHCN topics such as health care choices, family-centered care, partnering with parents/professionals, health delivery models, and leadership..

5) Some FVCA Council Member Agencies continued to renew their Parent Health Liaison contracts with their local Title V program (CCS).

6) FVCA developed a new pilot (funded by Lucile Packard Foundation) called "Project Leadership" to increase the number of family members of CSHCN, including those in CCS, who are prepared to partner and engage in all levels of public advocacy on behalf of CSHCN. The trainings to families in the San Diego/Imperial Counties region began September 2013.

7) LAPSNC worked with L.A. CCS and L.A. Family Resource Centers on improving the system of care for CSHCN in L.A. County. The meeting agendas were based on the MCHB core measures for children with special needs, focusing on self-education and advocacy.

8) The Los Angeles County CCS Workgroup, supported by LAPSNC, is a group of community stakeholders (providers, payers, community based organizations and parents) focused on improving the system of care for CSHCN in Los Angeles. The group followed an agenda based on the MCHB core measures for children with special needs, focusing on self-education and advocacy.

9) Los Angeles County CCS FCC Committee has been active for close to a decade. Members consist of parents of CSHCN and LAC medical, nurse and consultant staff. The FCCC collaborated with key agencies in the community (such as Family Voices; Family Resource Center; Patient Family Center Care Partners; CHLA UC Excellence in Developmental Disabilities) and was involved in many FCC activities, including review of communication with CCS families, education to CCS staff on FCC, "user friendliness" of transition forms, and problems encountered by clients/families when transitioning out of the CCS program.

10) Sonoma County CCS met regularly with Partnership Health Plan (PHP) and other PHP counties to discuss questions and issues. For FY 12/13, Sonoma mailed a Family Satisfaction Survey to enrolled CCS clients at the time of their annual program renewal. 97% of families reported being satisfied with the quality of services they received through the CCS Program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Systems of Care Division (SCD) stakeholder group will increase family participation. through the 20150 Needs Assessment process.				X
2. FVCA and CCS work together to enhance services for families of CYSHCN and involve families as partners in decision- making.		X		
3. The FCC Work Group of CRISS, comprised of 14 county programs, meets bimonthly to plan annual conferences, workshops, resource fairs, and address issues.				X
4. CCS programs partner with Family Resource Centers in their areas.		X		

5. SCD is partnering in the planning of annual educational FCC conferences (Northern and Southern California) for CCS administrators, medical, nurse and social work consultants, parent health liaison/leaders, and therapists		X		
6. County CCS programs evaluate and report their family participation in their programs.				X
7. The FCC Work Group provides TA for CCS administrators for hiring or contracting a parent liaison.				X
8. County agencies and families collaborate to provide workshops, resource fairs, and conferences for families of CSHCN.		X		
9.				
10.				

b. Current Activities

1) Eleven counties are currently developing and implementing parent surveys for families participating in the MTP.

2) In February 2014, FVCA held its 12th statewide Annual Health Summit in Sacramento,. The Summit focused on identifying and addressing challenges for CSHYCN.

3) FVCA continues their LPFCH funded pilot "Project Leadership".

4) FVCA continues to support and promote the use of CCS Parent Health Liaisons.

5) The Los Angeles County CCS Workgroup continues activities as described in Last Year's Accomplishments.

6) Los Angeles CCS FCC Committee continues to collaborate with key agencies.

c. Plan for the Coming Year

1) CSHCN stakeholder groups are included in the 2014 implementation of priorities selected for the 2015 Needs Assessment process.

2) Families included in stakeholder groups will continue to participate in activities to improve the delivery of care for CSHCN through the 1115 Waiver.

3) Family members will participate on advisory committees and in-service training of CCS staff and providers.

4) FVCA will continue to collaborate with SCD on family satisfaction issues and projects and respond to requests for input on materials and committees.

5) SCD medical director or designee will continue to attend bimonthly FVCA conferences and webinars.

6) CRISS convenes quarterly meetings of county CCS medical consultants, CRISS staff, and the CCS Chief Medical Officer in order to ensure consistent application of state CCS policy.

7) The FCC Committee in Los Angeles County CCS will continue activities, including education of new and existing staff on FCC; work with MTP Administration to review existing client satisfaction surveys; review of existing communication with CCS clients by nurse case manager staff; revision of existing LA Handbook for Clients/Families; and development of further

strategies to enhance the relationship between local FRCs and MTPs.

8) LAPSNC will continue to collaborate with CSHCN organizations and parent groups to plan conferences and meetings.

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	42.5	43	44	44	44
Annual Indicator	42.2	42.2	38.3	38.3	38.3
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	44	44	44	44	44

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

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

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the

questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

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

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

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

a. Last Year's Accomplishments
NPM 03 is from the National CSHCN Survey. Based on the 2009-2010 National Survey of CSHCN, 38.3 percent of the CSHCN in California receive coordinated, ongoing, comprehensive care within a medical home. The population in this survey is all CSHCN and is not restricted to CCS children. The survey estimate of 1 million CSHCN in California would indicate that around 25% of CSHCN have been CCS clients at any time in the past year. While many CSHCN are not eligible for CCS services, all CSHCN in CA benefit from the standards and infrastructure developed by the CCS program.

The state completed the expansion of MCMC services to all of California's 58 counties. With MCMC available statewide, many Medi-Cal members, including CSHCN in the CCS Program, will have a primary care physician and medical to coordinate all of their special health care to better manage their health condition. The CCS Program worked through 2013 to update and strengthen CCS case management procedures to accurately identify and appropriately document the client's primary care medical home provider in the CMS Net data system.

CRISS, through a grant from the San Francisco Foundation, extended their medical home activities from one CRISS county (Alameda) into three CRISS counties: Contra Costa, San Francisco, and San Mateo. CRISS works to implement regional and local strategies to promote medical homes for CSHCN, including distribution of updated hard copy medical home materials customized for each county in the CRISS region. Electronic medical home materials, including Child Health Notebooks, are available on the CRISS website.

The MCMC model of the CCS 1115 Waiver Program pilot began April 2013. Medical Home is incorporated into the comprehensive health care delivery system and is one of the areas of performance evaluation for the project.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. County CCS programs assess CCS eligible children to			X	

determine if they have a documented medical home and explore improvement strategies.				
2. The "Hospital Discharge Questionnaire" developed by FVCA and the PHL Network, is provided to families to improve the coordination of care for their child when they come home from the hospital.		X		
3. Child Health Notebooks to help organize healthcare information and medical records are distributed (hard copy and electronically) in the 27 CRISS counties.		X		
4. FVCA provides trainings for families and professionals on the Medical Home Initiative and distributes binders to help families organize healthcare information and medical records.				X
5. FVCA Agencies provide a “resource referral pads” to physicians that list local resources for families.			X	

b. Current Activities

1) State CCS is developing a medical home policy which supports the CCS program performance measure for medical homes.

2) CRISS continues to expand and improve the Alameda County Medical Home Project. The project targets clinics in Alameda with high numbers of CCS children. CRISS continues to recruit new sites, focusing on CHDP sites with high volumes of CCS children. The medical home project is currently active in 60 high volume sites in Alameda.38 of these sites include developmental screening and behavioral health assessments.

3) FVCA continues to promote collaboration of state and county CCS to identify and implement program changes to make CCS more efficient, effective, and family-centered.

4) FVCA continues to provide information and trainings to families and professionals as described in Last Year's Accomplishments.

5) Sonoma CCS continues to strengthen the coordination of primary and specialty care through medical homes.

6) Sonoma CCS' medical home activities involve communicating with Partnership Health Plan (PHP) and attending quarterly CCS/PHP meetings.

c. Plan for the Coming Year

1) CCS will continue to work with the counties to ensure CCS clients are connected to an appropriate medical home provide and will monitor the number of CCS clients who have a medical home identified in the database.

2) State CCS will work with counties and stakeholders, such as CRISS and FVCA, to develop a program policy specific to medical homes for CCS clients

3)

4) CRISS will continue to share Alameda County Medical Home Project activities and resources with three other counties, San Mateo, Contra Costa, and San Francisco.

5) CRISS will continue to provide technical assistance to sustain medical home approaches for CSHCN.

6) FVCA will continue to provide linkages to healthcare information to families and providers statewide through the FVCA listserv, council meetings and website.

7) Family Satisfaction survey planned for 2014 will assess whether clients receive coordinated care within a medical home.

8) The Medical Managed Care model of the CCS 1115 Waiver Program pilot continues to provide Medical Home into the comprehensive health care delivery system and the performance data continues to be analyzed.

9) SCD to clarify whether the CCS client's medical home is within the MCP or with a CCS-authorized primary care provider.

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	60.3	61	61	61
Annual Indicator	59.6	59.6	59.1	59.1	59.1
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	61	61	61	61	61

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

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

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

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

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

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

a. Last Year's Accomplishments
Efforts in 2013 to increase the percentage of families with insurance coverage included establishment of Covered California, a Health Benefit Exchange.

Beginning January 1, 2013 and through November 1, 2013, more than 750,000 Healthy Families Program (HFP) children were successfully transitioned to Medi-Cal. Infants previously enrolled into the HFP as a result of being born to a mother on the AIM Program with an income above 250 percent and up to 300 percent of the FPL were transitioned to DHCS and integrated into the new DHCS ALIP. Infants in the ALIP with CCS eligible medical conditions continued to receive case management and care coordination from the CCS Program.

By November 2013, California completed the expansion of Medi-Cal managed care services to more than 274,000 Medi-Cal members in 28 rural counties, bringing Medi-Cal managed care to all of California's 58 counties. The state's Medi-Cal Program prepared to enroll between one million and two million newly eligible individuals as a result of the ACA.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Systems of Care Division (SCD) continues to determine whether CCS eligible children have access to private health coverage utilizing DHCS' Other Health Coverage (OHC) file.		X		
2. CHDP programs and providers are identifying and "deeming" certain infants less than one year of age as eligible for ongoing, full scope, no cost Medi-Cal at the time of a CHDP Health Assessment.		X		
3. SCD continues to work with HF Medi-Cal and the AIM program to facilitate enrollment of eligible infants and those with		X		

CCS eligible conditions into the CCS program.				
4. SCD will continue to implement the CHDP Gateway and identify CCS-eligible children through the Gateway process.		X		

b. Current Activities

1) Systems of Care Division (SCD) continues to collaborate with various stakeholders in helping to ensure that families of CSHCN continue to receive necessary services.

2) Infants in the ALIP with CCS eligible medical conditions will continue to receive case management and care coordination from the CCS Program.

The CHDP Gateway pre-enrollment process serves as a means of assisting Medi-Cal eligible children and youth to access periodic preventive care.4. From January 1, 2013 through December 31, 2013, 461,774 children were pre-enrolled into Medi-Cal through the CHDP Gateway.

3) As of March 2014, over one million individuals are newly insured through Covered California.

c. Plan for the Coming Year

1) SCD will continue collaborative efforts with various stakeholders to identify and provide necessary services for CSHCN.

2) Infants in the ALIP with CCS-eligible medical conditions will continue to receive case management and care coordination from the CCS Program.

3) The CHDP Gateway pre-enrollment process will continue to serve as a means of assisting Medi-Cal eligible children and youth to access periodic preventive health assessments and the SCD will continue to support this process.

4) SCD will review the impact that Health Care Reform may have on families of CSHCN that are currently being served by CCS, AIM, and Medi-Cal.

5) As resources become available, SCD will continue to review initiatives that have the goal of promoting insurance coverage for children.

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	86	86.5	87	87	87
Annual Indicator	85.3	85.3	64.8	64.8	64.8
Numerator					
Denominator					
Data Source	National	National	National	National	National

	Survey of CSHCN	Survey of CSHCN	Survey of CSHCN	Survey of CSHCN	Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	87	87	87	87	87

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

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

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

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

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

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

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

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

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

The first 1115 Waiver Model, Medi-Cal Managed Care, began April 1, 2013 in San Mateo County. The contract requires coordination to improve access to community-based services as part of a whole child , family-centered health care approach.
Inter-county transfer policy was developed with stakeholder input to increase consistency in the application of policies and procedures across CCS counties.

Statewide CCS medical consultant group was established and meets frequently. Biannually a Southern CA medical consultant comes to the CRISS meeting, and a CRISS consultant attends the Southern California meeting.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CRISS Medical Eligibility Work Group meets quarterly with CCS medical consultants, hospital and pediatric representatives, to improve consistency in inter-county interpretation of CCS law, regulation, and policy.				
2. CHDP, HCPCFC, and CCS programs report on a performance measure evaluating effective care coordination.				X
3. LAPSNC focuses on increasing parent involvement by inviting representatives from the Family Resources Centers (FRC) to meetings, and joining committees				X
4. FVCA Council Agencies work with their local CCS agency to provide trainings to CCS employees, and connect families to FRC for community resources, support and information.				X
5. The FCC Committee meets bimonthly to review county FCC activities, share resources, and plan conferences, trainings, and activities.				X
6. SCD and Medi-Cal collaborate on the implementation of a pediatric Palliative Care program.				X

b. Current Activities
1) CRISS Medical Eligibility Work Group (CCS medical consultants, hospital and pediatric Representatives) meets quarterly to improve consistency in interpretation of CCS law, regulation and policy regarding medical eligibility and benefits in the 27-county CRISS region.

2) The 1115 Demonstration Waiver Project pilot contract with Health Plan of San Mateo encompasses coordination of care with community support services to provide family-centered care coordination across the entire continuum of care.

c. Plan for the Coming Year

1) CRISS Medical Eligibility Work Group (CCS medical consultants, hospital and pediatric Representatives) will continue to meet quarterly to improve consistency in inter-county interpretation of CCS law, regulation and policy regarding medical eligibility and benefits in the now 27-county CRISS region.

2) CHDP, HCPCFC, and CCS programs will continue to report on a performance measure evaluating effective care coordination.

3) LAPSNC will continue to focus on increasing parent involvement by inviting representatives from FRC to meetings, joining committees and by supporting the CCS workgroup.

4) FVCA will continue to collaborate with DHCS on an ongoing basis and FVCA's council member agencies will work with their local CCS agencies to provide trainings to CCS employees, and connect families to FRCs for community resources, parent-to-parent support and information.

5) The FCCC will continue to review county FCC activities, share resources, and plan conferences, trainings, and activities.

6) SCD will continue to monitor the first 1115 Waiver CCS Demonstration Project, Medi-Cal Managed Care Pilot Model. Monitoring will include but is not limited to analyzing encounter data to ensure family-centered care, appropriate healthcare, and community-based services have been and continue to be accessible. and will monitor the number of CCS clients who have a medical home identified in the database.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	37.5	38	39	39	39
Annual Indicator	37.1	37.1	37.4	37.4	37.4
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is					

fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	39	39	39	39	39

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

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

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

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

a. Last Year's Accomplishments
CCS strengthened health care transition planning case management procedures for the CCS client beginning at 14 years of age.

Several county CCS programs: Alameda, Los Angeles, San Diego, and Sonoma had effective transition planning. Alameda CCS distributed Child Health Records through the FRN; Santa Clara CCS distributes a booklet called "All About Me"; and San Mateo and Sacramento CCS distribute handbooks on transition called "Moving On". The FCC Committee in Los Angeles County (LAC) CCS evaluated, "user- friendliness" of transition forms, and problems encountered by clients/families when transitioning out of the CCS program.

SCD implemented an Age-Out Program designed to assist young adults who are currently receiving EPSDT PDN and/or PDHC services and who will age out of the EPSDT service category when they reach their 21st birthday. SCD will identify these young adults three years before they reach the age of 21 to develop a care and resource plan based on the beneficiaries level of care, medical needs, and home nursing needs. SCD will conduct home visits with these beneficiaries and case manage them until 21 years of age.

CRISS promoted family-centered care in CRISS counties, including transition planning efforts led by a transition specialist. CRISS provided state and county CCS transition resources and materials on their website -- including: the Alameda County Medical Home Project Transition Guide which provides information on transition from pediatric to adult services; and resources from the Adolescent Health Transition Project, Department of Rehabilitation, Disabled Students Programs and Services, Regional Occupational Centers and Programs, and WorkAbility Programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Activities 1. Counties continue to be involved in the implementation and evaluation of transition strategies.				X
2. CCS staff continue to instruct CCS-approved SCCs and those newly applying for approval on the importance and methods of integrating transition planning into patient care beginning at age 14 years.				X
3. SCD staff continue to meet quarterly with FVCA council members and PHL to develop strategies to improve transition for CSHCN to adult health care providers				X

b. Current Activities

CRISS and CCS county programs continue to promote transition planning efforts as described in Last Year's Accomplishments. The Medi-Cal Managed Care model of the CCS 1115 Waiver Program pilot began April 2013. Transition services is incorporated into the comprehensive health care delivery system.

c. Plan for the Coming Year

1) State CCS will continue working with counties to develop new transition planning performance measures for CCS children. The new performance measures align with HRSA's

guidelines for family- centered transition planning services.

2) State CCS will work to change current "recommendation" for transition planning to required policy procedures.

3) The FCC Committee in Los Angeles County CCS will continue activities, including creation of other activities in an extensive Scope of Work which includes education of new and existing staff on FCC; review of existing communication with CCS clients by nurse case manager staff; and examination of ways to enhance the relationship between local FRCs and MTPs.

4) State CCS will continue collaboration with counties, CRISS, and FVCA on transition issues for CSHCN.

5) State CCS will work with county programs, such as Alameda, Los Angeles, San Diego, and Sonoma, who have high percentage of staff compliance in transition planning activities to share their transition successes and ideas with other CCS counties via committees, conferences and/or webinars.

6) The Medical Managed Care model of the CCS 1115 Waiver Program pilot will continue to ensure enrollees have a transition plan completed on an annual basis beginning at 14 years of age.

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	79.4	79.9	82.1	82.1	82.1
Annual Indicator	75.8	76.5	81.7	73.5	73.5
Numerator	413608	423707	404197	359215	
Denominator	545657	553866	494733	488728	
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	82.1	82.1	82.1	82.1	82.1

Notes - 2013
A manual indicator is reported for 2013 based on 2012.

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

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

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

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

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

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

a. Last Year's Accomplishments
In 2012, the immunization rate for children age 19-35 months was 73.5 %. However this rate should not be compared to those reported for prior years since there has been a change in the way Hib vaccination coverage is defined in that it takes into consideration the brand type of the

vaccine.

MCAH and SCD advocated for families to enroll in Medi-Cal or HF. LHJs and MCAH programs, including CPSP, AFLP and BIH, continued to assess the immunization status of adolescent and women clients and their children on a periodic schedule, and promoted the importance of maintaining up-to-date immunizations by assisting program clients to access ongoing preventive care.

In 2011 (3,011 reported cases) and 2012 (1,022 reported cases), there were no recorded deaths attributed to pertussis.

MCAH continues to work with the IZB in promoting adolescent immunizations. Many MCAH LHJs conducted outreach at health fairs and other venues to provide education and resources for childhood/adolescent immunizations and health insurance. Programs such as CHVP, AFLP and BIH discuss and encourage clients to keep immunizations up-to-date. .

California's new personal beliefs exemption (PBE) law, (AB 2109), permits parents to request PBE from required immunizations for their children in child care or grade school. Under this law, the parents or guardians must document having obtained education about vaccine-preventable diseases and vaccines from an authorized health care provider. Many local MCAH programs focused activities on immunizations and participated on Immunization Collaboratives and coalitions to increase access to immunizations through health fairs, seasonal flu clinics and public health immunization clinics. For example, El Dorado County developed a vaccine safety and local resources campaign to target school districts with high Personal Belief Exemption rates.

The Perinatal Hepatitis B program enhanced the capacity of providers to integrate Hepatitis B Vaccine (HBV) testing, counseling and informed consent into their prenatal care services and in labor and delivery.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCAH and SCD advocate for eligible children to join Medi-Cal, which covers immunization.		X		
2. Healthy Start (HS), the Health Insurance Plan of California, and Access for Infants and Mothers (AIM) provide health care access, including immunizations, for children.			X	
3. Health promotion for adequate immunizations is also done through the CHDP Gateway and AFLP, BIH, and CPSP.				X
4. Nine regional immunization registries, covering 53 of 58 California counties, provide the foundation for a centralized system of maintaining immunization records.				X
5. Based on data from the regional immunization registries, pockets of need are identified, and interventions are developed.				X
6. Efforts are continuing to improve the electronic exchange of information for patients moving between regions, and to allow schools, childcare centers, Medi-Cal, WIC, and Cal-WORKS to link into regional registries.			X	
7. MCAH participates in ongoing activities: serving on local Immunization Coalitions, participating in health fairs, providing provider trainings, making referrals, evaluating data & establishing immunization clinic sites.			X	

b. Current Activities
SCD and IZ Branches, Medi-Cal, and MCMC meet thrice annually to discuss results of the ACIP-VFC National Meetings. SCD and IZ branches work together on adding new vaccines and modifying existing vaccine benefits in concordance with ACIP recommendations.

MCAH partners with IZB to provide immunization updates to Perinatal Services Coordinators (PSCs), review and develop educational materials on immunizations during pregnancy and stress the importance of influenza and Tdap vaccinations.

MCAH and SCD advocate for and assist families to enroll in low/no cost public and private health insurance entities. In 2013, there were 2, 372 reported pertussis cases (increased from 2012) and one infant death. There is increased influenza activity for 2013-2014, with severe respiratory illness reported among young and middle-aged adults, many of whom were infected with H1N1 virus. California had more than330 confirmed influenza-related deaths as of March 2014.

California usually has less than 40 measles cases reported annually after the U.S eradicated measles in 2000. As of March 2014, confirmed measles cases jumped to 49.

LHJs are conducting flu clinics that provide free vaccinations in their communities, especially to vulnerable MCAH populations.

MCAH and the IZ Branch partner with Text4Baby to remind mothers to immunize their babies and educate parents that all incoming 7th grade students will need a whooping cough booster immunization before enrollment.

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

MCAH partners with the IZB to provide immunization updates to MCAH Perinatal Services Coordinators, review immunization brochures on immunization during pregnancy, and emphasize the importance of influenza and Tdap vaccination for pregnant women and others in contact with young infants. MCAH continues to work closely with IZB to provide information on pertussis and influenza to MCAH providers.

ACA provider payments will include a significant increase to physicians performing health assessments and administering vaccinations to children.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

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

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance	19.4	19.1	17.4	17.4	17.4

Objective					
Annual Indicator	17.5	15.2	14.8	13.1	13.1
Numerator	15418	13308	11839	10359	
Denominator	883101	874581	801527	788279	
Data Source	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	17.4	17.4	17.4	17.4	17.4

Notes - 2013
A manual indicator is reported for 2013 based on 2012.

Notes - 2012
Numerator: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File. Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.Tabulations were done by the MCAH Program..

Data reported for 2012 should not be compared to data reported in 2010 due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 16.4.

Notes - 2011
Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File. Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.Tabulations were done by the MCAH Program.

Data reported for 2011 should not be compared to data reported in 2010 due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 16.4.

a. Last Year's Accomplishments
The overall birth rate to teens aged 15-17 dropped from 14.8 in 2011 to 13.1 per 1,000 in 2012 representing 11.5% decline; the Hispanic teen birth rate decreased 11.5%, from 23.4 to 20.7 (per 1,000 female teens aged 15-17 years) and the African American teen birth rate declined 19.2%, from 17.2 to 13.9 (per 1,000 female teens aged 15-17 years). The teen birth rate for Whites

decreased 6.8%, from 4.4 to 4.1 (per 1,000 female teens aged 15-17 years) and the Asian/Pacific Islander teen birth rates decreased 14.8%, from 2.7 to 2.3 (per 1,000 female teens aged 15-17 years). Rates for White and Asian/Pacific Islander teens continue to be lower than rates for Hispanic and African American teens.

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

Twenty-four I & E grantees continue to operate with funds awarded in 2011.

In 2012, CDPH/OFP was awarded $6.5 million annually through the CA PREP funds administered by the Family and Youth Services Bureau. Currently, CDPH/MCAH monitors these funds that replicate effective evidence-based program models that have been proven to change behavior .in19 California counties with the highest teen birth rates.

MCAH continued to fund and monitor AFLP. The number of AFLP sites has declined from 41 in 2009 to 32 in 2013.

MCAH implements a Support for Pregnant and Parenting Teens at High Schools and Community Service Centers award funded through the ACA Pregnancy Assistance Fund (PAF) and administered by the federal Office of Adolescent Health that provides $2 million annually for federal project periods 2010--2013. MCAH is developing a standardized case management model with integrated life planning for AFLP.

This grant is called AFLP PYD (Positive Youth Development), and it is being implemented in 11 AFLP sites. Activities included capacity building through a series of five trainings: Core Competencies for Providers of Adolescent Sexual and Reproductive Health; Positive Youth Development (PYD); Motivational Interviewing and Case Management; Life Planning; and "Pulling It All Together." The "Pulling It All Together" training provided skill building for local partners to practice using the newly developed, PYD-informed My Life Plan modules and corresponding Goal Setting tools in preparation for pilot implementation.

In April 2013, MCAH applied for the Office of Adolescent Health (OAH) grant for the Support for Expectant and Parenting Teens, Women, Fathers and Their Families to conduct outcome evaluation on its AFLP PYD intervention. In June 2013 was awarded $1.5 million annually for 4 years.

Cal-SAFE continued serving pregnant and parenting students. Some school districts have closed or decreased their Cal-SAFE programs, since flexible spending was implemented.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. AFLP provides case management services to pregnant and/or parenting teens to improve birth outcomes and prevent additional pregnancies.				
2. The Family PACT Program provides reproductive health services, education, and counseling to 300,000 adolescents annually, including comprehensive clinical exams and access to	X			

contraception.				
3. The CCG Program funds 116 community agencies.		X		
4. Cal-SAFE, operating in 137 school districts, enables expectant/parenting adolescents to improve academic achievement and parenting skills, and provides quality child care/developmental programs.			X	
5. MCAH, OFP, Office of AIDS, and the Sexually Transmitted Disease Branch collaborate with key stakeholders to better coordinate efforts in Human Immunodeficiency Virus (HIV), Sexually Transmitted Disease (STD), and teen pregnancy prevention.				X
6. MCAH, OFP and key stakeholders collaborate on data integration to generate STD, HIV, and birth data for 2000-2004.				X
7. MCAH, OFP and key stakeholders collaborate on Core Competencies, a document intended as an interdisciplinary guide for staff and professionals who work on adolescent sexual health issues.				X
8. The Teen SMART Outreach program funded 21 agencies through September 2008.		X		
9. The Male Involvement Program funded 21 agencies through September 2008.		X		
10. The Information & Education program funded 24 agencies in 2011.		X		

b. Current Activities

From last year's competitive grant process, MCAH monitors grantees in 19 California counties with the highest teen birth rates. MCAH continues to provide the necessary infrastructure to support effective program implementation including training, technical assistance, and systems for data collection, monitoring and evaluation.

I&E continues its teen pregnancy prevention efforts.

MCAH continues to support LHJs and CBOs that implement the AFLP program, particularly as they address the challenges of ongoing funding reductions. MCAH is piloting the AFLP PYD intervention in its 11 funded sites through a formative evaluation by an independent evaluator in order to develop a standardized case management intervention. Activities have focused on revising the intervention tools based on program implementation with active participation by all sites through site calls, surveys, key informant interviews, and focus groups with clients.

In addition, with new grant funding, MCAH is preparing for the AFLP PYD outcome evaluation. MCAH is currently working with Mathematica, as the AFLP PYD intervention is being considered for national evaluation.

c. Plan for the Coming Year

There are 38 counties with teen pregnancy prevention programs.
With newly integrated primary teen pregnancy prevention programs, MCAH looks forward to developing an enhanced focus on primary and secondary teen pregnancy prevention, youth sexual health and adolescent health promotion. These efforts will include an emphasis on positive youth development and healthy relationships with the goal of promoting adolescent sexual health as well as overall health and well-being. In addition, opportunities to leverage coordination of primary and secondary teen pregnancy prevention efforts will be identified in terms of local and expert input; professional development and training; replication and effective adaptation of evidence-based practice; process and program evaluation; and continuous quality improvement.

This youth focus is supported by the local MCAH needs assessments which have identified adolescent health and adolescent reproductive health as local priorities.

MCAH will continue primary teen pregnancy prevention efforts through I & E and CA PREP but with a broader goal of youth sexual health. CA PREP will continue program implementation and MCAH will work with UCSF and the CA Prevention Training Center to support and monitor local implementation and program quality in an effort to meet or exceed federal performance measures.

MCAH will continue to implement AFLP and apply the best practices learned from the AFLP PYD efforts into the overall statewide AFLP program. MCAH plans to work with the OAH, as it develops its outcome evaluation for AFLP PYD.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	28.6	29.1	29	29	29
Annual Indicator	27.6	27.6	27.6	16.4	16.4
Numerator	126908	127505	129101	146702	
Denominator	459813	461974	467758	893580	
Data Source	Dental Health Foundation	Dental Health Foundation	Dental Health Foundation	CMS Form 415	CMS Form 415
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	26.3	26.3	26.3	26.3	26.3

Notes - 2013
A manual indicator is reported for 2013 based on 2012.

Notes - 2012
Data Source: Center for Medicaid and CHIP Services. Early and Periodic Screening, Diagnostic, and Treatment, CMS Form 416, 2012 State Data. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT2012National.zip. Last accessed on March 12, 2014.

Unlike in prior years, data for 2012 represents the percentage of Medi-Cal beneficiaries ages 6-9 who are eligible for EPSDT for 90 continuous days for FFY 2012, receiving a sealant on a permanent molar tooth. Thus, data reported for 2012 is not comparable to data reported in prior years.

Notes - 2011
A Data source for percent of third grade children with sealants: Dental Health Foundation, California Smile Survey, "Mommy It Hurts to Chew," February 2006. Accessed 03/20/13.
Denominator source: California Department of Education. Accessed 03/20/13 at http://dq.cde.ca.gov/dataquest/Enrollment/GradeEnr.aspx?cChoice=StEnrGrd&cYear=2011-12&cLevel=State&cTopic=Enrollment&myTimeFrame=S&cType=ALL&cGender=B
*Based on weighted results from a completed survey of a representative sample of elementary schools in California conducted during 2004-05. Dental sealant information is based on one-minute, non-invasive oral health screening of all third graders in selected schools using protocols from the Association of State and Territorial Dental Directors at http://www.dentalhealthfoundation.org/index.php?option=com_content&task=view&id=43&Itemid=60. Accessed 02/21/12.

a. Last Year's Accomplishments
Children's access to preventive dental services is assessed in relation to the percent of third grade children who have received protective sealants on at least one permanent molar tooth. The percentage of children with sealant in California is estimated to be 27.6 percent. A new survey has not been implemented since 2005 to update this rate. So, for 2012, the percentage of Medi-Cal beneficiaries ages 6-9 who are eligible for EPSDT for 90 continuous days for FFY 2012. The data is from the CA Department of Health Care Services, Systems of Care Division. Form CMS-416, Annual EPSDT Participation Report, FFY 2011-2012.

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

About one-third of LHJs actively provides education, screenings, referrals and limited dental services for children and pregnant women. LHJs also rely on collaboration with local oral health coalitions to bring outreach programs and preventive services to MCAH target populations. Many LHJs select WIC sites, pre-schools, and public school locations to deliver these services. MCAH case management programs, such as CPSP, BIH and AFLP, enroll women and their families into Medi-Cal and provide them with necessary dental referrals.

California law requires that children receive a dental check-up within the last 12 months and up to May 31 of their first year in public school (kindergarten or first grade). Schools are encouraged to collect and submit data but are not mandated to do so because of state budget cuts. Last year, the California Dental Association collected assessment data from 42% of the school districts; 116,974 out of 191,192 eligible children submitted an assessment during the school year. Approximately 20.5% were found to have untreated decay, an increase over last year's results of 18.7%.

From January through November 2013, over 750,000 children, who were enrolled in the Healthy Families Program in 2012, transitioned into Medi-Cal's Targeted Low Income Children's Program, covering children with income up to and including 250 percent of federal poverty level. Another

287,000 newly enrolled children were added. Families needing to locate a new dentist can use the Beneficiary Customer Service line, which provides warm transfers (ensuring beneficiaries are connected to a provider and attempting to schedule an appointment before disconnecting from the call). The Denti-Cal website also includes provider network information allowing individuals to search for providers by state, name of provider, location of residence, specialty, accepting new patients, and other factors through the Insure Kids Now widget. Recruitment for providers who practice in communities with low Denti-Cal participation continues.
OHU is working with the University of the Pacific and other partners to implement an Oral Health Workforce Grant. Activities include developing a dental prevention and treatment pilot project in schools with FQHCs as a direct service model; identifying strategies to increase the current dental health workforce and addressing policy barriers; the development of an initial framework for a "value-based" payment mechanism for oral health services, and developing tool kits to implement school-based dental prevention programs. OHU's Community Water Fluoridation Program provides technical assistance to public water systems, local health jurisdictions, health providers, and other interested organizations and/or individuals regarding fluoridation. In 2012, the percentage of Californians receiving fluoridated water increased from 62.1-63.7%.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medi-Cal provides access to a comprehensive package of primary and preventive services, including dental care, for California's low-income children.				
2. CHDP provides dental screenings for over 1.8 million children a year and is developing an Oral Health for Infants and Toddlers Provider Training Manual for county programs.				
3. SCD is undertaking activities to encourage orthodontists and dentists to accept more CCS children into their practices, including more rapid reimbursement		X		
4. MCAH Program, with key State stakeholders (e.g. Medi-Cal, State First 5 Commission, SCD and APP), develops and promotes policy strategies that will improve the oral health of its targeted population.				X
5. MCAH Program has contracted with UCSF School of Dentistry for a dental hygienist to serve as the Branch's oral health policy consultant to provide TA at the state and local levels.				
6. Children are required to receive a dental check-up within 12 months of their enrollment into kindergarten or first grade, whichever is their first year of public school.				
7. LHJs are working with medical, dental and education providers in community dental health advisory boards to promote preventive oral health practices and provide fluoride varnish applications.				X
8. OHU, COH and partners were awarded a three year HRSA Oral Health Workforce grant to develop dental prevention and treatment models for underserved populations.				X
9. MCAH is disseminating State perinatal clinical oral health guidelines created for providers engaged in the care of pregnant women and their children.				X

b. Current Activities

MCAH promotes the California perinatal clinical oral health guidelines to assist health care professionals deliver oral health services to pregnant women and their children. MCAH also dispatches updated information, web links, grant resources and educational materials to local oral health advocates and coordinators. One area of interest is the new pediatric dental benefits offered by CA Health Benefit Exchange. MCAH has closely observed the creation of the Covered CA website and the process parents encounter when signing up for 2014 stand-alone dental plans for their children.

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

An effort to integrate oral health into CHVP has begun. The MCAH oral health consultant participates in meetings with local program staff to share information on finding Medi-Cal dental providers for both pregnant women and their children and tips on oral health care. Beginning January 2014, the consultant joined the staff of CHVP to incorporate more oral health activities into local programs.

c. Plan for the Coming Year

MCAH will continue to promote and disseminate the California perinatal clinical oral health guidelines for health care providers. Since the guidelines were released in 2010, MCAH hopes to detect an increase in the number of pregnant women receiving prenatal oral health counseling. Two multi-part questions from the 2009 MIHA survey were added back into the 2012 MIHA survey to discern any change among respondents. Data analysis is currently underway. MCAH is collaborating with DHCS to develop a State Action Plan to address two national Medicaid goals for oral health improvement in children. The first goal is to increase by 10 percentage points the proportion of children enrolled in Medicaid that receive a preventive dental service, over a 5-year period. The second goal is to increase by 10 percentage points the proportion of children ages six to nine enrolled in Medicaid that receive a dental sealant on a permanent molar tooth. Proposed activities include: work with local CHDP programs to identify and assist children in need of dental services; increase the number of school-based programs providing sealants; aid FQHCs in reporting dental services; encourage Head Start and WIC programs to bill for fluoride varnish applications; and allow registered dental hygienists (RDHs) to become Denti-Cal billing providers.

In July 2009, state officials cut Medi-Cal services including eliminating coverage for adult dental care. However, in accordance with the decision by the US Court of Appeals for the Ninth Circuit, all adult dental services are now reimbursable Medi-Cal services when provided by FQHCs and Rural Health Centers beginning on September 26, 2013.

In addition, health budget bill AB 82 declared that beginning May 1, 2014, the following dental benefits will be restored to three million Medi-Cal beneficiaries age 21 and older: initial examinations, radiographs/photographic images, prophylaxis, and fluoride treatments; amalgam and composite restorations; prefabricated stainless steel, resin, and resin window crowns; anterior root canal therapy; complete dentures, including immediate dentures; and complete denture adjustments, repairs, and relines.

The Children's Partnership, an advocacy group, is supporting AB 1174 to approve Medi-Cal reimbursements for tele-dentistry. The bill would emulate the Virtual Dental Home pilot project at the University of the Pacific's School of Dentistry. Under the program, RDHs in alternative practice, RDHs working in public health programs, and registered dental assistants can keep

people healthy in community settings by providing education, preventive care, interim therapeutic restorations triage, and case management. Radiographs and pictures are transmitted to collaborating dentists who diagnose and prescribe all treatment.

The Board of the CA Health Benefit Exchange has decided to offer embedded pediatric dental benefit plans side by side with a stand-alone benefit plans for 2015 in the individual market.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2.9	2.9	1.6	1.6	1.6
Annual Indicator	1.8	1.0	1.1	1.4	1.4
Numerator	148	84	85	105	
Denominator	8184071	8199138	7568037	7554127	
Data Source	CA Death Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	1.6	1.6	1.6	1.6	1.6

Notes - 2013
A manual indicator is reported for 2013 based on 2012.

Notes - 2012
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Death Statistical Master File [The International Classification of Diseases (ICD)-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.Tabulations (by place of residence) were done by the MCAH Program.

Data for 2011-2012 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010 using these updated population projections was 1.1.

Notes - 2011
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Death Statistical Master File [The International Classification of Diseases (ICD)-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.Tabulations (by place of residence) were done by the MCAH Program.

Data for 2011 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010 using these updated population projections was 1.1.

a. Last Year's Accomplishments
CIPPP maintained a calendar of online training opportunities and webinars to partially fill the gap created by declining resources and travel restrictions for in-person training opportunities. CIPPP developed age-appropriate recommendations to parents of infants, toddlers, children and adolescents for keeping their children safe at home, at play, and when traveling. These "Be Safe, Not Sorry" sheets are available in English, Spanish, and Vietnamese languages. SafetyLit services were enhanced through a complete redesign of the website interface, an improved search system, and the addition of gray literature (conference proceedings, doctoral theses, and technical reports), and of books and book chapters to the existing articles drawn from >12,000 scholarly journals published in 142 of the world's nations. These prevention articles (from places with different populations and cultures, different fiscal situations, and different levels of personnel and personal training and skills) can be readily adapted to inform activities in California's rural and inner city areas.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Local MCAH funded programs participating in the SAFE KIDS Coalitions to implement traffic safety training, child passenger safety checks and safety seat distribution, and bicycle helmet education programs.		X	X	X
2. AFLP, BIH, and CPSP provide educational materials on use of car seats and child injury prevention.		X		
3. To raise funds to support child injury and abuse prevention programs, the State sells special car license plates, called Kid's Plates.				X
4. The SAC Branch maintains an up-to-date list of locally operated CPS seat programs for use by traffic courts, community agencies, hospitals and clinics.		X		
5. CIPPP builds injury prevention capacity by providing technical assistance, including regular reviews of the current injury prevention literature and a database of relevant material published as far back as the mid-seventeenth century.				X
6. Office of Traffic Safety (OTS) funds “click it or ticket” campaigns for seatbelt safety.			X	

b. Current Activities
The CIPPP contract was cancelled in 2013/14 due to reductions in Title V funding.

c. Plan for the Coming Year
Due to the reduction of Title V funds there are no planned activities of MCAH.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	72	65	64.2	64.2	64.2
Annual Indicator	62.3	59.5	63.7	64.9	64.9
Numerator	237585	210982	240072	245022	
Denominator	381282	354888	376830	377290	
Data Source	MIHA	MIHA	MIHA	MIHA	MIHA
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	64.2	64.2	64.2	64.2	64.2

Notes - 2013
A manual indicator is reported for 2013 based on 2012.

Notes - 2012
Source: 2012 Maternal and Infant Health Assessment Survey (MIHA), MCAH Program, CA Department of Public Health.

Numerator: The number of women who delivered a live birth and who reported that they were still breastfeeding their infant at 3 months of age. Denominator: The number of women who delivered a live birth that reported whether or not they were still breastfeeding at 3 months of age. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year and exclude mothers who could not answer the question because they responded to the survey before 3 months post-partum.

2011 and 2012 data cannot be compared to data for prior years due to changes to the wording of the infant feeding questions. 2011 will serve as new baseline to track progress.

Notes - 2011
Numerator: The number of women who delivered a live birth and who reported that they were still breastfeeding their infant at 3 months of age. Denominator: The number of women who delivered

a live birth that reported whether or not they were still breastfeeding at 3 months of age. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year and exclude mothers who could not answer the question because they responded to the survey before 3 months post-partum.

Note: 2011 data cannot be compared to data for prior years due to changes to the wording of the infant feeding questions. 2011 will serve as new baseline to track progress.

a. Last Year's Accomplishments

MCAH developed a webpage and authored a letter to hospitals from WIC and MCAH providing them with resources and notification regarding CA Health & Safety Code SS123366, the Hospital Infant Feeding Act.

MCAH authored a letter from WIC and MCAH to CDC to support the continuation of MPINC, a national survey of maternity care practices and policies conducted every two years by the CDC.

The infant feeding guidelines for AFLP, CDAPP: Sweet Success and CPSP were updated with more current and science-based information.

MCAH developed a Systems and Environmental toolkit and webinar that support breastfeeding. The resources chosen are feasible projects for MCAH Program involvement. A success story shared in the toolkit is that during this year, the City of Pasadena's MCAH program is working to implement a citywide workplace breastfeeding policy as well as a department-wide Mother-Baby Friendly workplace. They hope to make Pasadena a Mother-Baby Friendly community by 2015.

MCAH collaborated with the CA Breastfeeding Coalition, the CA WIC Association and State programs to host the 3rd Annual CA Breastfeeding Summit on 01/31 - 02/01/13.

MCAH and SCD provided the DHCS, data and technical assistance in support of a quality improvement project to increase breastfeeding among Medi-Cal recipients as part of the DHCS Quality Strategy.

MCAH programs promoted exclusive breastfeeding until complementary foods are introduced and continued breastfeeding for at least the first year of life.

MCAH shared information with its programs during World Breastfeeding Week and encouraged county and community-based organizations to participate. MCAH coordinated with the CA Obesity Grant, WIC, WIC Association, and Breastfeeding Coalition to celebrate World Breastfeeding Week with a breastfeeding walk.

MCAH supported CDPH and DHCS in adhering to CA Health & Safety Code SS 123360 in creating a public health campaign to provide breastfeeding information and referrals, making available an 8-hour training course that promotes exclusive breastfeeding, and assisting hospitals in developing policies to support breastfeeding by keeping the Model Hospital Policy Recommendations Toolkit and hospital quality improvement resources updated. Per CA Health & Safety Code SS123365, WIC and MCAH finalized a hospital administrators web-based breastfeeding policy curriculum.

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

MCAH hospital initiation breastfeeding data was posted online and used by the CA WIC Association and UCD to produce a Hospital Breastfeeding Rates Report & County Fact Sheets. MCAH collaborated with CDC to show that evidence-based policies and practices measured by MPINC are associated with increased exclusive breastfeeding rates in CA hospitals; county and

regional MPINC benchmark report were posted online and shared at the annual Hospital Breastfeeding Summit.

MCAH participated in RPPC's emergency preparedness efforts for birthing hospitals and posted related resources on the web.

For home visiting efforts, MCAH developed breastfeeding benchmark indicators and researched WIC's Peer Counselor Curriculum.
Several LHJ activities promote breastfeeding. For example, Kings County collaborated with the local breastfeeding coalition to develop a "breastfeeding friendly sites" directory. Marin County adopted a workplace breastfeeding policy. Solano County implemented the "More Excellent Way," an African American, peer counseling, church-placed infant feeding and parenting training and intervention program.

El Dorado County had an "Express Stop" to loan breast pumps to local employers to help them meet workplace requirements. Fresno County prepared a training "How to Provide Breastfeeding Education and Support in CPSP" in collaboration with the WIC program. Kern County received input from nurses in their LHJ to improve the breastfeeding curriculum at California State University, Bakersfield.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. AFLP promotes breastfeeding among adolescent mothers, an age group that is less likely to breastfeed		X		
2. CDAPP promotes breastfeeding as beneficial for both mother and child in reducing the risk for diabetes.		X		
3. BIH collaborates with local breastfeeding coalitions to promote breastfeeding in several counties.		X		
4. CPSP promotes breastfeeding through nutrition assessment and counseling.	X			
5. MCAH is participating on the CDPH Obesity Prevention Group as breastfeeding promotion is one of the interventions for childhood obesity prevention.				X
6. MCAH staff help promote local breastfeeding coalitions, including participating at the California Breastfeeding Coalition meetings.				X
7. MCAH is providing toolkits, training and TA (via RPPC) to staff at labor and delivery hospitals to improve hospital lactation policies.		X		
8. MCAH maintains the CDPH and MCAH website's breastfeeding pages which includes breastfeeding information and answers many questions that local programs and the public may have.				X

b. Current Activities
MCAH collaborated with WIC, CA Obesity Prevention Program, CA Breastfeeding Coalition, and the CA WIC Association to host the Annual CA Breastfeeding Summit 2014 where MCAH showcased the improved easy to navigate CDPH Breastfeeding web page. Breastfeeding posters were shared at Chronic Disease's Advancing Prevention in the 21st Century Commitment to Action 2014 Conference.

RPPC coordinators are addressing the Infant Feeding Act which requires hospitals to have an infant feeding policy, including promotion of the Annual Breastfeeding Summit, provided breastfeeding trainings, information and data to regional hospitals, CHDP promotes and supports breastfeeding through nutrition assessment, anticipatory guidance, training for medical providers and ensuring referrals are made to WIC and other health programs. CHDP assists WIC with breastfeeding specific trainings for CHDP providers and CHDP county staff.

Using CDC funds, MCAH collaborated with the CA Obesity Prevention Program (COPP) on a statewide pilot project focused on increasing breastfeeding duration rates in California's low-income communities of color. 15 community health centers received training, technical assistance, and resources to assist them 1) implement a "breastfeeding-friendly" environmental and policy changes, and 2) improve reimbursement policies. Successful pilot strategies will be highlighted and shared for clinics statewide to adopt specific model "breastfeeding-friendly" clinic policies/practices.

c. Plan for the Coming Year

MCAH will strive to maintain its lead with the most Baby-Friendly certified hospitals (59) in the U.S. MCAH provides resources on the CDPH web page to implement CA Health & Safety Code SS123366, the Hospital Infant Feeding Act and SS123367 (2013) which requires all general acute care hospitals and special hospitals that have a perinatal unit shall, by 2025, adopt the "Ten Steps to Successful Breastfeeding," per the Baby-Friendly Hospital Initiative, or an alternate process adopted by a health care service plan that includes evidenced-based policies and practices and targeted outcomes, or the CA Model Hospital Policy Recommendations.

MCAH will continue to collaborate with the Office of Emergency Preparedness to develop an infant feeding policy with recommended tools that focus on keeping the mother-infant dyad together and supporting breastfeeding as the preferred and safest infant feeding method.

MCAH will continue to support conferences/meetings such as the Hospital Breastfeeding Summit, and Childhood Obesity Conferences.

MCAH will continue to have a representative on the U.S. Breastfeeding Committee and the Association of State Public Health Nutritionists (ASPHN) MCH Nutrition Council which address breastfeeding strategies. She participates in the following USBC workgroups: Emergency Preparedness, Media/Public Relations and the Reduce Infant Formula Marketing. MCAH collaborates on promoting breastfeeding within CDPH via a Center for Family Health Nutrition Coordination Workgroup and the Obesity Prevention Group.

Example 5Year Action Plan on breastfeeding provided to Local Health Jurisdictions include:

- Develop a lactation accommodation plan that addresses current national and state laws
- Adopt practices that support the exclusive initiation of breastfeeding within labor and delivery facilities as per state law
- Adopt practices that support breastfeeding within health centers
- Expand breastfeeding support within MCAH programs
- Include breastfeeding support within emergency preparedness plans

The SCD Registered Dietitian/Lactation Consultant will continue to provide specialized assistance in support of the quality improvement project to increase breastfeeding rates among Medi-Cal recipients as part of the DHCS Quality Strategy.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	95	95	98	99	99
Annual Indicator	98.0	99.0	97.9	95.0	
Numerator	517247	505847	492337	479430	
Denominator	527897	510981	503016	504814	
Data Source	Office of Vital Records	Office of Vital Records	Office of Vital Records	Office of Vital Records birth cert data;NHSP data	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	99	99	99	99	

Notes - 2013
no data available at this time due to change in contractor.

Notes - 2012
Hearing screening data are underreported for 2012 because there was a 4 month period with no Hearing Coordination Center contractor in Northern California. Aggregate and individual data from hospitals were not consistently collected during that time.

Notes - 2011
Measure based on hospitals carrying out universal newborn hearing screening in California. This measure is the percent of newborns who have been screened for hearing before hospital discharge.

Source: Numerator and denominator data are from the State of California, Department of Public Health, Office of Vital Records, birth certificate data.

Numerator: Number of newborns who have been screened for hearing before discharge for FY 2011.
Denominator: Number of live births by occurrence in California in FY 2011.

a. Last Year's Accomplishments
1) SCD provided TA and consultation support to HCCs to ensure that all general acute care hospitals with licensed perinatal services provide hearing screening tests to all newborns in a manner consistent with NHSP standards and requirements.
2) SCD continued to facilitate the NHSP Quality Improvement learning collaborative.
3) SCD was awarded continued funding from MCHB for the tele-audiology project to improve the quality of and access to audiology services and minimize the shortage of pediatric

audiology providers in Northern California.
4) SCD collaborated in the implementation of the parent support grant from MCHB.
5) SCD worked with the NHSP Data Management Service (DMS) vendor, Neometrics, to implement the DMS in all HCCs and to roll out the implementation in hospitals statewide.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SCD will work with the CDE to support the implementation of the parent support activities in the grant from MCHB		X		
2. The statewide data management service for the NHSP will be rolled out to additional hospitals.				X
3. TA and consultation support will continue for all HCCs.			X	
4. SCD will ensure that all general acute hospitals with licensed perinatal services participate in the NHSP.			X	
5. CD continues to work with Medi-Cal and its fiscal intermediary to address issues affecting access to outpatient hearing screening and audiology services.				X

b. Current Activities

1) All new general acute care hospitals with licensed perinatal services will be certified for participation in the NHSP.
2) SCD continues collaboration in the implementation of the parent support grant from MCHB.
3) The NHSP DMS vendor is implementing the DMS in additional hospitals.
4) SCD is an active participant in the NHSP QI learning collaborative.
5) SCD provides technical support to the HCCs.
6) SCD continues to collaborate with UC Davis Hospital to execute the activities in the tele-audiology grant.
7) SCD continues to work with Medi-Cal and its fiscal intermediary to address issues affecting access to outpatient hearing screening and audiology services.
8) SCD is initiating collaboration with UCLA for a comprehensive evaluation of the NHSP.

c. Plan for the Coming Year

1) SCD will finalize the certification of any new hospitals.
2) SCD will continue to collaborate in the implementation of the parent support grant from MCHB.
3) The DMS for NHSP will be rolled out to all remaining certified hospitals throughout the state.
4) SCD will continue participation and facilitation of the NHSP QI learning collaborative.
5) TA and consultation support will continue for all HCCs to ensure compliance with NHSP standards and requirements.
6) The Audiology Telehealth pilot project in the rural northern region of California will allow rural families to receive local diagnostic services without lengthy travel.
7) SCD will collaborate with UCLA in the evaluation of NHSP.

Performance Measure 13: *Percent of children without health insurance.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	13.1	12.9	10	10	10
Annual Indicator	11.2	11.2	11.3	10.2	10.2
Numerator	1190554	1185414	1102686	993064	
Denominator	10616624	10613742	9796707	9782535	
Data Source	Current Population Survey	Current Population Survey	Current Population Survey	Current Population Survey	Current Population Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	10	10	10	10	10

Notes - 2013
A manual indicator is reported for 2013 based on 2012.

Notes - 2012
Source: U.S. Census Bureau. 2013 Annual Social and Economic Supplement. Current Population Survey Table Creator. Available at: http://www.census.gov/cps/data/cpstablecreator.html. Last accessed on December 5, 2013. The numerator and denominator data were recalculated the California Department of Finance population projections for 2011 and prior years. The numerator and denominator data reported for 2012 is based on the U.S. Census Bureau projections weighted to the 2010 U.S. Census.

Notes - 2011
Source: Numerator of uninsured children age 0-18 is from the Kaiser Family Foundation analysis of the March 2011 release of the Current Population Survey. Denominator (estimate of the number of children 18 years of age and younger): State of California, Department of Finance, Report P-3 Population Projections by Race/Ethnic, Detailed Age, and Gender, 2010-2060, Sacramento, CA, January 2013.

The percent of uninsured children 0-18 years was calculated by dividing the numerator by the denominator. The percent uninsured is rounded to the fifth decimal point.

a. Last Year's Accomplishments
The percent of uninsured children in California has decreased since 2000 when the percent of children without health insurance was 15.7%. Over a million children still lack coverage. Data for NPM 13 are based on the U.S. Current Population Survey. Medi-Cal continues to fill the gap in coverage created by the decline in private insurance. Children received coverage from three main sources of coverage: job-based insurance, privately purchased insurance and Medi-Cal.

California began the process of combining Medi-Cal and the Healthy Families Program (HF). Beginning January 1, 2013 and through November 1, 2013 children who in the past would have enrolled in HF became eligible for full-scope, no share-of-cost Medi-Cal under a new Medi-Cal Optional Targeted Low-Income Children's (OTLIC) Program. Infants previously enrolled into HF as a result of being born to a mother on the AIM Program with an income above 250 percent and up to 300 percent of the FPL were transitioned to the new DHCS AIM-Linked Infants Program (ALIP).

Local MCAH programs, including AFLP, BIH, and CPSP, provided outreach and facilitated referrals to Medi-Cal, CHI, and Covered California insurance and care for pregnant women, infants and families, focusing on high risk populations. Activities included case finding, care coordination, public awareness media campaigns, and other targeted community education and outreach efforts. High-risk groups included CSHCN, low income pregnant women, and women of childbearing age who are at risk for adverse perinatal outcomes. Counties continue to provide assistance in Medi-Cal applications at County social service offices.

Medi-Cal Managed Care (MCMC) expanded into 28 rural counties that were formerly Fee-For-Service (FFS) only. By November 2013, California completed the expansion of MCMC services to all of California's 58 counties. This expansion provided beneficiaries throughout the state with care through an organized delivery system.

Many counties continued to provide coverage through Children's Health Initiatives (CHI) to locally fund insurance programs for children ineligible for Medi-Cal coverage. CHI is a collaboration of 29 local CHI's dedicated to ensuring that all California children have access to quality health coverage.

Local CHDP programs informed new providers about the Gateway and directed them to CHDP Gateway resources. The Systems of Care Division (SCD) continued to analyze CHDP Gateway data reports to monitor program operations and the needs of local programs and providers.

Through the CHDP Gateway, any child under 19 years with family income up to 200% of the FPL (and not already in the Medi-Cal Eligibility Data System (MEDS) system) is "presumed eligible" for Medi-Cal and given a temporary Medi-Cal Benefits identification card. This provides access to no-cost, full scope fee-for-service Medi-Cal benefits for up to 60 days. Most families with children pre-enrolled through the CHDP Gateway (91 percent) request a Medi-Cal/ application for ongoing coverage at the time of the pre-enrollment through the CHDP Gateway. Seventy-six percent of CDPH applications come from the Gateway. Twenty-three percent of children enrolled in CHDP from the Gateway go on to enroll in full-scope Medi-Cal.

Since December 2010, Californians have been able to use a self-service, online application for the Medi-Cal Program for Children and Pregnant Women. This enrollment option, called Health-e-App Public Access (HeAPA) offers a faster and more convenient access to public insurance for children. Its first full year of operation was 2011. Through the CHDP Gateway, any child under 19 years with family income up to 200% of the FPL (and not already in the Medi-Cal Eligibility Data System (MEDS) system) is "presumed eligible" for Medi-Cal and given a temporary Medi-Cal Benefits identification card. This provides access to no-cost, full scope fee-for-service Medi-Cal benefits for up to 60 days. Most families with children pre-enrolled through the CHDP Gateway (91 percent) request a Medi-Cal/ application for ongoing coverage at the time of the pre-

enrollment through the CHDP Gateway. Seventy-six percent of CDPH applications come from the Gateway. Twenty-three percent of children enrolled in CHDP from the Gateway go on to enroll in full-scope Medi-Cal.

Local CHDP programs informed new providers about the Gateway and directed them to CHDP Gateway resources.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCAH programs and LHJs encourage and facilitate enrollment in Medi-Cal, CHI and other low cost insurance programs via community outreach and education activities and local Toll-Free Telephone referral lines.			X	
2. SCD works to maximize the effectiveness of the Gateway for enrolling eligible children in Medi-Cal.				X
3. CHDP provides information and materials in multiple languages for the Gateway.				X
4. MCAH continues to implement and support improvements in the process of eligibility determination and enrollment for Medi-Cal.		X	X	

b. Current Activities

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

California began enrollment in ACA-compliant health insurance plans in September 1, 2013.. DHCS partners with Covered California to provide a one-stop shop for application to Medi-Cal or Covered California health coverage.

California implemented the Targeted Low Income Children's Program. California Children's Services provides coverage for certain medical conditions for families with incomes less than $40,000 or expenses more than 20% of their income.

Local CHDP programs inform new providers about the Gateway and direct them to CHDP Gateway resources. SCD will continue to analyze CHDP Gateway data reports to monitor program operations and the needs of CHDP local programs and providers. Infants in the new DHCS AIM-Linked Infants Program (ALIP) with CCS eligible medical conditions continue to receive case management and care coordination from the CCS Program.

DHCS implemented the use of the MAGI as an expansion of Medi-Cal to include those who are up to 266% of the FPL. This is an increase from the 200% of the FPL for the MAGI eligible population.

c. Plan for the Coming Year

California will continue to conduct outreach and education to encourage and facilitate enrollment in Covered California, Medi-Cal and other health insurance. California will continue to implement the Health Benefit Exchange to enroll eligible residents into Covered California health plans and DHCS will monitor and facilitate the Medi-Cal enrollment process.

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

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

Local CHDP programs will continue work with the fee-for-services health assessment providers on the referrals, and coordination of care for the residual beneficiaries who remain in fee-for-service Medi-Cal. SCD will continue to maximize the effectiveness of the Gateway for enrolling eligible children in Medi-Cal

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	33.5	33.5	31.4	31.4	31.4
Annual Indicator	32.9	33.4	32.7	32.7	32.7
Numerator	109446	95025	85882		
Denominator	332663	284506	262637		
Data Source	PedNSS	PedNSS	PedNSS	PedNSS	PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	31.4	31.4	31.4	31.4	31.4

Notes - 2013
A manual indicator is reported for 2013 based on 2011

Notes - 2012
A manual indicator is reported for 2012 based on 2011.

Notes - 2011

Data Source: CDC, Pediatric Nutrition Surveillance System (PedNSS) Annual Reports for CY 2011. Table 6D, 2011 Pediatric Nutrition Surveillance, National, Comparison of Growth and Anemia Indicators by Contributor, Children Aged < 5 years..

a. Last Year's Accomplishments

MCAH continued to focus on a life course perspective for addressing childhood obesity: preconception, pregnancy, interconception, infant feeding all have an effect on childhood obesity. MCAH provided expert input for the 2013 Childhood Obesity Conference. MCAH continued existing and began new collaborations, such as with the Coordinated Chronic Disease Program.

An online toolkit to provide nutrition, physical activity and breastfeeding resources for LHJ-MCAH Programs to address the built environment was developed and includes a sample PowerPoint and webinar featuring Dr. Richard Jackson and local MCAH Directors.

The revised CDAPP Sweet Success Guidelines for Care include medical nutrition therapy, breastfeeding and exercise sections. The Spanish CA MyPlate for Gestational Diabetes handout was developed. The CDAPP Sweet Success Resource and Training Center provided webinars on diabetes and pregnancy, e.g., on nutrition, eating for the holidays and exercise.

Extensive activities were implemented to promote breastfeeding (see NPM 11). BIH updated their curriculum to include breastfeeding and maternal weight.

MCAH finalized English and Spanish healthy cookbooks for AFLP to encourage healthy eating and physical activity. The physical activity section of the AFLP Nutrition and Physical Activity Guidelines was revised.

As part of a life course approach to prevent obesity, a MCAH webpage shares strategies and community-based interventions that support healthy weight for reproductive-aged women. MCAH assisted in developing interconception guidelines/handouts for women with risks, e.g., gestational diabetes, in a prior pregnancy. MCAH collaborated with FHOP to create a healthy weight webinar and fact sheet.

CPSP's Steps to Take Guidelines include a section on breastfeeding and MyPlate for Moms. CPSP nutrition, physical activity and breastfeeding handouts are posted online. MyPlate for Moms is a primary message for CPSP and AFLP. Prenatal weight gain grids were created for pregnant women with twins. In collaboration with UCLA, a CPSP Perinatal Food Group Recall which identifies food group and calorie deficiencies/excesses was evaluated for accuracy and ease of implementing by CPSP Community Health Workers. Findings and recommendations were presented to Perinatal Services Coordinators.

MCAH researched nutrition, physical activity and breastfeeding benchmarks for home visiting and disseminated WIC child nutrition and baby behavior educational materials to local MCAH.

MCAH helped author national guidelines released in 2011 promoting optimum nutrition, breastfeeding and physical activity in childcare centers.

Many laws were passed to support CDPH efforts to reduce obesity, such as making obtaining federal funds easier for CDPH and establishing a "Safe Routes to School Program."

State and local CHDP nutritionists developed and implemented nutrition education curricula, provided consultations, trained staff, and monitored childhood obesity. Online training modules for assessing and managing overweight children were updated and utilized by MCMC Health Plans and CHDP providers. CHDP nutritionists trained medical providers and clinic staff on the use of the WHO Growth Charts and the use of BMI as a screening tool for overweight and obesity CHDP nutritionists collaborated with numerous other public health entities including WIC and the Active and Healthy Families Program regarding obesity prevention and management.

The MCAH Nutrition and Physical Activity Coordinator was a Board member of the Association of State Public Health Nutritionists (ASPHN) and MCH Nutrition Council, which works to strengthen nutrition strategies, programs and environments at state and national levels. MCAH collaborates within CDPH via a Center for Family Health Nutrition Coordination Workgroup and the Obesity Prevention Group.. MCAH and SCD participated on the Obesity Prevention Group (OPG), which aims to integrate obesity prevention into CDPH programs.
Examples of local MCAH activities include nurses promoting healthy eating habits and increased physical activity to Alameda female clients of childbearing age. Monterey provides cooking demonstrations to migrant families. Riverside updated a Child and Adolescent Obesity Provider toolkit. San Francisco developed guidelines to improve physical activity and nutrition in child care centers and after school programs. Stanislaus promoted a built environment to support physical activity.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHDP program benefits include cholesterol and fasting blood glucose screening tests for children at risk for obesity, the complications of obesity and at risk for cardiovascular disease.	X		X	
2. State and local CHDP nutritionists develop and implement nutrition education, provide consultation and training modules for CHDP providers and office staff, and coordinate follow-up and referrals to related programs.		X		X
3. MCAH develops and/or provides nutrition education materials and initiatives, nutrition assessment materials, technical assistance and consultation, and funding opportunities to MCAH programs and colleagues.				X
4. BIH, AFLP, CDAPP and CPSP promote optimal weight gain in pregnancy, breastfeeding, and glycemic control as an effort to reduce the risk of obesity.		X		
5. MCAH partners with other state programs and agencies to dialogue with advocates, experts and local MCAH directors to prevent overweight among infants and pre-school aged children.				X
6. BIH, AFLP, CDAPP and CPSP promote physical activity and proper nutrition by encouraging healthy eating through discussions on how to cut fat, lower calories and move more.		X		
7. MCAH offers MCAH LHJs a “Here is Where Healthy Starts” award for strategies/programs in place to support good nutrition, physical activity, safety and breastfeeding.				X
8. MCAH and SCD collaborate with the California Nutrition Network for Healthy, Active Families to promote healthy eating and a physically active lifestyle among low income Californians.				X

b. Current Activities
MCAH completed revisions to the weight management and nutrition assessment sections for the AFLP Nutrition and Physical Activity Guidelines.

MCAH is participating in a Physical Activity (PA) Collaborative Impact Planning Group. In these sessions CDPH physical activity staff are 1) sharing about our current/future CDPH PA projects, programs, and interventions, 2) identifying where there are opportunities to integrate our PA-

related activities at the state and local levels, 3) developing PA priority areas and strategies for implementation , and 4) identifying gaps and opportunities for additional partnerships.

MCAH featured work to support breastfeeding and the nutrition, physical activity, and breastfeeding Systems and Environmental Change Toolkit at the Advancing Prevention in the 21st Century: Commitment to Action 2014 Conference.

CHDP is developing and revising education materials for medical providers and low-income families related to obesity prevention and breastfeeding promotion. CHDP continues to provide trainings, consultations and guidance to providers and other public health programs. Local CHDP programs are investigating ways to bridge essential functions of CHDP with MCMC plans.

c. Plan for the Coming Year

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

MCAH will continue to collaborate with experts and LHJ MCAH Directors to address MCAH's role in utilizing strategies and tools to advocate for environmental changes to support optimum nutrition, physical activity and breastfeeding. MCAH will continue to promote Food Day to LHJs as an opportunity to inform, engage and empower MCAH populations on matters related to nutrition. Food Day is a nationwide celebration and movement for healthy, affordable and sustainable food.

MCAH will continue to meet four times a year with WIC, Genetic Disease, and SCD to strengthen and coordinate child nutrition and physical activity messaging . MCAH will continue to coordinate with other programs promoting physical activity in CDPH.

MCAH will complete the revisions to the disordered eating section for the AFLP Nutrition and Physical Activity Guidelines. The CDAPP Sweet Success Resource and Training Center will continue to provide webinar trainings and education resources for both health care providers and pregnant women with diabetes.

MCAH is investigating developing alternative nutrition assessment forms for pregnant and postpartum women based on recent evaluation of the CPSP Perinatal Food Group Recall form.

MCAH and SCD will work with OPG to integrate obesity prevention into CDPH programs. MCAH will be on the Planning Committee for the 2015 Childhood Obesity Conference. The Nutrition and Physical Activity Coordinator of MCAH will be the 2014-2015 past-president of ASPHN. Efforts to promote nutrition and physical activity strategies will carry on. MCAH and SCD will continue to work with existing collaboratives, such as Center for Family Health Nutrition Coordination Workgroup, ASPHN, Coordinated Chronic Disease Program and the OPG to implement Nutrition, Physical Activity and Breastfeeding interventions.

MCAH and SCD are exploring ways to ensure that nutrition, physical activity and breastfeeding are adequately covered and marketed in the Affordable Care Act.

Example 5Year Action Plan on obesity and overweight provided to Local Health Jurisdictions include:

- Develop a nutrition and physical activity plan
- Address workplace nutrition and physical activity in the [Public Health Department (PHD)]
- Improve walkability of communities at high risk of obesity
- Implement a weight tracking intervention for pregnant and postpartum women
- Implement physical activity standards in child care centers.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3.5	3.4	2.6	2.6	2.6
Annual Indicator	2.8	3.0	2.9	2.6	2.6
Numerator	14417	14824	14269	12748	
Denominator	519623	498106	489359	491659	
Data Source	MIHA	MIHA	MIHA	MIHA	MIHA
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	2.6	2.6	2.6	2.6	2.6

Notes - 2013
A manual indicator is reported for 2013 based on 2012.

Notes - 2012
Source: 2012 MIHA survey, MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported any smoking in the third trimester of pregnancy. Denominator: The number of women who delivered a live birth and reported whether or not they had smoked during their third trimester of pregnancy.

Numerator and denominator are weighted to the number of resident women in the state who delivered a live birth in 2012.

Notes - 2011
Source: 2011 MIHA survey, MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported any smoking in the third trimester of pregnancy. Denominator: The number of women who delivered a live birth and reported whether or not they had smoked during their third trimester of pregnancy.

Numerator and denominator are weighted to the number of resident women in the state who delivered a live birth in 2011.

a. Last Year's Accomplishments
In 2012, 2.9 % of women aged 15 years and older who had a recent live birth reported smoking in the last trimester of pregnancy. Though the prevalence of smoking during the last trimester of pregnancy is stable as compared to the previous year, the prevalence has shown substantial decline since 1999, when the prevalence was 5.7% among all women in California.
In 2012, Black and White women had the highest rates of smoking in the last trimester of pregnancy (W% and X%, respectively) compared to Hispanic (Y%) and Asian/Pacific Islander

(Z%) women. Reported smoking declined in each of these groups since 2008, with the exception of Hispanic women, whose rate did not change.

In California, pregnant women continued to benefit from low smoking rates and a built environment that makes it difficult for one to smoke. The state's adult smoking prevalence has hit a record low of 11.9% in 2010, making California one of only two states to reach the HP 2020 target of reducing the adult smoking prevalence to 12%.

Starting in 2012, California Government Code 7597.1 gives governing bodies of the California State University and each community college district the authority to enforce smoking policies by citation and fine. California Civil Code 1947.5 authorizes a landlord of a residential dwelling unit to prohibit the smoking of tobacco products on the property premises or in a dwelling unit. California Welfare and Institutions Code 4139 dictates that a person who delivers or attempts to deliver tobacco products to a patient at a state hospital where tobacco use is prohibited is guilty of a misdemeanor punishable by a fine of up to $1000 per item. Local jurisdictions are able to regulate smoking more strictly than the state.

Smoking prevention efforts were prominent features of MCAH programs that serve pregnant women and teens. AFLP provided smoking exposure assessment and cessation assistance to pregnant teens. BIH provided health education and health promotion related to smoking cessation in groups and case management for Black pregnant and parenting women. CPSP included smoking cessation as a goal for improving pregnancy outcomes. Handouts, in English and Spanish, educated women about smoking cessation. PHCC provided information, tools and resources on the importance of optimal health before pregnancy, , including anti- smoking messages as part of the CDC preconception health campaign, Show Your Love. Data on non-pregnant women ages 18-44 show that fewer than half discussed smoking or future pregnancy plans during their most recent health care visit. To standardize the content of the preconception well-woman visit, PHCC developed provider screening guidelines.

As part of the local needs assessment data resources, MCAH provided, for the first time, county-level prevalence of smoking in households with children to all LHJs.

CTCP supported statewide and local smoking cessation projects to create effective and innovative tobacco control interventions throughout California. A primary intervention is the Medi-Cal Incentives to Quit Smoking Project that includes the California Smokers' Helpline to provide intensive tobacco cessation counseling for pregnant women, teens, and adults in multiple languages. Since its inception in July 2012, the Helpline has received over 28,000 calls from Medi-Cal members statewide.

Executive Order B-19-12 established an initiative and a statewide task force to develop a 10-year plan for improving the health of Californians. A priority area is "Health Across the Lifespan" with the goal of eliminating tobacco use and a strategy to affect numerous outcomes, including infant mortality and low birth weight.

CDPH released the "State Health Officer's Report on Tobacco Use and Promotion," highlighting successes (low rates) and problems (sale to minors, smokeless tobacco, marketing to low-income/minorities). A new law enhances enforcement and fees for retailers who sell tobacco products to minors.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. AFLP assess clients for smoking habits and exposure to second hand smoke and discuss the risks of smoking for the		X		

mother and baby during pregnancy and after birth.				
2. BIH clients receive education about smoking and health; the BIH Scope of Work includes smoking cessation to reduce low birth weight.		X		
3. CPSP guidelines assist providers and practitioners with health education, nutrition, and psychosocial intervention guidelines; handouts are also available, in English and Spanish, to educate women about smoking cessation.		X		
4. The California Tobacco Control Program supports statewide and local smoking cessation projects to create effective and innovative tobacco control interventions throughout California.		X		
5. The California Smokers' Helpline provides tailored counseling services for teens, adults, and pregnant women in English, Spanish, Korean, Mandarin, Cantonese, and Vietnamese.		X		
6. Diabetes educators throughout California have joined forces with the California Diabetes Program and the California Smokers' Helpline to assist patients with diabetes to quit smoking.				X
7. PHCC has developed a website with information for consumers and providers about health for women of reproductive age. It includes information about smoking during pregnancy and links to resources in English and Spanish.				X

b. Current Activities

AFLP/other teen programs, BIH, and CPSP provide smoking interventions which include historical use assessment, education, goal setting, and cessation activities, and referrals for pregnant and parenting women.

The Preconception Health Council of California Public Health Workgroup proposed language First Response to improve their health messaging for women with a negative test result. Among the recommendations were links to resources for smoking cessation. The PHCC is a primary outreach partner for the Smokers' Helpline.

Medi-Cal funds 60% of births and enrollees have high smoking rates. In response, Medi-Cal used ACA funded incentives to encourage enrollees to use the Smokers' Helpline and enroll in free cessation services. Starting in September 2013, 3,000 free nicotine patches and incentives have been provided to Medi-Cal members. MCAH programs disseminate MQIS information to encourage enrollment.

c. Plan for the Coming Year

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

The PHCC will continue to provide information, tools and resources--including the preconception and interconception guidelines--to local communities focusing on the importance of achieving optimal health before pregnancy. Messages emphasize refraining from tobacco use and avoiding relapse triggers. A continuing medical education module for interconception care is in development and will include instructions for developing a follow up plan for women with lifestyle or behavioral issues identified in pregnancy that pose a risk to their health and subsequent pregnancies.

CTCP will continue to support the Smokers' Helpline as well as other projects that facilitate community norm change and support local tobacco control efforts. The PHCC is a primary partner for the MQIS program and Smokers' Helpline and will distribute the new promotional materials highlighting the free nicotine patch incentive offer, the new Helpline web-based referral system, and recommended outreach ideas for health care providers.

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

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

At the January 2014 Association of Maternal and Child Health Programs (AMCHP) Conference, HRSA announced that the CoIIN to reduce infant mortality and improve birth outcomes will be implemented in all regions by the end of 201.

At the legislative level, MCAH will collaborate with CTCP to monitor their new local laws and ordinances database. MCAH will explore opportunities to examine smoking trends in relationship to changes in local legislation.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	4.6	4.6	4.1	4.1	4.1
Annual Indicator	4.7	4.9	5.8	4.6	4.6
Numerator	144	150	163	129	
Denominator	3055826	3054421	2819402	2792808	
Data Source	CA Deah Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	4.1	4.1	4.1	4.1	4.1

Notes - 2013
A manual indicator is reported for 2013 based on 2012.

Notes - 2012
2012 California Death Statistical Master File (ICD-10 Death Codes X78,X72-X74,X70,X80,X60-X69,X71,X75-X77,X79,X81-X84,U030,U039). Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.. Tabulations (by place of residence) were done by the MCAH Program.

Data reported for 2011-2012 should not be compared to data reported in previous years due to updates in the population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 5.3.

Notes - 2011
2011 California Death Statistical Master File (ICD-10 Death Codes X78,X72-X74,X70,X80,X60-X69,X71,X75-X77,X79,X81-X84,U030,U039). Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.. Tabulations (by place of residence) were done by the MCAH Program.

Data reported for 2011 should not be compared to data reported in 2010 due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 5.3.

a. Last Year's Accomplishments
The Department of Health Care Services Suicide Prevention Program (SPP) continues to serve as a statewide resource on suicide prevention to further the CA Strategic Plan on Suicide Prevention. In addition, Mental Health Services Act (MHSA) funding is dedicated to statewide suicide prevention programs which are currently being implemented by CalMHSA.

MCAH continues to work with programs in the local jurisdictions, including the CPSP, AFLP, and BIH programs, to identify and refer youth at risk for suicide to appropriate assessment and treatment. MCAH collaborates to maintain and improve appropriate linkages between other State departments to address systemic barriers and create pathways to service delivery. MCAH promotes provider screening, education, and referral to treatment and services for adolescence at risk of substance abuse, domestic violence, depression, and stress and encourage LHJs to incorporate mental health and behavioral issues into LHJ activities as they work toward improving the health and well-being of adolescents.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University is a resource center on child and adolescent injury prevention, including youth suicide.				X
2. AFLP case managers refer adolescent clients with suicide risk		X		

and other mental health problems to needed mental health services.				
3. AFLP case management strategies include both youth development and risk reduction activities and services.		X		
4. MCAH works with the Adolescent Health Collaborative and other key partners to promote best practices in mental health and suicide prevention.				X
5. Local MCAH Programs work with local collaboratives to address Adolescent Health issues including youth development, drug abuse prevention and intervention, and mental health issues including suicide prevention.				X
6. Local MCAH Programs screen clients for signs of depression.			X	
7. CalMHSA implements statewide suicide prevention programs across the life span including youth.	X	X	X	X
8. The Department of Health Care Services Suicide Prevention Program (SPP) continues to serve as a statewide resource on suicide prevention.				X
9. The Department of Health Care Services administers grants to local programs under the Mental Health Services Act (MHSA). Local programs provide direct services.	X	X	X	X

b. Current Activities

The CIPPP contract was cancelled in 2013/14 due to reductions in Title V funding. MCAH will continue to work with CAHC and others to promote best practices in adolescent mental health and to investigate best practices in suicide prevention, domestic violence, depression, and stress. MCAH will continue to work with programs in the local jurisdictions, including the CPSP, AFLP, and BIH programs, to identify and refer adolescents at risk for suicide to appropriate assessment and treatment. MCAH will work to maintain and improve appropriate linkages between other State departments to address systemic barriers and create pathways to service delivery.

c. Plan for the Coming Year

Due to the reduction of Title V funds there are no planned activities by MCAH. MCAH will promote partnership with other State organizations that are leading suicide prevention efforts in order to promote best practices in local MCAH programs.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	67.8	68.1	78.6	78.6	78.6
Annual Indicator	75.9	75.6	77.7	77.5	77.5
Numerator	4618	4379	4437	4350	
Denominator	6083	5790	5714	5615	
Data Source	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	78.6	78.6	78.6	78.6	78.6

Notes - 2013
A manual indicator is reported for 2013 based on 2012.

Notes - 2012
Source: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File and California Children Services (CCS), Approved Hospitals for NICUs as of December 2012.

Tabulations by place of occurrence were done by the MCAH. Data exclude births with unknown birth weight or births weighing <227g or >8165g. MCAH included births at three birthing hospitals that share a hospital campus or building with a CCS-approved Children's Hospital that has an appropriate level NICU (i.e., the birthing hospital and children's hospital are administratively different hospitals, but are co-located in the same building or campus). Data for 2008-2012 should be not compared to data reported in previous years due to a change in exclusion criteria and methodology.

Notes - 2011
Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File and California Children Services (CCS), Approved Hospitals for NICUs as of December 2011.

Tabulations by place of occurrence were done by the MCAH. Data exclude births with unknown birth weight or births weighing <227g or >8165g. MCAH included births at three birthing hospitals that share a hospital campus or building with a CCS-approved Children's Hospital that has an appropriate level NICU (i.e., the birthing hospital and children's hospital are administratively different hospitals, but are co-located in the same building or campus). Data for 2008-2011 should be not compared to data reported in previous years due to a change in exclusion criteria and methodology.

a. Last Year's Accomplishments
NPM 17, the percent of Very Low Birth Weight < 1500 grams (VLBW) infants delivered at facilities for high-risk deliveries and neonates, was 77.5 percent in 2012. This was a slight decrease from the 77.7% in 2011, and short of the Healthy People 2020 objective of 83.7%. There is some variation by race/ethnicity in the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates. In 2012, Pacific Islanders had the lowest percentages of these VLBW deliveries at NICU facilities at 61.5 %. African Americans had the highest percent (81.0), followed by Asians (79.8), Hispanic (78.3), and Whites (71.9).

The California figures are based on data from hospitals designated by the CCS program as Regional, Community or Intermediate NICUs. For 2013, there were 132 CCS-approved NICUs in

California; however, not all facilities providing care for VLBW infants seek certification by CCS. RPPCs provide planning and coordination to ensure that all high-risk patients are matched with the appropriate level of care. As of FY 2012-2013 RPPC regions were consolidated to 9 regions plus regions for Northern and Southern Kaiser. The RPPCs develop communication networks on many perinatal topics, disseminate education materials including toolkits, assist hospitals with data collection for quality improvement, and provide hospital linkages to CPeTS.

MCAH monitors perinatal outcomes through IPODR (http://www.cdph.ca.gov/data/indicators/Pages/InfantPerinatalOutcomesDataReport.aspx) .The IPODR website includes an annual county profile report based on California Birth/Death Vital Statistics and Hospital Discharge Data aggregated at the zip code level.
Efforts continue to improve data collected from birth certificates. Since 2004, OVR has collaborated with MCAH working with RPPC leaders to plan and present a statewide series of birth data quality trainings. The interactive presentations include discussions of difficulties in data collection, and explanations of medical terminology including illnesses, complications and procedures of labor and delivery. Fact sheets from the Birth Defects Monitoring Program have been included in the training packets. Awards for excellence and improvement in data collection have been presented to hospitals.

SCD collaborates with CPQCC to monitor outcomes of infants/children, 0-3 years of age in the HRIF Program. This monitoring capability, coupled with perinatal/neonatal CPQCC data elements, allows the assessment of infant outcomes in association with perinatal/neonatal care.

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

RPPC, with OVR, provided eight trainings beginning in March 2012, emphasizing the importance of hospital administration, nurses, and birth clerks working collaboratively to accurately report birth data. MCAH is working with OVR to capture more complete information on complications/procedures of pregnancy and complications/procedures of labor and delivery on the birth certificate.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. RPPCs provide regional planning and coordination and ensure that the needs of high-risk patients are matched with the appropriate level of care.				X
2. The CA Perinatal Transport System (CPeTS) assists in the referral of high-risk pregnant women and newborn infants by providing bed availability status for regional CCS-approved NICUs, updated daily, on the CPeTS website.		X		
3. RPPC and CPeTS assist hospitals with data collection and quality improvement activities.				X
4. MCAH shares information with the Emergency Preparedness Office (EPO) regarding Perinatal Disaster Preparedness.				X
5. CPQCC reports on the neonatal care of its NICU members, providing to CCS a useful and uniform reporting scheme for comparative assessment of hospitals on neonatal levels of care.				X
6. The Improved Perinatal Outcome Data Reports (IPODR), which include county profiles, provide information for health				X

planning, evaluation, and allocation decisions.				
7. MCAH and OVR collaborate to improve birth data quality by developing and convening a series of trainings with the assistance of RPPC regional leaders to improve the data quality of the California birth certificate.				X

b. Current Activities
RPPC and CPeTS continue matching high-risk patients with the appropriate level of care. RPPCs review birth outcomes data, and transport agreements with hospitals during site visits. All CCS approved NICUs are required to submit data annually, and CPQCC continues to analyze NICU data.

CPeTS maintains a web-based bed availability list where maternity hospitals can obtain information 24 hours a day, 7 days a week for assistance in the transfer coordination of high-risk infant or maternity patients. CPeTS also provides the collection and analysis of perinatal and neonatal transport data for regional planning, outreach program development, and outcome analysis. This information is utilized by RPPC and is reported back to the participating hospitals and to MCAH.

c. Plan for the Coming Year
RPPC and CPeTS continue their work in regional planning and coordination, matching the transport of high-risk patients with the appropriate level of care and assisting hospitals with data collection and quality improvement surrounding patient transfer.

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

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	87.1	87.3	86.8	86.8	86.8
Annual Indicator	82.9	83.5	83.5	83.8	83.8
Numerator	428449	416759	410213	412679	
Denominator	516879	499218	491034	492643	
Data Source	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	86.8	86.8	86.8	86.8	86.8

Notes - 2013
A manual indicator is reported for 2013 based on 2012.

Notes - 2012
Source: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program.

Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

Notes - 2011
Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program.

Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

a. Last Year's Accomplishments
The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester was 83.8% in 2012. Asians and Whites met the statewide annual objective for 2012 at 87.5%. Asians and Whites were more likely to receive prenatal care in the first trimester than women who were Hispanic (81.3%), African American (78.7%), Pacific Islander (69.6%)or American Indian (68.9%).

Local MCAH programs identified and monitored trends in access to care, including disparities, conducted targeted outreach, and worked in their local communities to address barriers to early prenatal care. All jurisdictions have a toll-free line that women can call to obtain referrals for pregnancy testing and prenatal care. Most also have websites that provide information on access to prenatal care. In 2012-13, there were 66,482 calls to toll-free lines and there were 369,570 hits to MCAH websites. Local MCAH programs also refer women to low-cost insurance. In 2012-13, MCAH programs made 427,615 referrals to Medicaid and low cost insurance. If women have insurance, they are more likely to obtain early prenatal care. California also has a Presumptive Eligibility program, whereby income- eligible pregnant women are presumed eligible for Medicaid and can immediately start prenatal care. AFLP, BIH, WIC, AIIHI continued to provide case management services and linkages to medical care for their target populations. CPSP provides nutrition, psychosocial and health education services in addition to obstetrical care, and CPSP providers receive incentive payments for women who access care within the first 16 weeks of pregnancy.

PHCC's EveryWomanCalifornia website provides information to consumers about the importance of being healthy before pregnancy, planning for pregnancy and obtaining early prenatal care. Local Perinatal Services Coordinators worked with CPSP providers to implement the PHCC Interconception Care Project Guidelines , which encourage providers to give information and counseling to postpartum clients about healthy behaviors before pregnancy, including planning for optimal pregnancy spacing, obtaining early prenatal care, addressing chronic medical conditions, and avoiding drug, alcohol and tobacco use.

About 40% of all births in California are unintended. [35] The Family PACT Program provides no-cost family planning services to all California residents with incomes at or below 200% FPL. Such services contribute indirectly to timely prenatal care, since women with planned pregnancies seek care earlier.

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

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

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CPSP provides Medi-Cal eligible women with prenatal care, health education, nutrition and psychosocial support services.	X	X	X	X
2. BIH identifies pregnant and parenting African American women who are at risk for poor birth outcomes and provides them assistance in accessing and maintaining health care and other support services.		X	X	X
3. AFLP provides case management services to pregnant adolescents at risk for poor birth outcomes. AFLP is increasing capacity of current services by promoting Positive Youth Development (PYD) through reproductive life planning.		X	X	
4. AIIHI serves prenatal and parenting AI women with direct health care services and case management services.	X	X		
5. MCAH works to provide ethnically diverse staff for recruiting clients into care, and LHJs employ a variety of methods to target diverse populations.		X	X	X
6. The Family PACT Program provides no-cost family planning services to low-income residents; these services help to reduce the rate of unintended pregnancy, and contribute indirectly to increased utilization of prenatal care	X			X
7. The PHCC plays a pivotal role in relaying the message of the importance of intended pregnancy, pregnancy spacing and preconception care to local communities.			X	X
8. The AIM program provides low-cost health coverage to pregnant women without adequate health insurance and whose income is too high for no-cost Medi-Cal.		X		
9. LHJs provide free pregnancy testing, referral to OB providers for pregnant women, and education on preconception health, family planning and the importance of early prenatal care to	X	X		

women of childbearing age.				
10. LHJs conduct social marketing to educate women about the importance of early prenatal care.		X	X	

b. Current Activities

LHJs continue to monitor access to early prenatal care. CPSP continues to emphasize the importance of interconception planning and early prenatal care. Local MCAH continues its efforts to conduct outreach, provide toll-free information lines, web resources, and refer eligible women for health insurance and early prenatal care. Family PACT continues to make available no-cost family planning services to all California residents with incomes at or below 200% of the FPL. The AIM program continues to make available low-cost health coverage to pregnant women with inadequate coverage and whose incomes are too high for Medi-Cal.

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

BIH, which targets at-risk African American pregnant and parenting women, is implementing the new group intervention model. Both AFLP and BIH continue to encourage and assist clients to receive early prenatal care.

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

c. Plan for the Coming Year

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

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

Local CPSP coordinators will continue provider recruitment and work with providers to improve interconception education during the postpartum period. MCAH and LHJs undertake these activities to ensure the availability and effectiveness of CPSP services, even in this era of budget constraints, and to achieve improvements in first trimester entry into prenatal care. MCAH will work to improve data on beneficiaries, paid claims, birth outcomes, and hospital discharge to develop baseline data on the efficacy of CPSP services. MCAH will continue to work closely with MCMC to improve the timeliness and quality of OB services to Medi-Cal-eligible pregnant women.

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

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

D. 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*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			0	30	40
Annual Indicator		0.0	0.0	0.0	0
Numerator		0	0	0	
Denominator		1	1	1	
Data Source		Pilot Programs Data, CMSNet	Pilot Programs Data, CMSNet	Pilot Programs	Pilot Programs
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	40	40	40	40	40

Notes - 2013
TBD

Notes - 2012
This measure is the percent of children birth to 21 years enrolled in the CCS program who have all their health care provided by and coordinated by one health care system. This is a new measure from the 2010 Needs Assessment. The 1115 Federal Waiver CCS Pilot Programs will begin January 2012 so there will be no data for this measure until 2013 for calendar year 2012.

a. Last Year's Accomplishments
After all implementation requirements were met, the first 1115 Waiver Model, Medi-Cal Managed Care, began April 1, 2013 in San Mateo County. Initial steps to evaluate the program have begun.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Convened Stakeholder Group to help determine components				X
2. Draft RFP to request Pilot Program Proposals				X
3. Select Pilot Programs				X
4. Implement Pilot Programs	X			
5. Monitor and Evaluate Pilot Programs	X			

b. Current Activities
The 1115 Demonstration Waiver Project pilot contract with Health Plan of San Mateo identifies a Medical Home for members as the foundation of an integrated and coordinated health care delivery system. Monitoring is ongoing with the first CCS 1115 Waiver M

c. Plan for the Coming Year
The 1115 Evaluation Oversight Committee will include a "dashboard" for rapid determination of any areas which require more attention, and extensive family/providers satisfaction to access, integration of care, and identify barriers to reform. A family survey is being developed for all counties, including pilot counties.

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.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			0	50	50
Annual Indicator		0.0	0.0	0.0	0
Numerator		0	0	0	
Denominator		1	1	1	
Data Source		On-line Survey and CCS County programs	On-line Survey and CCS County programs	On-line Survey	On-line Survey
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	55	55	55	55	55

Notes - 2013
TBD

Notes - 2012
Survey is currently being developed for children and families in the 1115 waiver by the UCLA Center for Health Policy Research. The CCS Pilot Evaluation Planning Committee, consisting of State and County CCS staff and family representatives, and the CCS Pilot Projects Stakeholder group, provide input into the survey. It is expected that survey will be expanded to representative sample of families with CCS eligible children who do not reside in county participating in 1115 waiver.

a. Last Year's Accomplishments
Family surveys have been implemented in the MTP program, as part of the alternative therapy model.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Expand potential base of surveys (from 1115 Waiver's CCS Pilot Projects) including with evaluations to assess satisfaction of families enrolled and not enrolled				X
2. Work with 1115 Waiver CCS Stakeholder Group to develop family survey				X

3. Utilize translation services to translate surveys into most frequently used languages for the region.				X
4. Work with Regional Office Staff and local programs to administer the surveys				X

b. Current Activities
A statewide family satisfaction survey is being developed based on survey done by counties, and with Title V stakeholder input.

c. Plan for the Coming Year
CCS Family survey currently in planning stages. Plan is to accept surveys online, and via phone administered by local CCS staff.

State Performance Measure 4: *The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			12.7	12.7	12.7
Annual Indicator	13.4	15.0	13.1	13.9	13.9
Numerator	68828	74243	64188	68000	
Denominator	513143	495981	488606	488545	
Data Source	MIHA	MIHA	MIHA	MIHA	MIHA
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	12.7	12.7	12.7	12.7	12.7

Notes - 2013
A manual indicator is reported for 2013 based on 2012.

Notes - 2012
Source: 2012 MIHA survey, MCAH Program, California Department of Public Health. Numerator: The number of women who reported that they had four or more drinks in one sitting at least once during the three months before they got pregnant with their most recent live-born infant. Denominator: The number of women who reported whether or not they had four or more drinks in one sitting at least once during the three months before they got pregnant with their most recent live-born infant plus the number of such women who reported drinking no alcoholic drinks in the past two years.

Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth in 2012.

Notes - 2011
Source: 2011 MIHA survey, MCAH Program, California Department of Public Health. Numerator: The number of women who reported that they had four or more drinks in one sitting at least once during the three months before they got pregnant with their most recent live-born infant.

Denominator: The number of women who reported whether or not they had four or more drinks in one sitting at least once during the three months before they got pregnant with their most recent live-born infant plus the number of such women who reported drinking no alcoholic drinks in the past two years.

Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth in 2011. In 2011, a new methodology (raking or iterative proportional fitting) was implemented to calculate MIHA survey weights. However, data from prior years are still comparable to 2011.

a. Last Year's Accomplishments

SPM 04 is the percent of women with a recent live birth that reported binge drinking during the three months prior to pregnancy. In 2012, 13.9 percent of mothers with a recent live birth reported binge drinking during the three months prior to pregnancy, an increase from 13.1 percent in 2010 . This rate differed by racial and ethnic group. White women (19.8%) were most likely to binge drink during the three months prior to pregnancy, followed by Hispanic (12.8%), Black (9.8%) and Asian/Pacific Islander women (8.5%). An estimated 4,460 to 6,050 babies with Fetal Alcohol Spectrum Disorder (FASD) are born each year in California.

FASD describes the range of effects in individuals whose mothers used alcohol during pregnancy, including physical, cognitive, behavioral and learning difficulties with lifelong implications.

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

PHCC continued to monitor its website, designed for mixed use by consumers and health professionals. The website connects people working in preconception health and features links to tools and resources related to alcohol use prevention for men, women and teenagers.

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

The CA Preconception Peer Educators (PPE) Program is a local implementation of the Federal Office of Minority Health Program. PPE teaches college students about preconception health risks and trains them to become campus and community ambassadors. Given the popularity of binge drinking among teenagers and college students, a key focus of PPE is alcohol. The PPE curriculum links high-risk drinking to risks relevant to women who are not actively planning a pregnancy including sexual assault, domestic violence, trauma, homicide, criminal prosecution, unintended pregnancy, risk taking behavior as well as traditional focus on FASD. The PPE program collaborated with the CDC Preconception Health Show Your Love campaign, which has separate targeted alcohol-related messages about abstinence for those planning a pregnancy and avoiding binge drinking and using contraception for those not planning a pregnancy.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Community-based prevention and support programs, including AFLP, BIH, CPSP and CDAPP, educate clients about the dangers of alcohol use during pregnancy and refer high-risk women for alcohol treatment services.		X		
2. MCAH participates in the statewide FASD Task Force and the SIT ADP Workgroup.				X
3. LHJs conduct prenatal substance use screening programs, with several using the 4-Ps Plus model.		X		
4. Santa Cruz County Public Health nurses provide home-based support, education, and professional assistance for families with premature and/or substance exposed babies, or mothers with mental health issues.		X		
5. PHCC continues to augment and monitor its website which connects people working in preconception health and features links to tools and resources related to alcohol use prevention among women of reproductive age.				X
6. Alameda County continues to implement the Pediatric System of Care Strategic Plan to improve care of substance-exposed children at risk for social/emotional, developmental, behavioral, psychological and physical problems				X

b. Current Activities
MCAH works to improve birth outcomes for women at risk for alcohol abuse through screening and referral for treatment services. Community-based prevention programs such as AFLP, BIH and CPSP identify at-risk mothers and refer them for treatment services.

LHJs continue to develop and strengthen coalitions with public/private agencies and providers to assess women at risk and develop appropriate referrals to resources including the statewide FASD Taskforce. Many are working to develop coordinated and integrated systems of care to address issues of perinatal substance use.

c. Plan for the Coming Year
LHJs will continue to work on developing and strengthening coalitions with public/private agencies and healthcare providers to determine how best to identify women at risk and how to develop appropriate referral sources. LHJs will continue to develop and implement coordinated and integrated systems of care to address perinatal substance use prevention. MCAH will continue to participate in the FASD Task Force and will continue its efforts on preconception health education and promotion, including augmenting and monitoring its preconception health website. The Federal Office of Minority Health established an Advisory Board to Preconception Peer Educators at California Community Colleges and Universities will partner with LHJs and local organizations to plan campus and community outreach campaigns and events to promote harm reduction strategies to reduce preconception alcohol exposure and prenatal alcohol exposure. These outreach strategies will include social media.

MCAH will continue ongoing quality improvement and education efforts to learn about emerging best practices for reducing binge drinking. Because California has unique alcohol consumption patterns arising from the popularity and cultural significance of locally produced wine, MCAH will continue to explore ways to find culturally appropriate strategies to reduce heavy consumption patterns and prevent illegal consumption by minors. Among the strategies will be to engage the

newly acquired TPPs, I&E and CA PREP, and strengthen their ability to include substance abuse prevention as a teen pregnancy prevention strategy.

State Performance Measure 5: *The percent of cesarean births among low-risk women giving birth for the first time.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			25.1	25.1	25.1
Annual Indicator	26.6	26.1	26.3	26.7	26.7
Numerator	42603	40713	40777	42429	
Denominator	160307	156112	155169	159030	
Data Source	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	25.1	25.1	25.1	25.1	25.1

Notes - 2013
A manual indicator is reported for 2013 based on 2012.

Notes - 2012
Source: State of California, Department of Public Health, 2012 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Numerator: The number of births delivered by cesarean section to low-risk women giving birth for the first time. Denominator: The number of live births to low-risk women giving birth for the first time. The numerator and denominator represent live births that occurred in California in 2012. Starting in 2010, births with gestational age greater than 37 weeks were excluded from the analysis. This new exclusion did not affect rates from prior years (2007-2009).Low-risk is defined as full-term (i.e., greater than or equal to 37 weeks gestation), singleton pregnancy, with vertex fetal presentation (head down in the uterus).

Notes - 2011
Source: 2011 Birth Statistical Master File, MCAH Program, California Department of Public Health. Numerator: The number of births delivered by cesarean section to low-risk women giving birth for the first time. Denominator: The number of live births to low-risk women giving birth for the first time. The numerator and denominator represent live births that occurred in California in 2011. Starting in 2010, births with gestational age greater than 37 weeks were excluded from the analysis. This new exclusion did not affect rates from prior years (2007-2009).
Low-risk is defined as full-term (i.e., greater than or equal to 37 weeks gestation), singleton pregnancy, with vertex fetal presentation (head down in the uterus).

a. Last Year's Accomplishments

In 2012, C-section births among low-risk women giving birth for the first time were at 26.7%. To explore the multifaceted contributors to maternal morbidity and develop valid indicators to provide surveillance for maternal health statewide, MCAH funded the MQI with UCLA. MQI and CMQCC provided expertise and support for development of new obstetrical measures for the National Quality Forum which were then incorporated by the Joint Commission.

As a result of surveillance efforts, CMQCC developed and disseminated a toolkit to reduce non-medically indicated labor induction and cesarean section prior to 39 weeks gestational age. MCAH has also collaborated with MOD to publish and disseminate the toolkit throughout the state. The toolkit provides guidelines to hospitals and materials for patient education. The toolkit is now in use nationwide and has been credited with reductions in elective delivery in six states.. CMQCC released a toolkit to improve the healthcare response to preeclampsia--a contributor to cesarean delivery.

MCAH previously funded a Local Assistance for Maternal Health (LAMH) project in San Bernardino to reduce non-medically indicated induction of labor by educating the community about labor induction and promoting best practices among clinicians and providers. Their efforts included labor induction guidelines and recommendations for local area hospitals to follow when scheduling labor inductions; patient consent document to inform patients of options; and, an Advisory Council comprised of public and private organizations Fourteen hospitals in San Bernardino participate in the project and are regularly involved in webinars and data sharing. Recently, San Bernardino County LAMH outcome data were analyzed and reported. Because the data collection strategy was implemented in concert with departmental policies and community education, it impacted practice patterns substantially. MQI published a manuscript in the Journal of Obstetric, Gynecologic and Neonatal Nursing which compared three methods of tracking elective delivery: electronic medical record data, hospital discharge data, and data from the LAMH project. The findings were that the San Bernardino LAMH quality improvement data collection and reporting project had advantages for monitoring elective delivery as compared with the other methods. Reduced resources has resulted in discontinuing the project but the model is available for replication.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminate and assess impact of state toolkit: “Elimination of Non-Medically Indicated Induction of Labor before 39 Weeks Gestation”				X
2. Support Local Assistance for Maternal Health to implement toolkit strategies at hospitals at the local level				X
3. Support Local Assistance for Maternal Health to promote patient education regarding the value of waiting until 39 weeks to deliver				X

b. Current Activities

The CMQCC is developing a data center to provide timely information on elective deliveries and induction among high and low risk patients.

Los Angeles County is conducting a county-wide campaign to reduce cesarean deliveries. CMQCC is addressing maternity care and birth data quality issues with RRPC

MCAH accepted the Association of State and Territorial Health Organizations/March of Dimes Preterm Birth Challenge. California met the ASTHO challenge by reducing prematurity to 9.6 percent.

The PHCC and MCAH Preconception Health and Nutrition and Physical Activity Initiatives conducted activities to ensure women are entering pregnancy with fewer risks that may increase the likelihood of cesarean delivery. (See Major State Initiatives).

MQI produced an internal report on the composite morbidity indicator which will be used in the maternal health report published next year. A preliminary draft of the maternal health report--addressing contributors to morbidity--is being drafted for internal review.

c. Plan for the Coming Year

MQI and MCAH will externally publish a maternal health report to increase our understanding of maternal morbidity in California which will include an overview of cesarean delivery. MQI will also continue to develop a composite maternal and infant health indicator and begin exploring the public payer (Medi-Cal) associated costs of morbidity using data from 2007-2009.

MQI is beginning to develop a separate exploratory analysis of the relationship between rising prevalence of cesarean delivery and maternal morbidity. This will involve estimating the contribution of pre-existing (preconception), pregnancy-related, and obstetric maternal morbidity to Nulliparous, Term, Singleton, and Vortex (NTSV) cesarean deliveries and to also estimate the contribution of NTSV cesarean delivery to postpartum maternal readmission rates, postpartum morbidity, and the severity of morbidity. Efforts will also be made to explore cumulative cesarean-related morbidity risk as parity increases.

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

MCAH is preparing to participate in the HRSA-initiated Collaborative Improvement and Innovative Network (CoIIN) to support the adoption of collaborative learning and quality improvement principles and practices to reduce infant mortality and improve birth outcomes. One of the state-identified priorities is reducing elective deliveries <39 weeks.

State Performance Measure 6: *The percent of women of reproductive age who are obese.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			21.7	21.7	21.7
Annual Indicator	21.8	20.9	21.3	21.6	
Numerator	1299520	1205673	1316522	1138418	
Denominator	5954750	5764922	6181065	5258411	
Data Source	Behavioral	Behavioral	Behavioral	Behavioral	

	Risk Factor Survey	Risk Factor Survey	Risk Factor Survey	Risk Factor Survey	
Is the Data Provisional or Final?				Final	
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	21.7	21.7	21.7	21.7	21.7

Notes - 2013
A manual indicator is reported for 2013 based on 2012.

Notes - 2012
Source: 2012 California Behavioral Risk Factor Survey (BRFS), California Department of Public Health. Numerator: The number of women aged 18-44 years who have a body mass index (BMI) greater than or equal to 30 kilograms body weight / body surface area in square meters (kg/m2). Denominator: The number of women aged 18-44 years for whom BMI can be calculated. Results are weighted using 2010 population estimates from the California Department of Finance and exclude women who reported being pregnant at the time of the survey, and women with height < 48 in. or = 84 in., weight < 75 lbs. or > 399 lbs. or those for whom BMI cannot be calculated (i.e. missing height and/or weight information). Data for 2010 to 2012 should not be compared to data reported in previous years due to a change in conversion factor for weight in kilograms used to compute BMI. Obesity rates for prior years using the new conversion factor: 2008 =20.9; 2009 =19.7. Data for 2011 and 2012 should not be compared to data reported in previous years (including 2010) as these data are weighted using 2010 population estimates and previous years are weighted using 2000 population estimates.

Notes - 2011
Source: 2011 California Behavioral Risk Factor Survey (BRFS), California Department of Public Health. Numerator: The number of women aged 18-44 years who have a body mass index (BMI) greater than or equal to 30 kilograms body weight / body surface area in square meters (kg/m2). Denominator: The number of women aged 18-44 years for whom BMI can be calculated. Results are weighted using 2010 population estimates from the California Department of Finance and exclude women who reported being pregnant at the time of the survey, and women with height < 48 in. or = 84 in., weight < 75 lbs. or > 399 lbs. or those for whom BMI cannot be calculated (i.e. missing height and/or weight information). Data for 2010 and 2011 should not be compared to data reported in previous years due to a change in conversion factor for weight in kilograms used to compute BMI. Obesity rates for prior years using the new conversion factor: 2008 =20.9; 2009 =19.7. Data for 2011 should not be compared to data reported in previous years (including 2010) as 2011 data are weighted using 2010 population estimates and previous years are weighted using 2000 population estimates.

a. Last Year's Accomplishments
Between 2000 and 2010 there was a 27% increase in obesity among women of reproductive age. In 2012, the prevalence of obesity in this population was 21.6%, up slightly from 21.3% in 2011. Hispanic (29.3%) and Black (27.1%) women were more likely to be obese than White (17.2%) women.

To reduce the burden of obesity among women of reproductive age, MCAH promoted obesity reduction and healthy strategies to achieve optimal preconception weight, prenatal weight gain, and breastfeeding.

MCAH provided input for the CDC preconception health campaign, Show Your Love, which emphasizes the importance of healthy weight before pregnancy.

MCAH and the PHCC launched the CDC Show Your Love campaign on Valentine's Day; resources featured healthy weight messages for women who are planning a pregnancy in the next two years and those who are not. In partnership with the campaign, the PHCC posts about healthy weight using social media.

San Joaquin Valley trained PPEs who are now training their peers and community members. Knowledge about pre-pregnancy weight was high initially, but overall knowledge improved.

To address the need for gestational diabetes resources in Asian languages, the ICPC gestational diabetes handout was translated into Vietnamese and posted online. It contains healthy weight tips to help prevent type 2 diabetes and reduce risks in a subsequent pregnancy.

Many women of reproductive age live in environments not supportive of healthy weight, so MCAH developed an online toolkit to provide nutrition, physical activity and breastfeeding resources for local MCAH Programs to address the built environment. It includes a sample PowerPoint and webinar featuring Dr. Richard Jackson and local MCAH Directors

Adolescent cookbooks were printed in English and Spanish and distributed to adolescent programs to encourage healthy eating and physical activity.

To address pregnancy weight gain, grids for twin pregnancies were developed. MyPlate for Gestational Diabetes was created in English and Spanish; it includes a food guide and goal setting tips. To learn more, see NPM 14. MyPlate for Moms was finalized and encourages pregnant/breastfeeding women to eat healthy meals, with limited sugar, solid fats and salt.

The physical activity section of the AFLP Nutrition and Physical Activity Guidelines was revised. MCAH continued existing collaborations and began collaborating with the Coordinated Chronic Disease Program.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCAH develops and/or provides nutrition education materials and initiatives, nutrition assessment materials, technical assistance and consultation, and funding opportunities to MCAH				X
2. BIH, AFLP, CDAPP and CPSP promote optimal weight gain in pregnancy, breastfeeding, and glycemic control as an effort to reduce the risk of obesity		X		
3. MCAH partners with other state programs and agencies to dialogue with advocates, experts and local MCAH directors to prevent obesity				X
4. BIH, AFLP, CDAPP and CPSP promote physical activity and proper nutrition by encouraging healthy eating through discussions on how to cut fat, lower calories and move more.		X		
5. MCAH offered MCAH LHJs a “Here is Where Healthy Starts” award for policies/programs in place to support good nutrition, physical activity, safety and breastfeeding.				X
6. MCAH and SCD collaborate with the California Obesity Prevention Program (COPP) the California Nutrition Network for Healthy, Active Families to promote healthy eating and a physically active lifestyle among low income Californians.				X

b. Current Activities
MCAH is updating CDAPP, CPSP, BIH, and AFLP nutrition and physical activity guidelines. MCAH programs continue to prioritize optimal nutrition and physical activity as important interventions to reduce obesity in women of childbearing age.

MCAH continues to focus on a life course perspective for addressing obesity since childhood, preconception, pregnancy, interconception, and infant feeding impact adult obesity.

MCAH collaborates with WIC to promote healthy weight among women of reproductive age by promoting appropriate gestational weight gain, breastfeeding, and postpartum weight loss.

MCAH featured the Systems and Environmental Change Toolkit to support optimal nutrition, physical activity, and breastfeeding through fostering partnerships between local health jurisdiction's MCAH Programs at the Advancing Prevention in the 21st Century: Commitment to Action 2014 Conference to release the CA Wellness Plan.

MCAH participates in a Physical Activity (PA) Collaborative Impact Planning Group. In the sessions CDPH physical activity staff are 1) sharing about current/future CDPH PA projects, programs, and interventions, 2) identifying where there are opportunities to integrate our PA-related activities at state and local levels, 3) developing PA priority areas and strategies for implementation , and 4) identifying gaps and opportunities for additional partnerships.

c. Plan for the Coming Year
MCAH will continue to collaborate with state programs and agencies, experts and local MCAH directors to reduce overweight and obesity among women of childbearing age.

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

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

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

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

MCAH will help to maximize use by women of Affordable Care Act provisions for well-woman care and obesity screening/counseling for all adults by partnering with Covered California and

Medi-Cal. MCAH will publicize resources that support healthy weight to healthcare providers and public health professionals and encourage their use during well-woman and prenatal care. Among these resources will be the Interconception Module which will provide continuing medical education credits on the Before, Between and Beyond website.

MCAH will explore new media strategies to popularize preconception health to a younger and more technologically-advanced audience. MCAH plans to explore the development of mobile applications or adaptation/use of the GABBY™ interactive system that provides personalized electronic preconception health education and follow-up. Pilot testing for the GABBY™ system is scheduled to conclude in early 2014.

State Performance Measure 7: *The percent of women whose live birth occurred less than 24 months after a prior birth*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			11.7	11.7	11.7
Annual Indicator	12.9	12.3	12.3	12.0	12
Numerator	66674	61798	56424	59326	
Denominator	518167	501837	459010	495781	
Data Source	CA Birth Statiscial Master File	CA Birth Statiscial Master File	CA Birth Statiscial Master File	CA Birth Statiscial Master File	A Birth Statiscial Master File
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	11.7	11.7	11.7	11.7	11.7

Notes - 2013
A manual indicator is reported for 2013 based on 2012.

Notes - 2012
Source: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Women with birth intervals less than five months were excluded from the analysis.

Notes - 2011
Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Women with birth intervals less than five months were excluded from the analysis

a. Last Year's Accomplishments
Between 2009 and 2010, SPM 7 decreased by 5% from 12.9% to 12.3%, and remained unchanged in 2011. By 2012, SPM 7 was 12.0% representing a 2% decrease overall from 2011.

Of the four race/ethnic groups with the largest birthing population in 2012. African American women were most likely to have a live birth less than 24 months after a prior birth (13.8%), followed by Hispanics and Whites each at12.2% and Asians (9.8%).

Preconception and interconception care is a priority for the MCAH Program. The Preconception Health Initiative (PHI) aims to improve the health of women prior to pregnancy to improve birth outcomes and reduce disparities in maternal and infant morbidity and mortality. A critical part of PHI is to ensure at least 18 months (or restoration of health and functioning) between pregnancies--especially among women with previous poor birth outcomes--to encourage healthy child development and to reduce health risks for mothers and subsequent infants. To reduce unintended pregnancy and improve birth spacing, MCAH and the Office of Family Planning (OFP) supported programs that help women and teens understand the importance of pregnancy timing, decrease risky health behaviors and increase access to and appropriate use of contraceptives.

PHCC disseminated messages about the importance of reproductive life planning (RLP), planned pregnancies, birth spacing and preconception care through stakeholders to local communities statewide. The website, www.everywomancalifornia.org, has resources for consumers and providers. In June 2012, the website was redesigned to integrate RLP into site navigation. Spanish-language webpages were developed to be more visually-appealing.

The PHCC preconception care guidelines are promoted to provide clinical guidance on the well-woman visit covered as preventive care (no cost-sharing) under ACA.

PHCC disseminates and conducts trainings on the Interconception Care Project of California for health care and public health professionals.

MCAH provides trainings on preconception and interconception health, including to the National WIC Association, and shares the clinical and public health tools available.

MCAH works with LHJs to promote reproductive life planning and adequate birth spacing through the PPE program. Post-secondary students trained in preconception health are able to support community outreach initiatives to address preconception and interconception health.

Family PACT, I&E, PREP and AFLP continue teen pregnancy prevention efforts. AFLP began the Positive Youth Development intervention centered on RLP to empower clients, encourage goal setting and reduce repeat teen births. The new BIH model that includes goal setting and RLP was implemented at all sites.

The CDAPP Sweet Success Resource Center website went live and guidance on preconception health and optimal birth spacing for women with diabetes is posted.

MCAH promotes the CDC preconception health campaign, Show Your Love, which includes focus on RLP. It includes videos and checklists with messaging tailored to one's plans to have a baby.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCAH Program and OFP support several programs that help women avoid unintended pregnancy by decreasing risky behavior and increasing access to and promoting the use of effective contraceptive methods.				X
2. ASHWG works to promote and protect the sexual and reproductive health of California youth, which includes a focus on				X

pregnancy prevention.				
3. The PHHI supports organizations to increase birthing intervals, prevent unintended pregnancy and improve preconception health by providing best practices and networking opportunities.				X
4. The PHCC plays a pivotal role in relaying the message of the importance of reproductive life planning, pregnancy intention, birth spacing and preconception care to local communities.			X	
5. The Family PACT Program provides family planning services, testing and treatment of sexually transmitted diseases, and education and counseling to low-income Californians.	X			
6. AFLP utilizes a case management and mentoring model to assess and address the risks and resources of adolescent clients and their children, including prevention of subsequent pregnancies.		X		
7. BIH incorporates discussion of contraception and pregnancy spacing into its case management, group sessions and health promotion activities.		X		
8. CPSP and CDAPP incorporate family planning and birth spacing in guidelines and educational materials.		X		

b. Current Activities

MCAH focuses on four priority areas: folic acid use, linkage to medical home, family planning and healthy relationships and developed the social media toolkit for young adults to help Preconception Peer Educators, local partners, and other health agencies target year-long messages to young men and women in the four areas.

MCAH is developing the Interconception Care Module, which will emphasize contraceptive counseling and appropriate birth spacing, especially for women with previous preterm/low birth weight infants and those with pregnancy or obstetrical complications.

PHCC collaborated with MOD to propose revised language to First Response(r) for inclusion in the home pregnancy test kit. The proposed information emphasizes available birth control options, links to bedsider.org and the CDC Show Your Love Healthier-Me resources to help with reproductive life planning and birth spacing.

MCAH implemented the Show Your Love campaign in CA. Pill boxes for birth control and folic acid with the Show Your Love logo were procured through local funding. Condom cases with the words "Love the Glove" were provided to encourage condom use among adolescents and young adults.

The MCAH LHJ scope of work has a sample objective to collaborate with RPPC and local hospitals on discharge counseling for women with pregnancy complications providing an opportunity to reinforce birth spacing messages for high risk women with postpartum readmissions.

c. Plan for the Coming Year

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

Adolescent programs will continue to revisit life planning tools and explore the best strategies for

reducing teen pregnancy and repeat births to teens.

Programs that target pregnant women will provide up-to-date messaging about birth spacing and overall preconception/interconception health.

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

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

MCAH will continue to educate at-risk groups about contraception and birth spacing and will explore the best strategies to effectively engage younger and electronically-inclined populations, empowering them to make healthy reproductive decisions. The social media toolkit will be pilot tested and revised for full-scale implementation.

The PHCC plans to develop clinical scripts and protocols for negative pregnancy test and to pilot test an in-store promotion in Sonoma County. The PHCC also plans to reach out to Pharmacist Associations. Because many women taking pregnancy tests receive a negative result, this is an important opportunity to provide contraception messages to reduce unintended pregnancy among women who do not want to be pregnant and are at risk; specifically for those who gave birth in the previous 24 months.

MCAH will continue to share national resources, including the preconception campaign materials developed by the CDC and PPE materials provided by the federal Office of Minority Health.

The ACA offers opportunities to help prevent unintended or mistimed pregnancies by improving health care coverage for women through Covered California and private health plans. MCAH will help raise awareness about ACA preventive care provisions that require new health plans to provide FDA-approved contraception without cost-sharing.

MCAH will continue to publicize the preconception and ICPC guidelines as clinical tools available to providers who connect with women of reproductive age, either in their well-women visit or postpartum visit (for women who just had a baby). These clinical visits are critical opportunities to help women prevent or delay pregnancy until they are ready. To ensure providers have adequate education regarding interconception health and birth spacing, an online module with continuing medical education credits is being developed for self-paced instruction to coincide with the ICPC.

State Performance Measure 8: *The percent of public school students in 9th grade reporting a high level of school connectedness.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			43	43	43
Annual Indicator	42.0	43.2	44.3	44.8	
Numerator	102319	105767	107535	216732	
Denominator	243896	244863	242857	483466	
Data Source	CA Healthy Kids Survey	CA Healthy Kids Survey	CA Healthy Kids Survey	CA Student	CA Student Survey

				Survey	
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	43	43	43	43	43

Notes - 2013
A manual indicator is reported for 2013 based on 2012.

Notes - 2012
Source: California Student Survey (CSS), 2011-2013. Unpublished data provided by WestEd on June 19, 2014. CSS data are collected by WestEd on behalf of the California Department of Education using a two year data collection cycle to provide representative data for students enrolled in California public schools. Data from the California Healthy Kids Survey (CHKS) are no longer available; no statewide School Connectedness data are available for the 2010-2012 period. Due to differences in sampling, data from CSS are not comparable to data reported for prior years from CHKS.

Notes - 2011
Source: California Healthy Kids Survey (CHKS), 2009-11. Unpublished data provided by WestEd on May 16, 2013. CHKS data are collected by WestEd on behalf of the California Department of Education using a two year data collection cycle to provide representative data for students enrolled in California public schools.

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

AFLP continues to support clients to graduate from high school through its strength-based positive youth development intervention. CAHC provides guidance and training in the use of a positive youth development framework that supports linking clients to education. ASHWG has developed indicators for positive youth development; by achieving these indicators, it is believed that providers will assist students in meeting education goals.

In June 2013 MCAH received a the U.S. Department of Health and Human Services, Office of Adolescent Health (OAH) grant to continue and enhance the existing activities begun under a previous OAH grant. This funding would continue the AFLP PYD case management with integrated life planning intervention for an additional 4 years in order to implement a standardized evidence-informed program strategy.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCAH and its partners develop adolescent positive youth development principles that support adolescent school retention.				X

2. MCAH develops program and policy recommendations that support school completion.				X
3. MCAH partners with other state programs and agencies to dialogue with advocates, experts and local MCAH directors to support positive youth development in schools.				X
4. MCAH promotes interventions supported by a positive youth development framework.				X

b. Current Activities
MCAH is continuing to implement AFLP and apply the best practices learned from the AFLP PYD efforts into the overall statewide AFLP program. Through a second OAH grant opportunity, MCAH is developing an outcome evaluation for the next 3 years in order to develop an evidence-informed intervention for AFLP in order to improve adolescent school and health outcomes. MCAH will also continue its work with CAHC to support local MCAH programs as they implement adolescent health measures.

c. Plan for the Coming Year
MCAH will continue to implement AFLP and apply the best practices learned from the AFLP PYD efforts into the overall statewide AFLP program. MCAH will use the results of the AFLP PYD process evaluation to develop an outcome evaluation plan that will lead to an evidence-informed intervention for AFLP in order to improve adolescent school and health outcomes. MCAH will also continue its work with CAHC to support local MCAH programs as they implement adolescent health measures.

State Performance Measure 9: *Low-income infant mortality rate.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			.	5.4	5.4
Annual Indicator	5.5	5.4	5.4	5.4	5.4
Numerator	1358	1338	1284		
Denominator	248705	246234	238562		
Data Source	Birth-Death Cohort file	Birth-Death Cohort file	Birth-Death Cohort file	Birth-Death Cohort file	Birth-Death Cohort file
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	5.4	5.4	5.4	5.4	5.4

Notes - 2013

A manual indicator is reported for 2013 based on 2011.

Notes - 2012
A manual indicator is reported for 2012 based on 2011.

Notes - 2011
Source: State of California, Department of Public Health, Center for Health Statistics, 2011 Linked Birth – Death Cohort File

Numerator: Infant deaths where the source of payment for prenatal care or delivery is indicated as Medi-Cal.

Denominator: Live births to California state residents where the source of payment for prenatal care or delivery is indicated as Medi-Cal.

a. Last Year's Accomplishments
The low income infant mortality rate reflects deaths among infants born to women for whom Medi-Cal was the principal source of payment for prenatal care or delivery. In 2011, the low-income infant mortality rate was 5.4 per 1,000 live births.

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

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

Various MCAH programs and initiatives, including CPSP, AFLP, BIH, RPPC and PHHI, work on improving infant health and birth outcomes and enroll mostly low-income women. CPSP aims to decrease the incidence of low birth weight (LBW<2500 grams) infants by providing at-risk women with comprehensive services including prenatal care, health education, nutrition and psychosocial support. Over 1,500 Medi-Cal obstetrical practitioners provide CPSP services, serving approximately 165,000 women annually. A primary goal of AFLP is to improve birth outcomes for babies born to adolescent clients, many of whom receive Medi-Cal services. AFLP assists pregnant adolescents to access prenatal and other necessary health care early in pregnancy, provides nutrition counseling, and works with teens to eliminate behaviors contributing to poor birth outcomes. African American infants are more than twice as likely as infants of other racial/ethnic groups to be born LBW in California. BIH identifies pregnant and parenting African American women at risk for poor birth outcomes and assists them in accessing and maintaining appropriate healthcare and support services.

MCAH and SCD collaborate with CPQCC on performance improvement in perinatal and neonatal outcomes. CPQCC has 132 member hospitals, accounting for over 90 percent of newborns requiring critical care. RPPC provides consultation to delivery hospitals and supports implementation of clinical quality improvement strategies by collaborating with maternal and neonatal providers to address evidence-based quality improvement projects and improve risk-appropriate care.

L.A. County participated in the Partnership to Eliminate Disparities in Infant Mortality, an 18-month collaborative project (September 2008-February 2010) sponsored by the Association of

Maternal Child Health Programs, CityMatCH and National Healthy Start Association, which provided tools to address infant mortality disparities. The L.A. County and Action Learning Collaborative (LAC ALC) aims to increase capacity at the community, State, and local levels to address the impact of racism on birth outcomes and infant health. Its website provides information on resources and best practices relating to infant mortality and undoing racism. In December 2011, the ALC held a successful Racial Justice Leadership Institute training on undoing racism for collaborative members' staff, with a total of 42 participants.

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

California accepted the Association of State and Territorial Officials (ASTHO) Healthy Babies Challenge in May 2012. Its specific objective is to reduce prematurity rates by 8% by the year 2014, using 2009 data as baseline.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Sixteen LHJs implement FIMR programs that review contributing factors to fetal/infant deaths and identify necessary actions for implementation to prevent these deaths.				X
2. LHJs conduct outreach to encourage pregnant women to seek early prenatal care through programs such as Prenatal Care Guidance.		X		
3. CPSP provides at-risk women with comprehensive services including prenatal care, health education, nutrition and psychosocial support.	X			
4. AFLP assists pregnant adolescents in accessing prenatal and other necessary healthcare early in pregnancy, provides nutrition counseling, and works with teens to eliminate behaviors contributing to poor birth outcomes.		X		
5. BIH identifies pregnant and parenting African American women at risk for poor birth outcomes and assists them in accessing and maintaining appropriate healthcare and support services.		X		
6. MCAH and SCD collaborate with CPQCC on performance improvement in perinatal and neonatal outcomes.				X
7. MCAH, CMQCC and RPPC provide technical assistance to hospitals seeking to reduce elective deliveries less than 39 weeks gestational age.	X	X		X
8. RPPC provides consultation to delivery hospitals and supports implementation of clinical quality improvement strategies to address evidence-based quality improvement projects and improve risk-appropriate care.				X
9. LAC ALC works on increasing capacity at the local and state levels to address the impact of racism on birth outcomes and infant health.				X
10. LHJs implement strategies to decrease their preterm birth rates.	X	X	X	X

b. Current Activities
MCAH participates in the ASTHO Healthy Babies Challenge, which aims to prevent premature births and reduce infant mortality. In partnership with MOD, ASTHO challenged states to reduce their percent of premature births by 8% by 2014, using 2009 data as baseline. The percent of premature births in California was 10.4% in 2009, decreasing to 9.6% in 2012, thus achieving the target 2014 goal in 2012. This accomplishment earned California the "A" grade in the MOD 2013 Premature Birth Report Card.

LHJs and various MCAH programs and initiatives, including CPSP, AFLP, BIH, RPPC and PHHI, continue their work on improving infant health and birth outcomes. The newly revised BIH intervention provides a 20- session group intervention (10 prenatal and 10 postpartum) with complementary case management that provides support to empower clients to make healthier choices for their babies. Case management ensures linkage to prenatal services. L.A. maintains the LAC ALC website to provide information on resources and best practices relating to infant mortality and undoing racism. With its multidisciplinary local partners, LAC ALC continues its mission of increasing capacity at the local and state levels to address the impact of racism on birth outcomes and infant health.

MCAH, CMQCC and MOD continue to promote the Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age Toolkit, which facilitates improvements in maternity practice care.

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

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

MCAH and SCD continue to collaborate with MOD and ASTHO on the Healthy Babies Challenge/Prematurity Campaign. The MCAH Scope of Work for LHJs will continue to include prematurity prevention specific objectives.

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

State Performance Measure 10: *The percent of CCS clients who have a designated primary care physician and/or a specialist physician who provides a medical home,*

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

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective				90	90
Annual Indicator			84.0	62.9	62.9
Numerator			206827	132974	
Denominator			246301	211538	
Data Source			CMS Net	CMS Net	CMS Net
Is the Data Provisional or Final?				Final	Provisional

	2014	2015	2016	2017	2018
Annual Performance Objective	90	90	90	90	90

Notes - 2013
TBD

Notes - 2011
This new performance measure is the percent of CCS clients with a designated primary care physician or subspecialist physician who provides a medical home.

The numerator is the number of CCS clients with a designated medical home, as indicated by the County CCS Office.
The denominator is the unduplicated number of CCS clients during state fiscal year 2010-11 who were entered into CMS Net, the CCS reporting system.

a. Last Year's Accomplishments
This is a new performance measure. In 2008, the current set of Performance measures for CCS were developed, which included that counties should indicate whether each CCS client has an identified medical home. Through 2013, a state CCS workgroup updated and strengthened the CCS annual performance measure for medical home.

In addition, state CCS staff developed case management procedures to identify each CCS client's primary care medical home provider and enter into the CMS Net Registration database.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improve the data base to provide the most accurate results for this performance measure.				X
2. As staffing permit, work with state CCS staff and local county programs to authorize a PCP in conjunction with the Special Care Center or specialist.		X		
3. Request that counties count only physician or nurse practitioner as primary care medical home provider in this Medical Home measure.				X
4. As staffing permits, work with state CCS staff, local CCS county program staff and CSHCN stakeholder groups to promote medical homes for children enrolled in CCS.				X

b. Current Activities
State CCS continues to develop a medical home policy which supports the CCS program's annual performance measure for medical home.

Obtain detailed reports from counties on number/percent of CCS children with ‘medical home' by physician or nurse practitioner provider in a usual place of care.
Meet with county CCS administrators to review Medical Home performance measure, its definition, how to consistently apply Medical Home definition in the SCD performance measure

reporting of a primary care medical home provider in a usual place of care.

Collaboration continues with CRISS on the development of CCS medical homes policy.
The Medi-Cal Managed Care model of the CCS 1115 Waiver Program pilot began April 2013. Medical Home is incorporated into the comprehensive health care delivery system and is one of the areas of performance evaluation for the project

c. Plan for the Coming Year
CCS will continue to work with the counties to ensure each CCS client has access to a medical home provider in a usual place of care.
1. CCS will have a CCS Medical Home Workgroup to assess how the medical home concept is applied differently across counties with different systems of care and different regions.
2. Develop and issue policy letter to request that County CCS offices identify only primary care providers, not clinics, as designated Medical Homes.

3. State CCS will continue to monitor the counties compliance to identify and document each CCS enrolled client's primary care medical home provider.

4. The Medical Managed Care model of the CCS 1115 Waiver Program pilot continues to provide Medical Home into the comprehensive health care delivery system and the performance data continues to be analyzed.

5. For counties not in an 1115 Waiver Pilot Project, CCS will continue to monitor the number of CCS clients with a designated Medical Home.

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	6.8	6.8	6.8	6.7	6.7
Numerator	35774	34624	33956	33657	
Denominator	526692	509884	501942	503691	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
A manual indicator is reported for 2013 based on 2012

Notes - 2012
Source: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File.

Tabulations (by place of residence) were done by the MCAH Program. Data exclude births with unknown birth weight or births weighing <227g or >8165g.

Notes - 2011
Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File.
Tabulations (by place of residence) were done by the MCAH Program. Data exclude births with unknown birth weight or births weighing <227g or >8165g. Data for 2009 should be not compared to data reported in previous years due to a change in exclusion criteria. Rates for prior years using the updated criteria: 2008 = 6.8

Narrative:
Funding for technical support activities provided by San Diego State University's Center for Injury Prevention Policy and Practice (CIPP) was eliminated due to cuts in Title V funding.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 03A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	4.4	3.3	3.7	3.7	3.7
Numerator	357	267	279	281	
Denominator	8184071	8199138	7568037	7554127	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
A manual indicator is reported for 2013 based on 2012.

Notes - 2012
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2012 Death Statistical Master File (ICD-10 Death Codes for unintentional injuries defined by CDPH, Safe and Active Communities Branch, http://www.cdph.ca.gov/HealthInfo/injviosaf/Pages/EpiCenterICD.aspx).

Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH Program.

Data reported for 2011-2012 should not be compared to data reported in prior years due to updates in the population projections released by the California Department of Finance (January2013) and revised ICD10 coding for deaths due to unintentional injuries. Rate for 2010 using the updated population estimate and ICD10 coding = 3.4.

Notes - 2011

Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 Death Statistical Master File (ICD-10 Death Codesfor unintentional injuries defined by CDPH, Safe and Active Communities Branch, http://www.cdph.ca.gov/HealthInfo/injviosaf/Pages/EpiCenterICD.aspx).

Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH Program.

Data reported for 2011 should not be compared to data reported in prior years due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013) and revised ICD10 coding for deaths due to unintentional injuries. Rate for 2010 using the updated population estimate and ICD10 coding = 3.4.

Narrative:
Funding for technical support activities provided by San Diego State University's Center for Injury Prevention Policy and Practice (CIPP) was eliminated due to cuts in Title V funding.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	37912405
Percent Below: 50% of poverty	7
100% of poverty	15.9
200% of poverty	36.5

Notes - 2015

Narrative:
The official poverty measure (OPM) does not account for geographic variation in cost of living, government policies and assistance, medical care, childcare, and transportation. OPM was adopted in 1963 defined as the cost of a minimum budget for nutritionally adequate food multiplied by three; the resulting value has been adjusted annually using the Consumer Price Index to account for inflation. Since its adoption, the OPM has been criticized for its inconsistency in the way it accounted for household costs and resources. On the fundamental level, the base food costs and multiplier used to generate the original OPM thresholds no longer reflect the typical amount or proportion of income that modern households spend on food. Concerns with the OPM have been regularly identified because it does not account for geographic variation in cost of living, government tax and benefit policies that alter resources available, family receipt of government assistance such as food stamps, and increases in life costs such as medical care, childcare, and transportation and the reduction in family size over time. Congress has been concerned by the measure's limitations and in 1990 a Congressional Appropriation resulted in an independent study of the concepts, measurement methods, and information needed for a poverty measure. The National Academy of Sciences established the Panel on Poverty and Family Assistance and in 1995 published their findings that the measure needs to better reflect social and economic realities, and government policies. [36] Further refinements was completed in 2004. The Census Bureau released experimental poverty measures in 1999 and 2001; and in 2010, the Obama administration directed the Census Bureau and the Bureau of Labor Statistics to produce a Supplemental Poverty Measure (SPM) that largely follows the methods recommended by the National Academy of Sciences. The

Interagency Technical Working Group on Developing a SPM was to begin publishing a SPM that could get released alongside the official annual poverty measure. The resulting SPM represents a dollar amount spent on basic goods (food, shelter, clothing), family types, geographic differences in housing, and income including receipt of cash-equivalent in-kind government assistance used to meet basic needs. SPM subtracts from family resources money spent on federal and state income taxes and federal payroll taxes as non-discretionary expenses, while adding to family resources money received through refundable tax credits. SPM more accurately picture of who is still poor after considering the effects of most of the existing government policies designed to prevent or ameliorate poverty. A comparison of the SPM and OPM for 2009 -- 2011 showed an additional 2.7 million in poverty in California with a net over-all increase of 2.5 million in poverty nationally; California alone accounted for the nationwide increase.

F. Other Program Activities

>MCAH Hotline, MCAH Web Hits and the National Text4baby
Both the State and LHJs have telephone hotlines that provide information regarding maternal, child and adolescent health services and programs. There are several statewide toll free telephone hotlines run by the State of California, including one for MCAH: 1-866-241-0395. /2014/ The State MCAH toll-free telephone line received 510 calls in FY 2011-12//2014//The combined number of telephone calls to the local MCAH toll-free lines was 49,748 in FY 2008-09, up from 42,239 in FY 2007-08.
/2014/Local Health Jurisdictions (LHJs) received 66,722 calls to their MCAH toll-free telephone lines and 246,104 MCAH web hits in FY 2011-12. Not all LHJs have the capacity to count web hits, therefore this number may be larger//2014// ***/2015/In FY 2012-13, LHJ MCAH toll-free phone lines received 66,482 calls and 369,570 web hits; the State MCAH received 70 calls and 25,502 web hits.//2015//***.

The MCAH web site received 57,323 hits in 2008/09 /2012/and 29,716 hits in 2009/10. /2014/ The State MCAH web site received 20,782 visits and 30,561views in 2011-12//2014Calls to the local MCAH toll-free lines decreased to 24,357 in FY 2009-10, partly due to increased use of local web pages. //2012// Local MCAH web sites have also been accessed by community members. For example, Contra Costa County reported receiving 84,074 hits to their MCAH web site.

Text4baby is a free mobile information service designed to promote maternal and child health. An educational program of the National Healthy Mothers, Healthy Babies Coalition, Text4baby provides pregnant women and new moms with information they need to take care of their health and give their babies the best possible start in life. Of the 42,518 who enrolled in text4baby nationwide as of May 2010, 9.5% (n= 4024) of women were from California./2014/According to Text4baby, in 2012 there were approximately 17,660 individuals who signed up for the service. Since Text4baby launch in 2010, California has had 44,940 ***/2015/about 54,000//2015//*** individuals who have signed up for Text4baby//2014//.

/2015/MCAH will partner with the National Text4baby program LHJs promote to pregnant and postpartum women. //2015//

>Emergency Preparedness
CDPH launched a program to help Californians find local H1N1 and seasonal influenza immunization information using cell phone texting inquiries, Facebook applications, Twitter and Web widgets. CDPH is promoting the campaign through outdoor advertising, public service announcements and social media. CDPH also launched a new television campaign, entitled "Hands", that lays out the simple facts about H1N1 and encourages vaccination.

MCAH continues to be active in providing updated information about H1N1, perinatal transport and breastfeeding in emergency situations on their website and to LHJs. The information offered

is appropriate for pregnant women, parents, clinicians and health officials. Several local MCAH programs participate in collaboratives and have developed activities regarding emergency preparedness for the MCAH population

>Home Visiting Programs
Ten ***/2015//Seventeen//2015//*** counties in California utilize Nurse Family Partnership (the David Olds home visiting model) to follow high-risk, first-time pregnant women, their children and families. The Olds model is a home visitation model that utilizes public health nurses; other counties utilize ***/2015/Healthy Families America,//2015//*** a home visitation format with staff ranging from community health workers to registered nurses.

A few counties are applying for federal grants to run the Nurse Family Partnership. Also, a few local Public Health Departments are developing or currently implementing their own home visiting programs to provide assessment of mother and infants, health education, and information and referral for needed services./2012/ MCAH is the designated state entity to apply for and administer HRSA and Administration of Children and Families (ACF) HVP. MCAH engaged stakeholders in selecting 20-30 communities to implement Nurse Family Partnership and HF America HVPs, based on the Federal FY 2010 budget.

>American Indian/ Native Alaskan Health (AI/AN)
MCAH provides $424,000 to the Indian Health Program of the Primary, Rural, and Indian Health Division of DHCS for improvement of AI/AN MCH outcomes and support of the American Indian Infant Health Initiative (AIIHI), which offers home visitation in 5 counties with the greatest AI/AN MCH disparities. Services include case management and lay (Community Health Representative) home visitation that includes health assessment, education, referral and transport. Bi-annual workshops provide professional development for staff and ***/2015/ conference calls permit group discussions and potential resolution of complex family dynamics during //2015//*** case review across sites. Collaboration with ***/2015/state, federal, and community partners including//2015//*** WIC and Child Protective Services is fostered to improve family outcomes.

Additional resources are available to AI/AN families throughout California. For example, the California Courts recently developed the Statewide Directory of Services for Native American Families. //2012//

/2015/MCAH compared congenital malformation risk of AI with non-Hispanic whites; AI had elevated risks for 8 of 51 groupings; four are related to cardiac defects.//2015//

>Human Stem Cell Research (HSCR) and Women's Reproductive Health
MCAH created the HSCR Program in 2005 to fulfill legislative mandates through the development of statewide research guidelines, protections for women donating oocytes for research, requirements for HSCR review and approval, and HSCR reporting requirements.

MCAH convened the HSCR Advisory Committee in 2006. In 2007, CDPH approved the statewide guidelines for HSCR submitted by the Advisory Committee. These guidelines were revised in 2008 and 2009 to reflect advancements in the HSCR field. /2013/ The guidelines were revised in 2011 to maintain consistency with changes in the HSCR field and state regulations. //2013//

The HSCR Program developed reporting forms for research involving human embryonic stem cells and oocyte retrieval in spring 2008. In the first year of data collection, 15 review committees reported on 244 HSCR projects. In the second year of reporting, 18 review committees reported on 303 HSCR projects. /2012/ The third year included reports on 350 HSCR projects. HSCR will submit its second biennial review to the Legislature in Spring 2011. //2012// /2013/ In 2011, 17 review committees reported on 364 HSCR projects. No projects involved women donating oocytes. //2013// ***/2015/ In 2012/13, 19 review committees reported on 376 HSCR projects.//2015//***

>Prenatal Screening Services, Umbilical Cord Blood Banking, and Pregnancy Blood Banking /2013/Prenatal screening services are discussed in Performance Measure 01. In 2011, GDSP fully integrated all components of first trimester screening (nuchal translucency ultrasound plus first and second trimester blood screens).//2013// The California Birth Defects Monitoring Program (CBDMP) was established in 1982 to conduct research and surveillance of birth defects and maintain a birth defect registry. /2013/In June 2010, the California legislature approved the use of federal funds for umbilical cord blood banking, and the cord blood program was transferred to the University of California Los Angeles (UCLA).//2013// CBDMP collaborates with GDSP to maintain the Pregnancy Blood Bank, which stores blood samples from GDSP's Prenatal Screening Program. /2013/The bank currently stores more than one million samples from California women.//2013//
>Oral Health Promotion
MCAH recognizes the importance of oral health as being integral to overall health and is responding with a variety of strategies to increase this awareness among its targeted populations. MCAH is contracting with UCSF for a dental hygienist to serve as the MCAH Oral Health Policy Consultant to provide technical assistance at both the state and local levels. Guidelines within MCAH programs have been revised to include oral health recommendations for pregnant and postpartum women and their young children. MCAH collaborates with organizations concerned with promoting oral health throughout the state, including formulating recommendations for the newly completed statewide perinatal oral health guidelines. /

State budget cuts to the Children's Dental Disease Prevention Program (CDDPP) and Medi-Cal adult dental services will be very challenging to MCAH LHJs which provide education and referrals to their clients. MCAH has 18 /2013/19//2013// /2014/ 22//2014//LHJs that have selected oral health as a priority objective. Eleven /2012/ Ten //2012// /2013/11//2013// /2014/Thirteen//2014//of these programs have a minimum of one part-time oral health coordinator/consultant on staff. Another 25 LHJs collaborate on community dental health advisory boards. The boards develop and implement local dental screening and prevention programs and work to increase access by encouraging more dentists to become Denti-Cal providers.

/2015/ Children Now is advocating for restoring state funds to CDDPP.

> Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Age Out Program DHCS targets 18-year olds receiving Private Duty Nursing (PDN) and/or Pediatric Day Health Care (PDHC) services ageing out of EPSDT.. SCD conducts home visits and case manages beneficiaries until they turn 21. CCS adjudicates EPSDT requests for skilled nursing services. In addition to Medi-Cal benefits, an EPSDT beneficiary may receive additional medically necessary services //2015//

G. Technical Assistance

MCAH requests training and resource materials in the area of capacity assessment, including: 1) Clinical capacity assessment (availability of and access to clinics, maternity beds, neonatal intensive care units, etc.); 2) Clinical workforce assessment at state and county levels (physicians, obstetrician/gynecologists, pediatricians, dentists, nurses, etc.); 3) Public health capacity assessment (epidemiologists, program evaluators, etc.); 4) Integration of needs assessment, capacity assessment, and implementation planning, and; 5) MCAH public health workforce assessment.

MCAH requests guidance in conducting the Home Visitation Program Needs Assessment as mandated by the Maternal, Infant, and Early Childhood Home Visiting Program in the Patient Protection and ACA. Specifically, MCAH requests assistance in identifying the criteria by which MCAH can measure the effectiveness of evidence-based early childhood home visiting models that qualify under the new legislation, guidelines for reporting to fulfill the needs assessment requirements and developing quantifiable measures for setting benchmarks.

MCAH requests training and resource materials in the area of capacity assessment, specifically on : 1) developing process indicators related to direct healthcare services; (2) community level capacity assessment; (3) linking needs analysis with capacity assessment to identify priorities and resource allocation and (4) "train the trainer" on conducting state and community-level capacity assessment 5) internal organizational capacity assessment 6) scope and breadth in assessing systems capacity beyond MCAH services.

MCAH requests assistance in reviving an annual (or biennial) MCAH California Conference. The conferences would be a collaborative effort undertaken by the MCAH, MCAH Action (the statewide organization of local MCAH Directors), and the UCB School of Public Health. Such conferences were held annually in California prior to discontinuation in 2002 due to budget constraints. The conferences were well attended, with approximately 700 participants each. Conference locations alternated between northern and southern California. The conference provided opportunities for participants --from the state, local jurisdictions, academia, and other interested groups --to network and strategize on issues affecting the health of women, children and families in California. Each year the conference had a theme. MCAH encouraged interested parties to submit general or scientific abstracts on current and emerging MCAH issues pertinent to the theme. Programs that addressed the conference theme were recognized.

MCAH has an excellent staff of researchers and analysts for epidemiological analyses and evaluation of Title V programs. However, MCAH requests training for recent hires and junior research staff on several aspects of the methodology of epidemiological analyses of MCAH and program evaluation. CMS would also benefit from receiving training on these issues, including epidemiological methods, analyses of the cost-effectiveness or budget neutrality of programs, and the analysis of trend data. While it would be desirable to obtain this training directly through seminars and workshops offered at CDC, HRSA, and other Federal agencies, policies designed to address budget constraints in California prohibit out-of state travel. /2014/ Reference to Children's Medical Services (CMS) is being gradually phased out and replaced by Systems of Care Division (SCD).//2014//

A workshop on epidemiology (e.g., risk ratios, sensitivity, specificity, validation, and bias) and appropriate statistical analyses commonly used in MCAH would be valuable to both the MCAH and CMS. Applied examples, including examples of analyses commonly used by comparable state and federal entities, would demonstrate concepts and inform possible areas for enhanced analysis and program development. Many MCAH programs are local; data collected at the state level may be useful for smaller areas, so an overview of small-area and geographic analysis would also enhance current and suggest future analyses.

Technical assistance on how to conduct cost-effectiveness, cost-benefit, and cost avoidance analyses for Title V programs would also be very beneficial for staff. During the current era of budget shortfalls in California, there has been greater scrutiny by decision-makers as to the cost effectiveness and fiscal neutrality of programs run by the MCAH and CMS.

Technical assistance on the steps involved in analyses, parameters to consider, accepted methodologies, and effective presentation of results would supplement staff's ability to provide this critical information to program managers and administration officials.

Hands-on training on smoothing techniques to deal with geographic areas (e.g., census tracts) for which there are too few observations to generate statistically stable counts or rates; recommended statistical tests for use with geospatial data, including for smoothed data.

The CDC reports that more than 40 percent of women experience some type of complication during childbirth; many of these complications are preventable. Maternal morbidity is a serious public health problem that can impact maternal, fetal, and infant health and can lead to maternal death. MCAH is working to monitor maternal morbidity. MCAH is developing a MQI project and

has contracted with an academic research group to assess variation in maternal outcomes and an evidence-based quality improvement collaborative to analyze the data. MCAH requests assistance in the development of systems for identifying, reviewing, and analyzing maternal morbidity that will serve as a framework for improved maternal standards of care.

MCAH requests assistance in how to obtain youth input into decision-making for the Branch and its adolescent-related programs. Currently, the Branch does not have sufficient manpower to carry out this activity, but would like to include more youth input into our decision-making process

/2012/MCAH requests assistance in the development of systems for identifying, reviewing, and analyzing maternal morbidity and mortality that will serve as a framework for improved maternal standard of care. Assistance is needed on study design, case selection, medical record review protocols, guidance on whether cases are pregnancy-related or pregnancy-associated, and development of recommendations to reduce morbidity and mortality based on findings.

MCAH requests assistance to translate current evidence regarding contributing factors to racial disparities into Title V programmatic activities and build capacity in addressing the impact of the social determinants of health. Disparities in infant and maternal health outcomes persist and are widening in regards to maternal mortality so MCAH needs to expand current strategies. MCAH is also invested in moving to primary prevention and applying the life course theory to interventions but moving from a programmatic approach to reaching out to influence decision making in other disciplines is a new and emerging role.

It is essential to communicate the value and make the case for the importance of MCAH programs in contributing to health across the life course. MCAH requests assistance in developing a set of standardized messages that state and local MCAH programs could use.//2012//

/2013/ MCAH requests assistance in the area of capacity development related to methodological training for new and junior staff on epidemiological methods and conducting cost-effectiveness analysis, assistance on obtaining youth input, translational research, addressing social determinants of health, methodology development for longitudinal analysis of preconception and interconception health and standardized messaging.

CCS requests assistance from MCHB in adapting the National CSHCN survey to California's CCS population in order to move forward with 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. The national survey results offer some insight into satisfaction, insurance, access of families of CSHCN in California, but does not differentiate between CCS eligible and other CSHCN so that results are not directly applicable to the CCS program. Its length is also limiting. Use of an adapted survey will allow assessment, specific to families and children in the CCS program, of several priority objectives of the Title V needs assessment, including implementation of medical homes, increasing family partnership in decision making, and satisfaction with services;. In addition, an adapted survey would allow the CCS program to monitor family satisfaction as changes are made to the CCS over the next 5 years. //2013// /2014/ Family Satisfaction Survey has been developed for the 1115 Waiver Counties. CCS is exploring using this survey for the representative sample of CCS clients and families residing in the other counties. //2014// ***/2015/SCD will request from HRSA technical assistance for an onsite consultant to guide CCS Title V workgroup in the steps to develop and implement/administer this family survey.***

California reviewed strategies used by other grantees to gain public input but information gathered from other Title V grantees' report/ application did not provide insight of how effective the selected strategies had been. Thus, California is requesting MCHB to provide technical assistance in identifying effective processes of engaging stakeholders to provide input and establish clearly defined measures for public input reporting and

evaluation. This will provide California with the ability to learn from past collective grantees' experience, understand the effectiveness of engagement and identify what approaches work best. Knowing how to make the public input activity more effective presupposes an understanding of the desired outcomes, expected benefits and the ability to measure how effective the activity is to begin with. Understanding the challenges, tradeoffs and adverse consequence of not gaining enough public input is also integral in measuring its overall impact and effectiveness While leadership is crucial for the success of MCH Transformation 3.0, transforming our communities will require a clear path in engaging our stakeholders.//2015//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2013		FY 2014		FY 2015	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	41389219	35582819	35292014		37731581	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	1306322819	1319869167	1402450145		1535926539	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	1272272105	1366838589	1382181012		1549128757	
7. Subtotal	2619984143	2722290575	2819923171		3122786877	
8. Other Federal Funds *(Line10, Form 2)*	30690686	32278630	30100239		28677836	
9. Total *(Line11, Form 2)*	2650674829	2754569205	2850023410		3151464713	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2013		FY 2014		FY 2015	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	28008354	25391311	30603459		31880037	
b. Infants < 1 year old	41436955	31970874	40092165		37473607	
c. Children 1 to 22 years old	132469454	101388708	131804924		123733456	
d. Children with Special Healthcare Needs	2415869622	2561782550	2615602486		2927548312	
e. Others	0	0	0		0	
f. Administration	2199758	1757132	1820137		2151465	
g. SUBTOTAL	2619984143	2722290575	2819923171		3122786877	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		66392		100000	
c. CISS	150000		140000		140000	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	148800		148800		148800	
j. Education	0		0		0	
k. Home Visiting	0		0		0	
k. Other						
Expect Pregnant Teen					1500000	
MIECHV-Competitive					8949070	
MIECHV-Formula					11923154	
PREP			6454368		5916812	
EPT/PAF			1500000			
HVP - Formula			11510679			
HVP - Expansion			9430000			
Project LAUNCH	850000		850000			
Home Visiting - Expa	9430000					
Home Visiting - Form	11510679					

Pregnant & Parenting	2000000					
PREP	6501207					

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2013		FY 2014		FY 2015	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	2267878641	2391913565	2454068811		2722808417	
II. Enabling Services	255442699	247124541	271574961		311397940	
III. Population-Based Services	65174957	48847732	64100863		56872601	
IV. Infrastructure Building Services	31487846	34404737	30178536		31707919	
V. Federal-State Title V Block Grant Partnership Total	2619984143	2722290575	2819923171		3122786877	

A. Expenditures

The budget and expenditures for FFY 2011 are presented in Forms 2, 3, 4, and 5. /2014/Expenditures and budget amounts include over $2 billion in Medicaid funds that California expends on direct care services and case management of some of the CSHCN programs. California's state match/ overmatch is primarily the result of direct care services and case management of CSHCN.//2014//

/2013/ The reductions in federal Title V funding has resulted in programmatic adjustments to reduce expenditures in infrastructure building services which will affect the following:

MCAH Division

MCAH is 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.

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.

Audits and Investigations (A&I) Division
A & I performs audits on MCAH local contracts to ensure fiscal accountability and that federal requirements are met. A proposed reduction of $182,000 to A&I 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 and complete elimination by July 2012.

> CDAPP
For FY 2011/12 funding for CDAPP was reduced by 50% to about $600,000 and the program will be eliminated starting July 2012. A resource and training center was contracted to provide resource materials, educational webinars and maintain the CDAPP website and listings of local CDAPP affiliates.//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//

/2013/The FFY 2013 allocation is $41,389,219. Services for pregnant women, mothers, and infants are designated to receive $13,055,182(31.54 %) services for children to receive $13,573,945 (32.80 %) and CSHCN to receive $12,560,334 (30.35%). The required match is $31,041,914 California's FFY 2013 budget for Title V MCH programs includes $1,306,322,819 in state funds.//2013//

/2014/The FFY 2014 allocation is $35,292,014. Services for pregnant women, mothers, and infants are designated to receive $11,139,029(31.56 %) services for children to receive $11,520,848(32.64 %) and CSHCN to receive $10,811,999 (30.64%). The required match is $26,469,010 California's FFY 2014 budget for Title V MCH programs includes $1,402,450,145 in state funds.//2014//

/2015/The FFY 2015 allocation is $37,731,581. Services for pregnant women, mothers, and infants are designated to receive $12,885,570 (34.15 %) preventive and primary care services for children to receive $11,350,563 (30.08 %) and CSHCN to receive $11,343,983 (30.06 %). The required match is $28,298,686. California's FFY 2015 budget for Title V MCH programs includes $1,535,926,539 in state funds.//2015//

> 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. //2011//

/2012/ California expects to receive $42,300,760 in Title V funds for FFY 2012. The required match is $31,,725,5701 California's FFY 2012 budget for Title V MCH programs includes $1,366,907,980 in state funds.//2012

>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 % of Title V funds on administrative costs.

/2012/ In FFY 2012 /2013/and 2013//2013// no more than 10 % of the Title V MCH Block Grant

funds will be used for administrative costs and California will expend only 5.74% /2013/ and 5.31%, respectively,//2013// on administrative costs.//2012// /2014/ Administrative costs will be 5.16% of the total allocation for FFY 2014.//2014// ***/2015/ Administrative costs will be 5.7% of the total allocation for FFY 2015.//2015//***

>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// /2014/The State's General Fund contribution for FFY 2012 and FFY 2014 is $1,279,749,230 and $1,315,291,395 greater than for base year FFY 1989...//2014// ***/2015/The State's General Fund contribution for FFY 2015 is $1,535,926,539 which is $1,448,767,789 greater than the State's General Fund contribution of $87,158,750 in base year FFY 1989. //2015//***

>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//

>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/ In FFY 2012, 2 AFLP sites discontinued operations. Funding for AFLP programs will be reduced by $1,900,000 through reductions to local assistance resulting in 13,435 fewer person-months of service in FFY 2013.//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// ***/2015/The 2014-15 Budget includes $3.9 million General Fund to the BIH program. //2015//***

>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 of $200,000 in administrative costs and $405,000 will be reduced from HRIF. //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.

The State's economic recession hit single women supporting families particularly hard with the largest decline in their average workweek in at least two decades. [54]

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.

Continued shortfalls threaten programs and services that California's women and their families depend on. The budget contained proposals for downsizing and achieving efficiencies including reorganization of State government, elimination of some 700 legislative reports and staff furloughs.//2013//

/2014/ The 2013-14 California budget highlights investments in education and a resolution for a timely state-based Medi-Cal expansion as required by ACA. It shifts pregnant women and recent legal immigrants currently in state-funded programs onto private insurance through Covered California.

Federal budget cuts or "sequestration" began on March 2013 as an austerity fiscal policy with reductions starting in FY 2013 to FY 2021. It is projected that California's public health would lose about $2.6 million in funds to help upgrade its ability to respond to public health threats including infectious diseases, natural disasters, and biological, chemical, nuclear, and radiological events.//2014//

/2015/The 2014-15 enacted budget reflects full implementation of ACA which estimates that 825,000 additional people with receive Medi-Cal benefits. The budget expands full Medi-Cal services to pregnant women with incomes at or below 138% of FPL and a benefit program for pregnant women with incomes between 138 to 208% of FPL who qualified under a health plan through Covered California. The budget include $1 million General Fund for a pilot pediatric vision services program. Beginning 2015, the budget includes $7.9 million general fund for the Early Start Program based on expanded eligibility criteria.//2015//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.

Title V Block Grant Application
Forms (2-21)
State: CA
Application Year: 2015

- Form 2 - MCH Budget Details
- Form 3 - State MCH Funding Profile
- Form 4 - Budget Details By Types of Individuals Served and Sources of Federal Funds
- Form 5 - State Title V Program Budget and Expenditures by Types of Services
- Form 6 - Number and Percentage of Newborn and Others Screened, Case Confirmed, and Treated
- Form 7 - Number of Individuals Served (Unduplicated) Under Title V
- Form 8 - Deliveries and Infants Served by Title V and Entitled to Benefits under Title XIX
- Form 9 - State MCH Toll-Free Telephone Line Data
- Form 10 - Title V Maternal and Child Health Services Block Grant State Profile for FY 2013
- Form 11 - National and State Performance Measures
- Form 12 - National and State Outcome Measures
- Form 13 - Characteristics Documenting Family Participation in Children with Special Health Care Needs
- Form 14 - List of MCH Priority Needs
- Form 15 - Technical Assistance (TA) Request and tracking
- Form 16 - State Performance/Outcome Measure Detail Sheets
- Form 17 - Health System Capacity Indicators (01 through 04,07,08) - Multi-year Data
- Form 18
  - Medicaid and Non-Medicaid comparison
  - Medicaid Eligibility Level (HSCI 06)
  - SCHIP Eligibility Level (HSCI 06)
- Form 19
  - General MCH Data Capacity (HSCI 09A)
  - Adolescent Tobacco Use Data Capacity (HSCI 09B)
- Form 20 - Health Status Indicators 01-05 - Multi-year Data
- Form 21
  - Population Demographics Data (HSI 06)
  - Live Birth Demographics Data (HSI 07)
  - Infant and Children Mortality Data (HSI 08)
  - Miscellaneous Demographics Data (HSI 09)
  - Geographic Living Area Demographic Data (HSI 10)
  - Poverty Level Demographic Data (HSI 11)
  - Poverty Level for Children Demographics Data (HSI 12)

Form 2

MCH Budget Details for FY 2015

[Secs. 504 (d) and 505(a)(3)(4)]

State: CA

1. Federal Allocation
(Item 15a of the Application Face Sheet [SF 424])
Of the Federal Allocation (1 above), the amount earmarked for:
$ 37,731,581

A.Preventive and primary care for children:
$ 11,350,563 (30.08 %)

B.Children with special health care needs:
$ 11,343,983 (30.06 %)
(If either A or B is less than 30%, a waiver request must accompany the application)[Sec. 505(a)(3)]

C.Title V admininstrative costs:
$ 2,151,465 (5.7 %)
(The above figure cannot be more than 10%)[Sec. 504(d)]

2. Unobligated Balance (Item 15b of SF 424) $ 0

3. State MCH Funds (Item 15c of the SF 424) $ 1,535,926,539

4. Local MCH Funds (Item 15d of SF 424) $ 0

5. Other Funds (Item 15e of SF 424) $ 0

6. Program Income (Item 15f of SF 424) $ 1,549,128,757

7. Total State Match (Lines 3 through 6) $ 3,085,055,296
(Below is your State's FY 1989 Maintainence of Effort Amount)
$ 87,158,750

8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP (SUBTOTAL) $ 3,122,786,877
(Total lines 1 through 6. Same as line 15g of SF 424)

9. Other Federal Funds
(Funds under the control of the person responsible for the administration of the Title V program)

a. SPRANS:	$ 0
b. SSDI:	$ 100,000
c. CISS:	$ 140,000
d. Abstinence Education:	$ 0
e. Healthy Start:	$ 0
f. EMSC:	$ 0
g. WIC:	$ 0
h. AIDS:	$ 0
i. CDC:	$ 148,800
j. Education:	$ 0
k. Home Visiting:	$ 0
l. Other:	
Expect Pregnant Teen	$ 1,500,000
MIECHV-Competitive	$ 8,949,070
MIECHV-Formula	$ 11,923,154
PREP	$ 5,916,812

10. Other Federal Funds (SUBTOTAL of all Funds under item 9) $ 28,677,836

11. STATE MCH BUDGET TOTAL $ 3,151,464,713
(Partnership subtotal + Other Federal MCH Funds subtotal)

Form Notes for Form 2

None

Field Level Notes

None

Form 3
State MCH Funding Profile
[Secs. 505(a) and 506((a)(I-3)]
State: CA

	FY 2010		FY 2011		FY 2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation *(Line1, Form 2)*	$ 43,328,678	$ 51,379,045	$ 43,315,317	$ 44,632,445	$ 42,300,762	$ 42,239,399
2. Unobligated Balance *(Line2, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
3. State Funds *(Line3, Form 2)*	$ 1,245,840,182	$ 1,241,182,648	$ 1,290,479,684	$ 1,292,129,195	$ 1,366,907,980	$ 1,211,417,353
4. Local MCH Funds *(Line4, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
6. Program Income *(Line6, Form 2)*	$ 1,158,080,012	$ 1,249,151,620	$ 1,236,656,992	$ 1,399,992,782	$ 1,353,823,835	$ 1,286,837,908
7. Subtotal	$ 2,447,248,872	$ 2,541,713,313	$ 2,570,451,993	$ 2,736,754,422	$ 2,763,032,577	$ 2,540,494,660
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 94,644	$ 552,303	$ 2,221,953	$ 2,201,633	$ 14,775,679	$ 11,756,440
9. Total *(Line11, Form 2)*	$ 2,447,343,516	$ 2,542,265,616	$ 2,572,673,946	$ 2,738,956,055	$ 2,777,808,256	$ 2,552,251,100
	(STATE MCH BUDGET TOTAL)					

Form 3
State MCH Funding Profile
[Secs. 505(a) and 506((a)(I-3)]
State: CA

	FY 2013		FY 2014		FY 2015	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation *(Line1, Form 2)*	$ 41,389,219	$ 35,582,819	$ 35,292,014	$	$ 37,731,581	$
2. Unobligated Balance *(Line2, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
3. State Funds *(Line3, Form 2)*	$ 1,306,322,819	$ 1,319,869,167	$ 1,402,450,145	$	$ 1,535,926,539	$
4. Local MCH Funds *(Line4, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
5. Other Funds *(Line5, Form 2)*	$ 0	$ 0	$ 0	$	$ 0	$
6. Program Income *(Line6, Form 2)*	$ 1,272,272,105	$ 1,366,838,589	$ 1,382,181,012	$	$ 1,549,128,757	$
7. Subtotal	$ 2,619,984,143	$ 2,722,290,575	$ 2,819,923,171	$ 0	$ 3,122,786,877	$ 0
	(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)					
8. Other Federal Funds *(Line10, Form 2)*	$ 30,690,686	$ 32,278,630	$ 30,100,239	$	$ 28,677,836	$
9. Total *(Line11, Form 2)*	$ 2,650,674,829	$ 2,754,569,205	$ 2,850,023,410	$ 0	$ 3,151,464,713	$ 0
	(STATE MCH BUDGET TOTAL)					

Form Notes for Form 3

None

Field Level Notes

1. **Section Number:** Form3_Main
   Field Name: FedAllocExpended
   Row Name: Federal Allocation
   Column Name: Expended
   Year: 2013
   Field Note:
   Expenditures decrease due to sequestration.
2. **Section Number:** Form3_Main
   Field Name: StateMCHFundsExpended
   Row Name: State Funds
   Column Name: Expended
   Year: 2012
   Field Note:
   The budgeted amounts were projections at a point in time. Expenditures reflect caseload changes.
3. **Section Number:** Form3_Main
   Field Name: OtherFedFundsExpended
   Row Name: Other Federal Funds
   Column Name: Expended
   Year: 2012
   Field Note:
   Delayed start up of new ACA programs due to state budgeting policies

Form 4

Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds (II)

[Secs 506(2)(2)(iv)]

State: CA

	FY 2010		FY 2011		FY 2012	
I. Federal-State MCH Block Grant Partnership	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
a. Pregnant Women	$ 45,696,427	$ 33,741,848	$ 28,042,839	$ 25,490,798	$ 28,504,437	$ 24,048,354
b. Infants < 1 year old	$ 38,258,951	$ 39,328,097	$ 35,440,694	$ 40,756,466	$ 34,687,361	$ 36,020,769
c. Children 1 to 22 years old	$ 145,201,447	$ 120,461,419	$ 120,612,014	$ 122,301,136	$ 117,382,670	$ 110,775,387
d. Children with Special Healthcare Needs	$ 2,213,690,656	$ 2,345,258,260	$ 2,383,717,501	$ 2,545,164,487	$ 2,580,029,837	$ 2,367,571,330
e. Others	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
f. Administration	$ 4,401,391	$ 2,923,689	$ 2,638,945	$ 3,041,535	$ 2,428,272	$ 2,078,820
g. SUBTOTAL	$ 2,447,248,872	$ 2,541,713,313	$ 2,570,451,993	$ 2,736,754,422	$ 2,763,032,577	$ 2,540,494,660
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	$ 0		$ 0		$ 0	
b. SSDI	$ 94,644		$ 93,713		$ 100,000	
c. CISS	$ 0		$ 132,000		$ 140,000	
d. Abstinence Education	$ 0		$ 0		$ 0	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 0		$ 0		$ 0	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 0		$ 175,000		$ 175,000	
j. Education	$ 0		$ 0		$ 0	
k. Home Visiting	$ 0		$ 0		$ 0	
l. Other						
Home Visiting Prog.	$		$		$ 11,510,679	
Pregnant & Parenting	$		$		$ 2,000,000	
Project LAUNCH	$		$		$ 850,000	
Others	$		$ 1,821,240		$	
III. TOTAL	$ 94,644		$ 2,221,953		$ 14,775,679	

Form 4

Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds (II)

[Secs 506(2)(2)(iv)]

State: CA

	FY 2013		FY 2014		FY 2015	
I. Federal-State MCH Block Grant Partnership	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
a. Pregnant Women	$ 28,008,354	$ 25,391,311	$ 30,603,459	$	$ 31,880,037	$
b. Infants < 1 year old	$ 41,436,955	$ 31,970,874	$ 40,092,165	$	$ 37,473,607	$
c. Children 1 to 22 years old	$ 132,469,454	$ 101,388,708	$ 131,804,924	$	$ 123,733,456	$
d. Children with Special Healthcare Needs	$ 2,415,869,622	$ 2,561,782,550	$ 2,615,602,486	$	$ 2,927,548,312	$
e. Others	$ 0	$ 0	$ 0	$	$ 0	$
f. Administration	$ 2,199,758	$ 1,757,132	$ 1,820,137	$	$ 2,151,465	$
g. SUBTOTAL	$ 2,619,984,143	$ 2,722,290,575	$ 2,819,923,171	$ 0	$ 3,122,786,877	$ 0
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	$ 0		$ 0		$ 0	
b. SSDI	$ 100,000		$ 66,392		$ 100,000	
c. CISS	$ 150,000		$ 140,000		$ 140,000	
d. Abstinence Education	$ 0		$ 0		$ 0	
e. Healthy Start	$ 0		$ 0		$ 0	
f. EMSC	$ 0		$ 0		$ 0	
g. WIC	$ 0		$ 0		$ 0	
h. AIDS	$ 0		$ 0		$ 0	
i. CDC	$ 148,800		$ 148,800		$ 148,800	
j. Education	$ 0		$ 0		$ 0	
k. Home Visiting	$ 0		$ 0		$ 0	
l. Other						
Expect Pregnant Teen	$		$		$ 1,500,000	
MIECHV-Competitive	$		$		$ 8,949,070	
MIECHV-Formula	$		$		$ 11,923,154	
PREP	$		$ 6,454,368		$ 5,916,812	
EPT/PAF	$		$ 1,500,000		$	
HVP - Formula	$		$ 11,510,679		$	
HVP - Expansion	$		$ 9,430,000		$	
Project LAUNCH	$ 850,000		$ 850,000		$	
Home Visiting - Expa	$ 9,430,000		$		$	
Home Visiting - Form	$ 11,510,679		$		$	
Pregnant & Parenting	$ 2,000,000		$		$	
PREP	$ 6,501,207		$		$	
III. TOTAL	$ 30,690,686		$ 30,100,239		$ 28,677,836	

Form Notes for Form 4

None

Field Level Notes

1. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: PregWomenExpended
   Row Name: Pregnant Women
   Column Name: Expended
   Year: 2012
   Field Note:
   The budgeted amounts were projections at a point in time. Expenditures reflect caseload changes.
2. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_0_1Expended
   Row Name: Infants <1 year old
   Column Name: Expended
   Year: 2013
   Field Note:
   The budgeted amounts were projections at a point in time. Expenditures reflect caseload changes.
3. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: Children_1_22Expended
   Row Name: Children 1 to 22 years old
   Column Name: Expended
   Year: 2013
   Field Note:
   The budgeted amounts were projections at a point in time. Expenditures reflect caseload changes.
4. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: AdminExpended
   Row Name: Administration
   Column Name: Expended
   Year: 2013
   Field Note:
   Expenditures decrease due to sequestration.
5. **Section Number:** Form4_I. Federal-State MCH Block Grant Partnership
   Field Name: AdminExpended
   Row Name: Administration
   Column Name: Expended
   Year: 2012
   Field Note:
   The budgeted amounts were projections at a point in time. Expenditures reflect actuals.

Form 5

State Title V Program Budget and Expenditures by Types of Services

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

State: CA

Type of Service	FY 2010		FY 2011		FY 2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 2,079,144,312	$ 2,192,327,238	$ 2,247,648,806	$ 2,395,005,281	$ 2,441,246,289	$ 2,208,366,508
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 268,379,701	$ 238,549,585	$ 260,227,739	$ 239,908,163	$ 254,669,900	$ 240,708,530
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 62,092,633	$ 62,577,818	$ 36,067,685	$ 66,184,574	$ 36,188,755	$ 56,184,666
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 37,632,226	$ 48,258,672	$ 26,507,763	$ 35,656,404	$ 30,927,633	$ 35,234,956
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 2,447,248,872	$ 2,541,713,313	$ 2,570,451,993	$ 2,736,754,422	$ 2,763,032,577	$ 2,540,494,660

Form 5

State Title V Program Budget and Expenditures by Types of Services

[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

State: CA

Type of Service	FY 2013		FY 2014		FY 2015	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services (Basic Health Services and Health Services for CSHCN.)	$ 2,267,878,641	$ 2,391,913,565	$ 2,454,068,811	$	$ 2,722,808,417	$
II. Enabling Services (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$ 255,442,699	$ 247,124,541	$ 271,574,961	$	$ 311,397,940	$
III. Population-Based Services (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$ 65,174,957	$ 48,847,732	$ 64,100,863	$	$ 56,872,601	$
IV. Infrastructure Building Services (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$ 31,487,846	$ 34,404,737	$ 30,178,536	$	$ 31,707,919	$
V. Federal-State Title V Block Grant Partnership Total (Federal-State Partnership only. Item 15g of SF 42r. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$ 2,619,984,143	$ 2,722,290,575	$ 2,819,923,171	$ 0	$ 3,122,786,877	$ 0

Form Notes for Form 5

None

Field Level Notes

1. **Section Number:** Form5_Main
   Field Name: DirectHCBudgeted
   Row Name: Direct Health Care Services
   Column Name: Budgeted
   Year: 2013
   Field Note:
   No Title V Block Grant funds are used for Direct Health Care Services. These services were funded through state funding and program income.
2. **Section Number:** Form5_Main
   Field Name: PopBasedExpended
   Row Name: Population-Based Services
   Column Name: Expended
   Year: 2013
   Field Note:
   The budgeted amounts were projections at a point in time. Expenditures reflect caseload changes.
3. **Section Number:** Form5_Main
   Field Name: PopBasedExpended
   Row Name: Population-Based Services
   Column Name: Expended
   Year: 2012
   Field Note:
   Budget amounts were projections at a point in time. Expenditures reflect caseload changes.
4. **Section Number:** Form5_Main
   Field Name: InfrastrBuildExpended
   Row Name: Infrastructure Building Services
   Column Name: Expended
   Year: 2012
   Field Note:
   Budget amounts were projections at a point in time. Expenditures reflect caseload changes.

Form 6

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

Sect. 506(a)(2)(B)(iii)

State: CA

Total Births by Occurrence: 503,788

Reporting Year: 2012

Type of Screening Tests	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%			No.	%
Phenylketonuria	496,919	98.6	287	22	22	100
Congenital Hypothyroidism	496,919	98.6	463	273	273	100
Galactosemia	496,919	98.6	100	6	6	100
Sickle Cell Disease	496,919	98.6	4,848	61	61	100
Other Screening (Specify)						
Cystic Fibrosis	496,919	98.6	176	59	59	100
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	496,919	98.6	781	19	19	100
Tandem Mass Spectrometry (MS/MS) screening for non-PKU inborn errors of metabolism	496,919	98.6	2,277	136	136	100
Severe Combined Immunodeficiency	496,919	98.6	74	6	6	100
Biotinidase Deficiency (BD+ Partials)	496,919	98.6	200	20	20	100
Screening Programs for Older Children & Women (Specify Tests by name)						
HIV Oraquick	8,258		3	20	17	85
HIV Enzyme	3,319		10	10	8	80
Expanded Alpha Fetoprotein (Prenatal Screening)	391,480		22,761	846	846	100

(1) Use occurrent births as denominator.
(2) Report only those from resident births.
(3) Use number of confirmed cases as denominator.

Form Notes for Form 6

Data Source for newborn screening tests: California Department of Public Health, 2012 Newborn Screening Records (retrieved using SQL queries from Screening Information System (SIS).

Newborn screening includes screening for the following conditions: PKU, congenital hypothyroidism, galactosemia, sickle cell disease (Hb S/S, Hb S/+Thalassemia, and Hb S/B0Thalassemia only), congenital adrenal hyperplasia, over 40 non-PKU inborn errors of metabolism tested by tandem mass spectrometry, cystic fibrosis, biotidinase deficiency and severe combined immunodeficiency.

The California Genetic Disease Screening Program screens for 26 hemoglobinopathies using high-pressure liquid chromatography (HPLC). In a study of 2.2 million screens, the test accuracy was 97% for screen-positives (Shafer FE, Lorey F, Cunningham GC, Klump C, Vichinsky E, Lubin B. Newborn screening for sickle cell disease: 4 years of experience from California's newborn screening program. J Pediatr Hematol Oncol. 1996 Feb;18(1):36-41, p. 37).

The number of cases reported is restricted to the sickle cell disease cases confirmed for the S/S variant, plus Hb S/+BThalassemia and Hb S/B0Thalassemia.

Cystic fibrosis and biotidinase deficiency were added in July 2007 while severe combined immunodeficiency was piloted starting August 16, 2010. This pilot was converted to routine newborn screening in March, 2013.

Every effort is taken to screen all newborns delivered in California; however, the percent receiving at least one screen for each of the tests do not equal to 100% primarily due to some families opting-out of screening, births at military hospitals that do not participate in California's NBS screening program, very early infant deaths occurring prior to screening or newborns being delivered at home, despite our best effort to work with all birth practitioners in the state including midwives and birth attendants. A more accurate understanding of the newborns that are missed though newborn screening would require direct linkage of the newborn screening record with the birth certificate, which is one of the program goals for the future.

It is assumed that all confirmed cases need treatment and received treatment. For those tested for phenylketonuria (PKU, classic), the number of presumptive positive screens excludes other screened positive combinations , those who screened positive for PKU plus another disorder.

Field Level Notes

1. **Section Number:** Form6_Main
   Field Name: BirthOccurence
   Row Name: Total Births By Occurence
   Column Name: Total Births By Occurence
   Year: 2015
   Field Note:
   Data Source for Occurrent Births: State of California, Department of Public Health, Birth Statistical Master File, 2012.
2. **Section Number:** Form6_Screening Programs for Older Children and Women
   Field Name: OtherWomen
   Row Name: All Rows
   Column Name: All Columns
   Year: 2015
   Field Note:
   Data source for Expanded Alpha Fetoprotein screening data: State of California, Department of Public Health, Genetic Disease Screening Program, 2012 Prenatal Screening Records.

   Notes for Expanded Alpha Fetoprotein screening data: The expanded alpha fetoprotein screening test is an optional prenatal screening test that may be offered to pregnant women, but is not a necessary test for all women. The denominator equals the number of women who received this test regardless of residency.

   Data Source for HIV Screening Data: California Department of Public Health, Office of AIDS, Program Evaluation and Research Section. Local Evaluation Online System (LEO). Includes data for Year 2012, reported and processed as of March 4, 2013.

   Notes for HIV Screening Data:

   1. Data represent the number of services provided and not unique clients receiving these services. The data include only tests funded by the CDC Category-A prevention funds granted to OA through PS12-1201; Category-B funded tests are excluded. Screening procedures conducted by San Francisco and Los Angeles, CDC directly-funded Community Based Organizations (CBOs),blood banks, plasma centers, inmate facilities, military service or by private testing sites are unavailable and not included in the totals.

   2. Older children are defined as 13-19 years of age, women are defined as females 20-45 years of age.

   3. Conventional (HIV Enzyme) and OraQuick tests are conducted using either blood or oral fluid samples. Oraquick presumptive positive screens include only records for which confirmatory testing was not conducted. For conventional (HIV Enzyme) testing, there are no HIV presumptive positive screens because all serologically reactive cases are confirmed using Western Blot or IFA.

   4. Individuals who need treatment and receive treatment are defined as individuals who have a confirmed positive test result, receive a referral to medical care, and have a verified medical visit on file.

FORM 7

Number of Individuals Served (Unduplicated) under Title V
(By Class of Individuals and Percent of Health Coverage)

[Sec. 506(a)(2)(A)(i-ii)]

State: CA

Number of Individuals Served - Historical Data by Annual Report Year

Types of Individuals Served	2008	2009	2010	2011	2012
Pregnant Women	566,089	551,567	526,774	509,979	502,023
Infants < 1 year old	580,680	552,084	589,656	557,757	557,757
Children 1 to 22 years old	1,435,878	1,395,491	1,605,499	1,707,006	1,707,006
Children with Special Healthcare Needs	163,845	164,656	179,306	246,301	234,997
Others	0	0	0	0	0
Total	2,746,492	2,663,798	2,901,235	3,021,043	3,001,783

Reporting Year: 2013

	TITLE V	PRIMARY SOURCES OF COVERAGE				
Types of Individuals Served	(A) Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private/Other %	(E) None %	(F) Unknown %
Pregnant Women	503,788	46.9	0.0	50.3	2.6	0.0
Infants < 1 year old	469,920	99.7	0.0	0.0	0.3	0.0
Children 1 to 22 years old	1,550,401	98.5	0.0	0.0	1.5	0.0
Children with Special Healthcare Needs	242,601	72.5	12.8	14.7	0.0	0.0
Others	0	0.0	0.0	0.0	0.0	0.0
TOTAL	2,766,710					

Form Notes for Form 7

None

Field Level Notes

1. **Section Number:** Form7_Main
   Field Name: PregWomen_TS
   Row Name: Pregnant Women
   Column Name: Title V Total Served
   Year: 2015
   Field Note:
   Estimate of the number of pregnant women served is based on the number of live births. Source: State of California, Department of Public Health, 2012 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Both expected source of payment for delivery and prenatal care coverage were used to determine "Primary Source of Coverage" for pregnant women. A woman who had Medi-Cal coverage for either prenatal care or delivery was considered covered by Title XIX. Codes are as follows:(B) Title XIX=Medi-Cal (02), [and Medi-Cal CPS(13) for prenatal care variable]; (C) Title XXI=no codes used; (D) Private/Other= all payment source codes except those used in (B), (E), and (F); (E) None=Medically unattended / No prenatal care (00), Self pay (09), and
   (F) unknown=Unknown payment source (99). Some of the payment source codes used for (D) might include some persons for whom health coverage was actually "none" but could not be separated from "covered" persons within the pertinent codes.

   The number of pregnant women served is assumed to include an estimated 2,374 individuals in the Adolescent Family Life Program, 19,568 in the California Diabetes and Pregnancy Program (CDAPP) and 2,291 individuals in the Black Infant Health Program.
2. **Section Number:** Form7_Main
   Field Name: Children_0_1_TS
   Row Name: Infants <1 year of age
   Column Name: Title V Total Served
   Year: 2015
   Field Note:
   his is a placeholder - final value to be submitted at future time.
3. **Section Number:** Form7_Main
   Field Name: Children_1_22_TS
   Row Name: Children 1 to 22 years of age
   Column Name: Title V Total Served
   Year: 2015
   Field Note:
   his is a placeholder - final value to be submitted at future time.
4. **Section Number:** Form7_Main
   Field Name: CSHCN_TS
   Row Name: Children with Special Health Care Needs
   Column Name: Title V Total Served
   Year: 2015
   Field Note:
   This is the number of clients enrolled in CCS at any point during calendar year 2013. Source: CMS Net
5. **Section Number:** Form7_Main
   Field Name: AllOthers_TS
   Row Name: Others
   Column Name: Title V Total Served
   Year: 2015
   Field Note:
   his is a placeholder - final value to be submitted at future time.

FORM 8
Deliveries and Infants Served By Title V and Entitled to Benefits Under Title XIX
(By Race and Ethnicity)
[Sec. 506(a)(2)(C-D)]
State: CA

Reporting Year: 2012

I. UNDUPLICATED COUNT BY RACE

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than one race reported	(H) Other and Unknown
Deliveries								
Total Deliveries in State	503,788	361,767	27,250	2,427	68,954	2,129	17,571	23,690
Title V Served	503,788	361,767	27,250	2,427	68,954	2,129	17,571	23,690
Eligible for Title XIX	233,058	180,052	15,682	1,468	15,123	1,063	7,150	12,520
Infants								
Total Infants in State	503,788	361,767	27,250	2,427	68,954	2,129	17,571	23,690
Title V Served	503,788	361,767	27,250	2,427	68,954	2,129	17,571	23,690
Eligible for Title XIX	233,058	180,052	15,682	1,468	15,123	1,063	7,150	12,520

II. UNDUPLICATED COUNT BY ETHNICITY

				HISPANIC OR LATINO (Sub-categories by country or area of origin)				
	(A) Total NOT Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(B.1) Mexican	(B.2) Cuban	(B.3) Puerto Rican	(B.4) Central and South American	(B.5) Other and Unknown
Deliveries								
Total Deliveries in State	247,560	244,616	11,612	189,222	723	2,106	25,184	27,381
Title V Served	247,560	244,616	11,612	189,222	723	2,106	25,184	27,381
Eligible for Title XIX	68,427	160,747	3,884	125,792	219	822	16,445	17,469
Infants								
Total Infants in State	247,560	244,616	11,612	189,222	723	2,106	25,184	27,381
Title V Served	247,560	244,616	11,612	189,222	723	2,106	25,184	27,381
Eligible for Title XIX	68,427	160,747	3,884	125,792	219	822	16,445	17,469

Form Notes for Form 8

None

Field Level Notes

1. **Section Number:** Form8_I. Unduplicated Count By Race
   Field Name: DeliveriesTotal_All
   Row Name: Total Deliveries in State
   Column Name: Total All Races
   Year: 2015
   Field Note:
   For the number of Total deliveries, Title V deliveries, Total infants and Title V infants, the number of 2012 live births (by place o1 residence) was used as an estimate. For the number of "Deliveries Eligible for XIX" and "Infants Eligible for XIX" a subset of 2012 live births was used as an estimate (subset of all live births for which "expected source of payment for delivery"= Medi-Cal by place of residence). Race and Hispanic origin of mother were used for Section I and II respectively. Column D includes American Indian, Eskimo, and Aleutian. Column E includes Chinese, Japanese, Korean, Vietnamese, Cambodian, Thai, Laotian, Hmong, Asian Indian, Filipino, Asian-specified, and Asian-unspecified. Column F includes Hawaiian, Samoan, Guamanian, and other Pacific Islander.

   Data Source: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File. Data by race/ethnicity were analyzed using mother's multi-race code. Tabulations were done by the MCAH Program.

   The discrepancy between this number and Form 7, total infants served under one year of age, is likely due in part to some infants enrolled in the CHDP program being identified for services more than once due to having more than one client index number or the infant being identified for services with both the mother's client index number and its own client index number. It can take several months after birth to rectify these client index number issues.

   "Title V deliveries served" is assumed to include an estimated 2,374 served by the Adolescent Family Life Program. 19,568 in the California Diabetes and Pregnancy Program (CDAPP) and 1,751 served by the Black Infant Health Program.
2. **Section Number:** Form8_I. Unduplicated Count By Race
   Field Name: InfantsTotal_All
   Row Name: Total Infants in State
   Column Name: Total All Races
   Year: 2015
   Field Note:
   The discrepancy between this number and Form 7, total infants served under one year of age, is likely due in part to some infants enrolled in the CHDP program being identified for services more than once due to having more than one client index number or the infant being identified for services with both the mother's client index number and its own client index number. It can take several months after birth to rectify these client index number issues.
3. **Section Number:** Form8_II. Unduplicated Count by Ethnicity
   Field Name: DeliveriesTotal_TotalNotHispanic
   Row Name: Total Deliveries in State
   Column Name: Total Not Hispanic or Latino
   Year: 2015
   Field Note:
   For the number of Total deliveries, Title V deliveries, Total infants and Title V infants, the number of 2012 live births (by place of residence) was used as an estimate. For the number of "Deliveries Eligible for XIX" and "Infants Eligible for XIX" a subset of 2012 live births was used as an estimate (subset of all live births for which "expected source of payment for delivery"= Medi-Cal by place of residence). Race and Hispanic origin of mother were used for Section I and II respectively.

   Data Source: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File. Data by race/ethnicity were analyzed using mother's multi-race code. Tabulations were done by the MCAH Program.

   The discrepancy between this number and Form 7, total infants served under one year of age, is likely due in part to some infants enrolled in the CHDP program being identified for services more than once due to having more than one client index number or the infant being identified for services with both the mother's client index number and its own client index number. It can take several months after birth to rectify these client index number issues.

   "Title V deliveries served" is assumed to include an estimated 2,374 served by the Adolescent Family Life Program and 19,568 in the California Diabetes and Pregnancy Program (CDAPP).

Form 9
State MCH Toll-Free Telephone Line Data Form (Optional)
[Secs. 505(a)(E) and 509(a)(8)]
State: CA

	FY 2015	FY 2014	FY 2013	FY 2012	FY 2011
1. State MCH Toll-Free "Hotline" Telephone Number			1-800-639-0597	1-800-639-0597	1-800-639-0597
2. State MCH Toll-Free "Hotline" Name			Genetically Handicapped Persons Program (GHPP) Information Line	Genetically Handicapped Persons Program (GHPP) Information Line	Genetically Handicapped Persons Program (GHPP) Information Line
3. Name of Contact Person for State MCH "Hotline"			David Banda	Gloria Padre	Gloria Padre
4. Contact Person's Telephone Number			(916)327-1706	(916) 327-2376	(916) 327-2376
5. Contact Person's Email			V.David.Banda@dhcs.ca.gov	gloria.padre@dhcs.ca.gov	gloria.padre@dhcs.ca.gov
6. Number of calls received on the State MCH "Hotline" this reporting period	0	0	0	0	0

Form 9
State MCH Toll-Free Telephone Line Data Form
[Secs. 505(a)(E) and 509(a)(8)]
State: CA

	FY 2015	FY 2014	FY 2013	FY 2012	FY 2011
1. State MCH Toll-Free "Hotline" Telephone Number	1-866-241-0395	1-866-241-0395	1-866-241-0395	1-866-241-0395	1-866-241-0395
2. State MCH Toll-Free "Hotline" Name	MCAH Toll Free Information Line	MCAH Toll Free Information Line	MCAH Toll Free Information Line	MCAH Toll Free Information Line	MCAH Toll Free Information Line
3. Name of Contact Person for State MCH "Hotline"	Michele Naves	Michele Naves	Michele Naves	Michele Naves	Michele Naves
4. Contact Person's Telephone Number	916-650-0377	916-650-0377	916-650-0377	916-650-0377	916-650-0377
5. Contact Person's Email	Michele.Naves@cdph.ca.gov	Michele.Naves@cdph.ca.gov	Michele.naves@cdph.ca.gov	1. Contact Person's E-mail Michele.naves@cdph.ca.gov	michele.naves@cdph.
6. Number of calls received on the State MCH "Hotline" this reporting period	0	0	470	510	597

Form Notes for Form 9

None

Field Level Notes

1. **Section Number:** Form9_Main
   Field Name: calls_2
   Row Name: Number of calls received On the State MCH Hotline This reporting period
   Column Name: FY
   Year: 2013
   Field Note:
   Total number of calls received on the state MCAH hotline: 470 and includes calls to the state MCAH toll-free information line (866-241-0395; (July 1, 2012 to June 30, 2013. It does not include 66,482 calls received collectively by the 61 MCAH local health jurisdiction toll free numbers.

Form 10
Title V Maternal & Child Health Services Block Grant
State Profile for FY 2015
[Sec. 506(a)(1)]
State: CA

1. State MCH Administration:
(max 2500 characters)

Title V funds are administered by the MCAH Program and the Children's Medical Services (CMS) Branch in the State of California. The CMS Branch is part of the Department of Health Care Services. The MCAH Program is part of the Center for Family Health within the Department of Public Health. The Center for Family Health also includes the Women, Infants and Children (WIC) program, the Genetic Disease Screening Program, and the Office of Family Planning. The MCAH Program conducts statewide assessment of needs, develops policies, plans and programs to improve the health of women, infants, adolescents, and families in California utilizing the core public health functions. The CMS Branch is responsible for the Child Health and Disability Prevention Program (CHDP), California Children's Services (CCS), and the Genetically Handicapped Persons Program (GHPP). CCS is the Children with Special Health Care Needs (CSHCN) program.

Block Grant Funds	
2. Federal Allocation (Line 1, Form 2)	$ 37,731,581
3. Unobligated balance (Line 2, Form 2)	$ 0
4. State Funds (Line 3, Form 2)	$ 1,535,926,539
5. Local MCH Funds (Line 4, Form 2)	$ 0
6. Other Funds (Line 5, Form 2)	$ 0
7. Program Income (Line 6, Form 2)	$ 1,549,128,757
8. Total Federal-State Partnership (Line 8, Form 2)	$ 3,122,786,877

9. Most significant providers receiving MCH funds:

61 Local Health Dept. MCAH Programs

Public/private universities

Community-based organizations

CCS-approved providers

10. Individuals served by the Title V Program (Col. A, Form 7)

a. Pregnant Women	503,788
b. Infants < 1 year old	469,920
c. Children 1 to 22 years old	1,550,401
d. CSHCN	242,601
e. Others	0

11. Statewide Initiatives and Partnerships:

a. Direct Medical Care and Enabling Services:
(max 2500 characters)

>Adolescent Family Life Program (AFLP) AFLP uses a case management model to address the social, medical, educational, and economic consequences of adolescent pregnancy and parenting on the adolescent, her child, family, and society. >Black InfantHealth (BIH) BIH whose goal is reducing African American infant mortality in California, uses a group intervention and complementary case management to support African American maternal and interconception health and improve birth outcomes. >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.

b. Population-Based Services:
(max 2500 characters)

>Sudden Infant Death Syndrome (SIDS) Program SIDS is funded in all 61 LHJs to enable them to provide support to families that experience a SIDS death, conduct prevention activities, and enable staff to attend annual training. SIDS Program focuses on providing education about SIDS, grief counseling, and what can be done to reduce the risk of SIDS, like placing babies on their back to sleep. > California Birth Defects Monitoring Program (CBDMP) CBDMP maintains a birth defect registry and analyzes data to identify opportunities for preventing birth defects and improving the health of babies. Birth year information is linked to vital statistics data for 8 counties. >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, five hospitals were pending certification and 253 hospitals certified as Inpatient Infant Hearing Screening Providers.

c. Infrastructure Building Services:
(max 2500 characters)

>Local Health Department Maternal Child and Adolescent Health Program (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. >Breastfeeding Technical Assistance Program The Breastfeeding Program promotes and supports public health and health care efforts to make breastfeeding the normal method of infant feeding in California for at least the first year of life in order to provide proven benefits to the mother, infant, and society. >Neonatal Quality Improvement Initiative (NQI) Under the joint sponsorship of the California Department of Health Care Services, Systems of Care Division and the California Children's Hospital Association (CCHA), partnering with the California Perinatal Quality Care Collaborative (CPQCC), an initiative to reduce/eliminate catheter associated blood stream infections (CABSIs) in Regional Neonatal Intensive Care Units (NICUs) began in 2006-07. In 2011, the initiative continues with CMS partnering with CPQCC to reduce/eliminate all bloodstream infections in 14 Regional NICUs.

12. The primary Title V Program contact person:

Name	Addie Aguierre
Title	Acting Chief - Maternal, Child and Adolescent Health Divis
Address	1615 Capitol Avenue, MS 8304, PO Box 997420
City	Sacramento
State	CA
Zip	95899-7420
Phone	(916) 650-0300
Fax	(916) 650-0305
Email	Addie.Aguirre@cdph.ca.gov
Web	http://www.cdph.ca.gov/programs/MCAH/Pages/default.

13. The children with special health care needs (CSHCN) contact person:

Name	Louis R. Rico
Title	Chief, Systems of Care Division
Address	1515 K Street, Room 400, MS 8100, PO Box 997413
City	Sacramento
State	CA
Zip	95899-7413
Phone	(916) 449-5240
Fax	(916) 327-1106
Email	Louis.Rico@dhcs.ca.gov
Web	http://www.dhcs.ca.gov/services/Pages/CMS.aspx

Form Notes for Form 10

None

Field Level Notes

None

Form 11
Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]
State: CA

Form Level Notes for Form 11

None

Performance Measure # 01

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	574	561	663	602	
Denominator	574	561	663	602	
Data Source	Genetic Disease Screening Program	Genetic Disease Screening Program	Genetic Disease Screening Program	Genetic Disease Screening Program	Genetic Disease Screening Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	100	100	100	100	100
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #1
   Field Name: PM01
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A provisional indicator is reported for 2013.

2. **Section Number:** Form11_Performance Measure #1
   Field Name: PM01
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   NBS includes screening for the following conditions: Phenylketonuria (PKU), congenital hypothyroidism, galactosemia, sickle cell disease (Hb S/S, Hb S/+Thalassemia, and Hb S/B0 Thalassemia only), congenital adrenal hyperplasia, over 40 non-PKU inborn errors of metabolism tested by tandem mass spectrometry, cystic fibrosis, biotidinase deficiency, and severe combined immunodeficiency disorders (SCID).

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

3. **Section Number:** Form11_Performance Measure #1
   Field Name: PM01
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   NBS includes screening for the following conditions: Phenylketonuria (PKU), congenital hypothyroidism, galactosemia, sickle cell disease (Hb S/S, Hb

S/+Thalassemia, and Hb S/B0 Thalassemia only), congenital adrenal hyperplasia, over 40 non-PKU inborn errors of metabolism tested by tandem mass spectrometry, cystic fibrosis, biotidinase deficiency, , and pilot testing for severe combined immunodeficiency disorders (SCID).

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

Performance Measure # 02

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	47	47.5	48	48	48
Annual Indicator	46.6	46.6	61.8	61.8	61.8
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey	National Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	48	48	48	48	48
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

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

2. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

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

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

3. **Section Number:** Form11_Performance Measure #2
   Field Name: PM02
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same

questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

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

Performance Measure # 03

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	42.5	43	44	44	44
Annual Indicator	42.2	42.2	38.3	38.3	38.3
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	44	44	44	44	44
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM3. However, the same questions were used to generate the NPM3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

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

2. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM3. However, the same questions were used to generate the NPM3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

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

3. **Section Number:** Form11_Performance Measure #3
   Field Name: PM03
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM3. However, the same questions were used to generate the NPM3 indicator for both the 2005-2006 and 2009-2010,

therefore these two surveys are comparable.

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

Performance Measure # 04

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	60	60.3	61	61	61
Annual Indicator	59.6	59.6	59.1	59.1	59.1
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	61	61	61	61	61
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

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

2. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

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

3. **Section Number:** Form11_Performance Measure #4
   Field Name: PM04
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

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

Performance Measure # 05

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	86	86.5	87	87	87
Annual Indicator	85.3	85.3	64.8	64.8	64.8
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	87	87	87	87	87
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

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

2. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

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

3. **Section Number:** Form11_Performance Measure #5
   Field Name: PM05
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

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

Performance Measure # 06

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	37.5	38	39	39	39
Annual Indicator	37.1	37.1	37.4	37.4	37.4
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	39	39	39	39	39
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
   All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

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

3. **Section Number:** Form11_Performance Measure #6
   Field Name: PM06
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording

changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

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

Performance Measure # 07

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	79.4	79.9	82.1	82.1	82.1
Annual Indicator	75.8	76.5	81.7	73.5	73.5
Numerator	413,608	423,707	404,197	359,215	
Denominator	545,657	553,866	494,733	488,728	
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	82.1	82.1	82.1	82.1	82.1
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source of percent immunized: US, National Immunization Survey, Q1/2012-Q4/2012.

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

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

   .

3. **Section Number:** Form11_Performance Measure #7
   Field Name: PM07
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source of percent immunized: Estimated Vaccination Coverage with 4:3:1:3:3 Among Children 19-35 Months of Age by Race/Ethnicity‡ and by State and Local Area -- US, National Immunization Survey, Q1/2011-Q4/2011. Data requested from CDC.

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

percent of immunized children by the denominator.

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

Performance Measure # 08

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	19.4	19.1	17.4	17.4	17.4
Annual Indicator	17.5	15.2	14.8	13.1	13.1
Numerator	15,418	13,308	11,839	10,359	
Denominator	883,101	874,581	801,527	788,279	
Data Source	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	17.4	17.4	17.4	17.4	17.4
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Numerator: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File. Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.Tabulations were done by the MCAH Program..

   Data reported for 2012 should not be compared to data reported in 2010 due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 16.4.

3. **Section Number:** Form11_Performance Measure #8
   Field Name: PM08
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File. Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.Tabulations were done by the MCAH Program.

   Data reported for 2011 should not be compared to data reported in 2010 due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 16.4.

Performance Measure # 09

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	28.6	29.1	29	29	29
Annual Indicator	27.6	27.6	27.6	16.4	16.4
Numerator	126,908	127,505	129,101	146,702	
Denominator	459,813	461,974	467,758	893,580	
Data Source	Dental Health Foundation	Dental Health Foundation	Dental Health Foundation	CMS Form 415	CMS Form 415
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	26.3	26.3	26.3	26.3	26.3
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data Source: Center for Medicaid and CHIP Services. Early and Periodic Screening, Diagnostic, and Treatment, CMS Form 416, 2012 State Data. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT2012National.zip. Last accessed on March 12, 2014.

   Unlike in prior years, data for 2012 represents the percentage of Medi-Cal beneficiaries ages 6-9 who are eligible for EPSDT for 90 continuous days for FFY 2012, receiving a sealant on a permanent molar tooth. Thus, data reported for 2012 is not comparable to data reported in prior years.

3. **Section Number:** Form11_Performance Measure #9
   Field Name: PM09
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   A Data source for percent of third grade children with sealants: Dental Health Foundation, California Smile Survey, "Mommy It Hurts to Chew," February 2006. Accessed
   03/20/13.
   Denominator source: California Department of Education. Accessed 03/20/13 at http://dq.cde.ca.gov/dataquest/Enrollment/GradeEnr.aspx?cChoice=StEnrGrd&cYear=2011-12&cLevel=State&cTopic=Enrollment&myTimeFrame=S&cType=ALL&cGender=B
   *Based on weighted results from a completed survey of a representative sample of elementary schools in California conducted during 2004-05. Dental sealant information is based on one-minute, non-invasive oral health screening of all third graders in selected schools using protocols from the Association of State and Territorial Dental Directors at http://www.dentalhealthfoundation.org/index.php?option=com_content&task=view&id=43&Itemid=60. Accessed 02/21/12.

Performance Measure # 10

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	2.9	2.9	1.6	1.6	1.6
Annual Indicator	1.8	1.0	1.1	1.4	1.4
Numerator	148	84	85	105	
Denominator	8,184,071	8,199,138	7,568,037	7,554,127	
Data Source	CA Death Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	1.6	1.6	1.6	1.6	1.6
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Death Statistical Master File [The International Classification of Diseases (ICD)-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83- V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

   Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.Tabulations (by place of residence) were done by the MCAH Program.

   Data for 2011-2012 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010 using these updated population projections was 1.1.

3. **Section Number:** Form11_Performance Measure #10
   Field Name: PM10
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Death Statistical Master File [The International Classification of Diseases (ICD)-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

   Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.Tabulations (by place of residence) were done by the MCAH Program.

   Data for 2011 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010 using these updated population projections was 1.1.

Performance Measure # 11

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	72	65	64.2	64.2	64.2
Annual Indicator	62.3	59.5	63.7	64.9	64.9
Numerator	237,585	210,982	240,072	245,022	
Denominator	381,282	354,888	376,830	377,290	
Data Source	MIHA	MIHA	MIHA	MIHA	MIHA
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	64.2	64.2	64.2	64.2	64.2
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source: 2012 Maternal and Infant Health Assessment Survey (MIHA), MCAH Program, CA Department of Public Health.

   Numerator: The number of women who delivered a live birth and who reported that they were still breastfeeding their infant at 3 months of age. Denominator: The number of women who delivered a live birth that reported whether or not they were still breastfeeding at 3 months of age. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year and exclude mothers who could not answer the question because they responded to the survey before 3 months post-partum.

   2011 and 2012 data cannot be compared to data for prior years due to changes to the wording of the infant feeding questions. 2011 will serve as new baseline to track progress.

3. **Section Number:** Form11_Performance Measure #11
   Field Name: PM11
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Numerator: The number of women who delivered a live birth and who reported that they were still breastfeeding their infant at 3 months of age. Denominator: The number of women who delivered a live birth that reported whether or not they were still breastfeeding at 3 months of age. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year and exclude mothers who could not answer the question because they responded to the survey before 3 months post-partum.

   Note: 2011 data cannot be compared to data for prior years due to changes to the wording of the infant feeding questions. 2011 will serve as new baseline to track progress.

Performance Measure # 12

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	95	95	98	99	99
Annual Indicator	98.0	99.0	97.9	95.0	
Numerator	517,247	505,847	492,337	479,430	
Denominator	527,897	510,981	503,016	504,814	
Data Source	Office of Vital Records	Office of Vital Records	Office of Vital Records	Office of Vital Records birth cert data;NHSP data	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	99	99	99	99	
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   no data available at this time due to change in contractor.

2. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Hearing screening data are underreported for 2012 because there was a 4 month period with no Hearing Coordination Center contractor in Northern California. Aggregate and individual data from hospitals were not consistently collected during that time.

3. **Section Number:** Form11_Performance Measure #12
   Field Name: PM12
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Measure based on hospitals carrying out universal newborn hearing screening in California. This measure is the percent of newborns who have been screened for hearing before hospital discharge.

   Source: Numerator and denominator data are from the State of California, Department of Public Health, Office of Vital Records, birth certificate data.

   Numerator: Number of newborns who have been screened for hearing before discharge for FY 2011.
   Denominator: Number of live births by occurrence in California in FY 2011.

Performance Measure # 13

Percent of children without health insurance.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	13.1	12.9	10	10	10
Annual Indicator	11.2	11.2	11.3	10.2	10.2
Numerator	1,190,554	1,185,414	1,102,686	993,064	
Denominator	10,616,624	10,613,742	9,796,707	9,782,535	
Data Source	Current Population Survey	Current Population Survey	Current Population Survey	Current Population Survey	Current Population Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	10	10	10	10	10
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source: U.S. Census Bureau. 2013 Annual Social and Economic Supplement. Current Population Survey Table Creator. Available at: http://www.census.gov/cps/data/cpstablecreator.html. Last accessed on December 5, 2013. The numerator and denominator data were recalculated the California Department of Finance population projections for 2011 and prior years. The numerator and denominator data reported for 2012 is based on the U.S. Census Bureau projections weighted to the 2010 U.S. Census.

3. **Section Number:** Form11_Performance Measure #13
   Field Name: PM13
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: Numerator of uninsured children age 0-18 is from the Kaiser Family Foundation analysis of the March 2011 release of the Current Population Survey. Denominator (estimate of the number of children 18 years of age and younger): State of California, Department of Finance, Report P-3 Population Projections by Race/Ethnic, Detailed Age, and Gender, 2010-2060, Sacramento, CA, January 2013.

   The percent of uninsured children 0-18 years was calculated by dividing the numerator by the denominator. The percent uninsured is rounded to the fifth decimal point.

Performance Measure # 14

Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	33.5	33.5	31.4	31.4	31.4
Annual Indicator	32.9	33.4	32.7	32.7	32.7
Numerator	109,446	95,025	85,882		
Denominator	332,663	284,506	262,637		
Data Source	PedNSS	PedNSS	PedNSS	PedNSS	PedNSS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	31.4	31.4	31.4	31.4	31.4
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2011

2. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   A manual indicator is reported for 2012 based on 2011.

3. **Section Number:** Form11_Performance Measure #14
   Field Name: PM14
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data Source: CDC, Pediatric Nutrition Surveillance System (PedNSS) Annual Reports for CY 2011. Table 6D, 2011 Pediatric Nutrition Surveillance, National, Comparison of Growth and Anemia Indicators by Contributor, Children Aged < 5 years..

Performance Measure # 15

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	3.5	3.4	2.6	2.6	2.6
Annual Indicator	2.8	3.0	2.9	2.6	2.6
Numerator	14,417	14,824	14,269	12,748	
Denominator	519,623	498,106	489,359	491,659	
Data Source	MIHA	MIHA	MIHA	MIHA	MIHA
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	2.6	2.6	2.6	2.6	2.6
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source: 2012 MIHA survey, MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported any smoking in the third trimester of pregnancy. Denominator: The number of women who delivered a live birth and reported whether or not they had smoked during their third trimester of pregnancy.

   Numerator and denominator are weighted to the number of resident women in the state who delivered a live birth in 2012.

3. **Section Number:** Form11_Performance Measure #15
   Field Name: PM15
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: 2011 MIHA survey, MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported any smoking in the third trimester of pregnancy. Denominator: The number of women who delivered a live birth and reported whether or not they had smoked during their third trimester of pregnancy.

   Numerator and denominator are weighted to the number of resident women in the state who delivered a live birth in 2011.

Performance Measure # 16

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	4.6	4.6	4.1	4.1	4.1
Annual Indicator	4.7	4.9	5.8	4.6	4.6
Numerator	144	150	163	129	
Denominator	3,055,826	3,054,421	2,819,402	2,792,808	
Data Source	CA Deah Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	4.1	4.1	4.1	4.1	4.1
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   2012 California Death Statistical Master File (ICD-10 Death Codes X78,X72-X74,X70,X80,X60- X69,X71,X75-X77,X79,X81-X84,U030,U039). Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.. Tabulations (by place of residence) were done by the MCAH Program.

   Data reported for 2011-2012 should not be compared to data reported in previous years due to updates in the population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 5.3.

3. **Section Number:** Form11_Performance Measure #16
   Field Name: PM16
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   2011 California Death Statistical Master File (ICD-10 Death Codes X78,X72-X74,X70,X80,X60-X69,X71,X75-X77,X79,X81-X84,U030,U039). Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.. Tabulations (by place of residence) were done by the MCAH Program.

   Data reported for 2011 should not be compared to data reported in 2010 due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 5.3.

Performance Measure # 17

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	67.8	68.1	78.6	78.6	78.6
Annual Indicator	75.9	75.6	77.7	77.5	77.5
Numerator	4,618	4,379	4,437	4,350	
Denominator	6,083	5,790	5,714	5,615	
Data Source	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	78.6	78.6	78.6	78.6	78.6
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File and California Children Services (CCS), Approved Hospitals for NICUs as of December 2012.

   Tabulations by place of occurrence were done by the MCAH. Data exclude births with unknown birth weight or births weighing <227g or >8165g. MCAH included births at three birthing hospitals that share a hospital campus or building with a CCS-approved Children's Hospital that has an appropriate level NICU (i.e., the birthing hospital and children's hospital are administratively different hospitals, but are co-located in the same building or campus). Data for 2008-2012 should be not compared to data reported in previous years due to a change in exclusion criteria and methodology.

3. **Section Number:** Form11_Performance Measure #17
   Field Name: PM17
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File and California Children Services (CCS), Approved Hospitals for NICUs as of December 2011.

   Tabulations by place of occurrence were done by the MCAH. Data exclude births with unknown birth weight or births weighing <227g or >8165g. MCAH included births at three birthing hospitals that share a hospital campus or building with a CCS-approved Children's Hospital that has an appropriate level NICU (i.e., the birthing hospital and children's hospital are administratively different hospitals, but are co-located in the same building or campus). Data for 2008-2011 should be not compared to data reported in previous years due to a change in exclusion criteria and methodology.

Performance Measure # 18

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	87.1	87.3	86.8	86.8	86.8
Annual Indicator	82.9	83.5	83.5	83.8	83.8
Numerator	428,449	416,759	410,213	412,679	
Denominator	516,879	499,218	491,034	492,643	
Data Source	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	86.8	86.8	86.8	86.8	86.8
Annual Indicator					
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program.

   Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

3. **Section Number:** Form11_Performance Measure #18
   Field Name: PM18
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program.

   Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

Form 11
Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]
State: CA

Form Level Notes for Form 11

None

State Performance Measure # 1 - Reporting Year

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			0	30	40
Annual Indicator		0.0	0.0	0.0	0
Numerator		0	0	0	
Denominator		1	1	1	
Data Source		Pilot Programs Data, CMSNet	Pilot Programs Data, CMSNet	Pilot Programs	Pilot Programs
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	40	40	40	40	40
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   TBD

2. **Section Number:** Form11_State Performance Measure #1
   Field Name: SM1
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   This measure is the percent of children birth to 21 years enrolled in the CCS program who have all their health care provided by and coordinated by one health care system. This is a new measure from the 2010 Needs Assessment. The 1115 Federal Waiver CCS Pilot Programs will begin January 2012 so there will be no data for this measure until 2013 for calendar year 2012.

State Performance Measure # 3 - Reporting Year

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.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			0	50	50
Annual Indicator		0.0	0.0	0.0	0
Numerator		0	0	0	
Denominator		1	1	1	
Data Source		On-line Survey and CCS County programs	On-line Survey and CCS County programs	On-line Survey	On-line Survey
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	55	55	55	55	55

Annual Indicator
Numerator
Denominator

Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   TBD

2. **Section Number:** Form11_State Performance Measure #3
   Field Name: SM3
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Survey is currently being developed for children and families in the 1115 waiver by the UCLA Center for Health Policy Research. The CCS Pilot Evaluation Planning Committee, consisting of State and County CCS staff and family representatives, and the CCS Pilot Projects Stakeholder group, provide input into the survey. It is expected that survey will be expanded to representative sample of families with CCS eligible children who do not reside in county participating in 1115 waiver.

State Performance Measure # 4 - Reporting Year

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			12.7	12.7	12.7
Annual Indicator	13.4	15.0	13.1	13.9	13.9
Numerator	68,828	74,243	64,188	68,000	
Denominator	513,143	495,981	488,606	488,545	
Data Source	MIHA	MIHA	MIHA	MIHA	MIHA
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	12.7	12.7	12.7	12.7	12.7
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #4
   Field Name: SM4
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form11_State Performance Measure #4
   Field Name: SM4
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source: 2012 MIHA survey, MCAH Program, California Department of Public Health. Numerator: The number of women who reported that they had four or more drinks in one sitting at least once during the three months before they got pregnant with their most recent live-born infant. Denominator: The number of women who reported whether or not they had four or more drinks in one sitting at least once during the three months before they got pregnant with their most recent live-born infant plus the number of such women who reported drinking no alcoholic drinks in the past two years.

   Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth in 2012.

3. **Section Number:** Form11_State Performance Measure #4
   Field Name: SM4
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: 2011 MIHA survey, MCAH Program, California Department of Public Health. Numerator: The number of women who reported that they had four or more drinks in one sitting at least once during the three months before they got pregnant with their most recent live-born infant. Denominator: The number of women who reported whether or not they had four or more drinks in one sitting at least once during the three months before they got pregnant with their most recent live-born infant plus the number of such women who reported drinking no alcoholic drinks in the past two years.

   Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth in 2011. In 2011, a new methodology (raking or iterative proportional fitting) was implemented to calculate MIHA survey weights. However, data from prior years are still comparable to 2011.

State Performance Measure # 5 - Reporting Year

The percent of cesarean births among low-risk women giving birth for the first time.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			25.1	25.1	25.1
Annual Indicator	26.6	26.1	26.3	26.7	26.7
Numerator	42,603	40,713	40,777	42,429	
Denominator	160,307	156,112	155,169	159,030	
Data Source	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	25.1	25.1	25.1	25.1	25.1
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form11_State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source: State of California, Department of Public Health, 2012 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Numerator: The number of births delivered by cesarean section to low-risk women giving birth for the first time. Denominator: The number of live births to low-risk women giving birth for the first time. The numerator and denominator represent live births that occurred in California in 2012. Starting in 2010, births with gestational age greater than 37 weeks were excluded from the analysis. This new exclusion did not affect rates from prior years (2007-2009).Low-risk is defined as full-term (i.e., greater than or equal to 37 weeks gestation), singleton pregnancy, with vertex fetal presentation (head down in the uterus).

3. **Section Number:** Form11_State Performance Measure #5
   Field Name: SM5
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: 2011 Birth Statistical Master File, MCAH Program, California Department of Public Health. Numerator: The number of births delivered by cesarean section to low-risk women giving birth for the first time. Denominator: The number of live births to low-risk women giving birth for the first time. The numerator and denominator represent live births that occurred in California in 2011. Starting in 2010, births with gestational age greater than 37 weeks were excluded from the analysis. This new exclusion did not affect rates from prior years (2007-2009).
   Low-risk is defined as full-term (i.e., greater than or equal to 37 weeks gestation), singleton pregnancy, with vertex fetal presentation (head down in the uterus).

State Performance Measure # 6 - Reporting Year

The percent of women of reproductive age who are obese.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			21.7	21.7	21.7
Annual Indicator	21.8	20.9	21.3	21.6	
Numerator	1,299,520	1,205,673	1,316,522	1,138,418	
Denominator	5,954,750	5,764,922	6,181,065	5,258,411	
Data Source	Behavioral Risk Factor Survey	Behavioral Risk Factor Survey	Behavioral Risk Factor Survey	Behavioral Risk Factor Survey	
Is the Data Provisional or Final?				Final	

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	21.7	21.7	21.7	21.7	21.7
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source: 2012 California Behavioral Risk Factor Survey (BRFS), California Department of Public Health. Numerator: The number of women aged 18-44 years who have a body mass index (BMI) greater than or equal to 30 kilograms body weight / body surface area in square meters (kg/m2). Denominator: The number of women aged 18-44 years for whom BMI can be calculated. Results are weighted using 2010 population estimates from the California Department of Finance and exclude women who reported being pregnant at the time of the survey, and women with height < 48 in. or = 84 in., weight < 75 lbs. or > 399 lbs. or those for whom BMI cannot be calculated (i.e. missing height and/or weight information). Data for 2010 to 2012 should not be compared to data reported in previous years due to a change in conversion factor for weight in kilograms used to compute BMI. Obesity rates for prior years using the new conversion factor: 2008 =20.9; 2009 =19.7. Data for 2011 and 2012 should not be compared to data reported in previous years (including 2010) as these data are weighted using 2010 population estimates and previous years are weighted using 2000 population estimates.

3. **Section Number:** Form11_State Performance Measure #6
   Field Name: SM6
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: 2011 California Behavioral Risk Factor Survey (BRFS), California Department of Public Health. Numerator: The number of women aged 18-44 years who have a body mass index (BMI) greater than or equal to 30 kilograms body weight / body surface area in square meters (kg/m2). Denominator: The number of women aged 18-44 years for whom BMI can be calculated. Results are weighted using 2010 population estimates from the California Department of Finance and exclude women who reported being pregnant at the time of the survey, and women with height < 48 in. or = 84 in., weight < 75 lbs. or > 399 lbs. or those for whom BMI cannot be calculated (i.e. missing height and/or weight information). Data for 2010 and 2011 should not be compared to data reported in previous years due to a change in conversion factor for weight in kilograms used to compute BMI. Obesity rates for prior years using the new conversion factor: 2008 =20.9; 2009 =19.7. Data for 2011 should not be compared to data reported in previous years (including 2010) as 2011 data are weighted using 2010 population estimates and previous years are weighted using 2000 population estimates.

State Performance Measure # 7 - Reporting Year

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			11.7	11.7	11.7
Annual Indicator	12.9	12.3	12.3	12.0	12
Numerator	66,674	61,798	56,424	59,326	
Denominator	518,167	501,837	459,010	495,781	
Data Source	CA Birth Statiscial Master File	CA Birth Statiscial Master File	CA Birth Statiscial Master File	CA Birth Statiscial Master File	A Birth Statiscial Master File
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	11.7	11.7	11.7	11.7	11.7
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Women with birth intervals less than five months were excluded from the analysis.

3. **Section Number:** Form11_State Performance Measure #7
   Field Name: SM7
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Women with birth intervals less than five months were excluded from the analysis

State Performance Measure # 8 - Reporting Year

The percent of public school students in 9th grade reporting a high level of school connectedness.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			43	43	43
Annual Indicator	42.0	43.2	44.3	44.8	
Numerator	102,319	105,767	107,535	216,732	
Denominator	243,896	244,863	242,857	483,466	
Data Source	CA Healthy Kids Survey	CA Healthy Kids Survey	CA Healthy Kids Survey	CA Student Survey	CA Student Survey
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	43	43	43	43	43
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #8
   Field Name: SM8
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form11_State Performance Measure #8
   Field Name: SM8
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source: California Student Survey (CSS), 2011-2013. Unpublished data provided by WestEd on June 19, 2014. CSS data are collected by WestEd on behalf of the California Department of Education using a two year data collection cycle to provide representative data for students enrolled in California public schools. Data from the California Healthy Kids Survey (CHKS) are no longer available; no statewide School Connectedness data are available for the 2010-2012 period. Due to differences in sampling, data from CSS are not comparable to data reported for prior years from CHKS.

3. **Section Number:** Form11_State Performance Measure #8
   Field Name: SM8
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: California Healthy Kids Survey (CHKS), 2009-11. Unpublished data provided by WestEd on May 16, 2013. CHKS data are collected by WestEd on behalf of the California Department of Education using a two year data collection cycle to provide representative data for students enrolled in California public schools.

State Performance Measure # 9 - Reporting Year

Low-income infant mortality rate.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective			.	5.4	5.4
Annual Indicator	5.5	5.4	5.4	5.4	5.4
Numerator	1,358	1,338	1,284		
Denominator	248,705	246,234	238,562		
Data Source	Birth-Death Cohort file	Birth-Death Cohort file	Birth-Death Cohort file	Birth-Death Cohort file	Birth-Death Cohort file
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	5.4	5.4	5.4	5.4	5.4
Annual Indicator	Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2011.

2. **Section Number:** Form11_State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   A manual indicator is reported for 2012 based on 2011.

3. **Section Number:** Form11_State Performance Measure #9
   Field Name: SM9
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2011 Linked Birth – Death Cohort File

   Numerator: Infant deaths where the source of payment for prenatal care or delivery is indicated as Medi-Cal.

   Denominator: Live births to California state residents where the source of payment for prenatal care or delivery is indicated as Medi-Cal.

State Performance Measure # 10 - Reporting Year

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

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective				90	90
Annual Indicator			84.0	62.9	62.9
Numerator			206,827	132,974	
Denominator			246,301	211,538	
Data Source			CMS Net	CMS Net	CMS Net
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	90	90	90	90	90

Annual Indicator
Numerator
Denominator

Future year objectives for state performance measures from needs assessment period 2006-2010 are view-only. If you are continuing any of these measures in the new needs assessment period, you may establish objectives for those measures on Form 11 for the new needs assessment period.

Field Level Notes

1. **Section Number:** Form11_State Performance Measure #10
   Field Name: SM10
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   TBD

2. **Section Number:** Form11_State Performance Measure #10
   Field Name: SM10
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   This new performance measure is the percent of CCS clients with a designated primary care physician or subspecialist physician who provides a medical home.

   The numerator is the number of CCS clients with a designated medical home, as indicated by the County CCS Office.
   The denominator is the unduplicated number of CCS clients during state fiscal year 2010-11 who were entered into CMS Net, the CCS reporting system.

Form 12
Tracking Health Outcome Measures
[Secs 505 (a)(2)(B)(iii) and 506 (a)(2)(A)(iii)]
State: CA

Form Level Notes for Form 12

None

Outcome Measure # 01

The infant mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	5	5.2	4.8	4.8	4.8
Annual Indicator	4.9	4.7	4.8	4.5	4.5
Numerator	2,593	2,419	2,397	2,247	
Denominator	526,774	509,979	502,023	503,788	
Data Source	CA Birth and Death Statistical Master Files	CA Birth and Death Statistical Master Files	CA Birth and Death Statistical Master Files	CA Birth and Death Statistical Master Files	CA Birth and Death Statistical Master Files
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	4.8	4.8	4.8	4.8	4.8
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2012 California Death Statistical Master File.

   Denominator: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program

3. **Section Number:** Form12_Outcome Measure 1
   Field Name: OM01
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Death Statistical Master File.

   Denominator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program.

Outcome Measure # 02

The ratio of the black infant mortality rate to the white infant mortality rate.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	2.4	2.4	2.2	2.2	2.2
Annual Indicator	2.6	2.3	2.6	2.6	2.6
Numerator	10.6	9.5	10.5	9.8	
Denominator	4.1	4.1	4.1	3.8	
Data Source	CA Birth and Death Statistical Master Files	CA Birth and Death Statistical Master Files	CA Birth and Death Statistical Master Files, 2011	CA Birth and Death Statistical Master Files	CA Birth and Death Statistical Master Files
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	2.2	2.2	2.2	2.2	2.2
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2012 California Death Statistical Master File.
   Denominator: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program.

3. **Section Number:** Form12_Outcome Measure 2
   Field Name: OM02
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Death Statistical Master File.

   Denominator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program.

Outcome Measure # 03

The neonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	3.4	3.5	3.2	3.2	3.2
Annual Indicator	3.3	3.3	3.4	3.1	3.1
Numerator	1,755	1,685	1,692	1,575	
Denominator	526,774	509,979	502,023	503,788	
Data Source	CA Birth and Death Statistical Master Files	CA Birth and Death Statistical Master Files, 2010	CA Birth and Death Statistical Master Files, 2011	CA Birth and Death Statistical Master Files, 2012	CA Birth and Death Statistical Master Files
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	3.2	3.2	3.2	3.2	3.2
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2012 California Death Statistical Master File.

   Denominator: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program.

3. **Section Number:** Form12_Outcome Measure 3
   Field Name: OM03
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Death Statistical Master File.

   Denominator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program.

Outcome Measure # 04

The postneonatal mortality rate per 1,000 live births.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	1.6	1.7	1.6	1.6	1.6
Annual Indicator	1.6	1.4	1.4	1.3	
Numerator	838	734	705	672	
Denominator	526,774	509,979	502,023	503,788	
Data Source	CA Birth and Death Statistical Master Files	CA Birth and Death Statistical Master Files	CA Birth and Death Statistical Master Files, 2011	CA Birth and Death Statistical Master Files	CA Birth and Death Statistical Master Files
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	1.6	1.6	1.6	1.6	1.6
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2012 California Death Statistical Master File.

   Denominator: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program.

3. **Section Number:** Form12_Outcome Measure 4
   Field Name: OM04
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Death Statistical Master File.

   Denominator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program.

Outcome Measure # 05

The perinatal mortality rate per 1,000 live births plus fetal deaths.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	5.3	5.3	5.1	5.1	5.1
Annual Indicator	5.1	5.1	5.3	5.3	5.3
Numerator	2,711	2,617	2,644		
Denominator	528,056	511,226	503,321		
Data Source	Office of Vital Statistics	CA Birth, Death, and Fetal Death Statistical Maste	CA Birth, Death, and Fetal Death Statistical Maste	CA Birth, Death, and Fetal Death Statistical Maste	CA Birth, Death, and Fetal Death Statistical Maste
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Provisional	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	5.1	5.1	5.1	5.1	5.1
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2011

2. **Section Number:** Form12_Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   A manual indicator is reported for 2012 based on 2011.

3. **Section Number:** Form12_Outcome Measure 5
   Field Name: OM05
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, California Birth Statistical Master File for 2011, Fetal Death Statistical Master File for 2011 and Death Statistical Master File for 2011. Tabulations (by place of residence) were done by the MCAH Program.

   Denominator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File and 2011 California Fetal Death Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program.

Outcome Measure # 06

The child death rate per 100,000 children aged 1 through 14.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	17	16.8	13.5	13.5	13.5
Annual Indicator	14.4	12.9	13.6	12.9	
Numerator	1,095	982	963	904	
Denominator	7,623,985	7,630,429	7,061,481	7,033,680	
Data Source	CA Death Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	13.5	13.5	13.5	13.5	13.5
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form12_Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2012. California Death Statistical Master File by place of residence.
   Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations were done by the MCAH Program.

   Data reported for 2011-2012 should not be compared to data reported in previous years due to updates in the population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 13.8.

3. **Section Number:** Form12_Outcome Measure 6
   Field Name: OM06
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011. California Death Statistical Master File by place of residence.

   Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations were done by the MCAH Program.

   Data reported for 2011 should not be compared to data reported in 2010 due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 13.8.

Form 12
Tracking Health Outcome Measures
[Secs 505 (a)(2)(B)(iii) and 506 (a)(2)(A)(iii)]
State: CA

Form Level Notes for Form 12

None

State Outcome Measure # 1 - Reporting Year

The pregnancy-related mortality rate per 100,000 live births.

Annual Objective and Performance Data

	2009	2010	2011	2012	2013
Annual Performance Objective	12.4	12.1	15.4	15.4	15.4
Annual Indicator	18.0	15.7	16.9	15.5	15.5
Numerator	95	80	85	78	
Denominator	526,774	509,979	502,023	503,788	
Data Source	CA Birth and Death Statistical Master Files	CA Birth and Death Statistical Master Files	CA Birth and Death Statistical Master Files	CA Birth and Death Statistical Master Files	CA Birth and Death Statistical Master Files
Is the Data Provisional or Final?				Final	Provisional

Annual Objective and Performance Data

	2014	2015	2016	2017	2018
Annual Performance Objective	15.4	15.4	15.4	15.4	15.4
Annual Indicator	Please fill in only the Objectives for the above years. Numerator, Denominator and Annual Indicators are not required for future year data.				
Numerator					
Denominator					

Field Level Notes

1. **Section Number:** Form12_State Outcome Measure 1
   Field Name: SO1
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form12_State Outcome Measure 1
   Field Name: SO1
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2012 California Death Statistical Master File (ICD-10 Group Cause of Death Codes 261-273). NOTE: Deaths coded as O97 (deaths greater than 365 days) are excluded from the numerator. Denominator: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File.

3. **Section Number:** Form12_State Outcome Measure 1
   Field Name: SO1
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Death Statistical Master File (ICD-10 Group Cause of Death Codes 261-273). NOTE: Deaths coded as O97 (deaths greater than 365 days) are now excluded from the numerator. Denominator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File.

Form 13
Characteristics Documenting Family Participation in CSHCN Programs
State: CA

1. Family members participate on advisory committee or task forces and are offering training, mentoring, and reimbursement, when appropriate.

1

2. Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.

1

3. Family members are involved in the Children with Special Health Care Needs elements of the MCH Block Grant Application process.

1

4. Family members are involved in service training of CSHCN staff and providers.

1

5. Family members hired as paid staff or consultants to the State CSHCN program (a family member is hired for his or her expertise as a family member).

1

6. Family members of diverse cultures are involved in all of the above activities.

1

Total Score: 6

Rating Key
0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

Form Notes for Form 13

None

Field Level Notes

None

Form 14
List of MCH Priority Needs

[Sec. 505(a)(5)]

State: CA FY: 2015

Your State's 5-year Needs Assessment should identify the need for preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children and services for Children with Special Health Care Needs. With each year's Block Grant application, provide a list (whether or not the priority needs change) of the top maternal and child health needs in your state. Using simple sentence or phrase ,list below your State's needs. Examples of such statements are: "To reduce the barriers to the delivery of care for pregnant women, " and "The infant mortality rate for minorities should be reduced."

MCHB will capture annually every State's top 7 to 10 priority needs in an information system for comparison, tracking, and reporting purposes; you must list at least 7 and no more than 10. Note that the numbers listed below are for computer tracking only and are not meant to indicate priority order. If your State wishes to report more than 10 priority needs, list additional priority needs in a note at the form level.

1. Modify the CCS program, with appropriate funding, to cover the whole child.
2. Expand the number of qualified providers of all types in the CCS program.
3. CCS will work with appropriate partners to define and create and implement standards for Medical Homes for CCS children.
4. Improve maternal health by optimizing the health and well-being of girls and women across the life course.
5. Promote healthy nutrition and physical activity among MCAH populations throughout the lifespan beginning with exclusive breastfeeding of infants to six months of age.
6. Reduce maternal morbidity and mortality and the increasing disparity in maternal health outcomes.
7. Reduce infant mortality and address disparities by promoting preconception health and health care and by preventing causes such as birth defects, low birth weight/prematurity, SIDS, and maternal complications in pregnancy.
8. Support the physical, socio-emotional, and cognitive development of children, including the prevention of injuries, through the implementation of prevention, early identification and intervention strategies.
9. Promote positive youth development strategies to support the physical, mental, sexual and reproductive health of adolescents.
10. Link the MCAH population to needed medical, mental, social, dental, and community services to promote equity in access to quality services.

Form Notes for Form 14

None

Field Level Notes

None

Form 15
Technical Assistance(TA) Request

STATE: CA

APPLICATION YEAR: 2015

No.	Category of Technical Assistance Requested	Description of Technical Assistance Requested *(max 250 characters)*	Reason(s) Why Assistance Is Needed *(max 250 characters)*	What State, Organization or Individual Would You suggest Provide the TA (if known) *(max 250 characters)*
1.	**General Systems Capacity Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: N/A	MCAH requests assistance in identifying effective processes of engaging stakeholders to provide input and establish clearly defined measures for public input reporting and evaluation	This will provide California with the ability to learn from past collective grantees' experience, understand the effectiveness of engagement and identify what approaches work best.	unknown
2.	**General Systems Capacity Issues** If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here: N/A	SCD requests technical assistance for an onsite consultant to guide the California Children's Services Title V workgroup in the steps to develop and implement/ administer this family survey	To improve our capacity to collect feedback from the families of children we serve	unknown
3.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
4.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
5.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
6.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
7.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
8.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
9.	If you selected State or National			

	Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
10.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
11.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			
12.	If you selected State or National Performance Measure Issue categories above, identify the performance measure to which this issue pertains by entering the measure number here:			

Form Notes for Form 15

None

Field Level Notes

None

Form 16
State Performance and Outcome Measure Detail Sheet
State: CA

SP() # 1

Performance Measure:	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
Status:	Active
Goal	To pilot models of care whereby children enrolled in the CCS program have all their health care provided by and coordinated by one health care system and to increase over time the number of children enrolled in these pilot programs.
Definition	. **Numerator:** Number of children birth to 21 years enrolled in the CCS program who are also enrolled in a specified pilot program **Denominator:** Number of children birth to 21 years enrolled in the CCS program with open cases **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	
Data Sources and Data Issues	Numerator: Data provided by the specified pilot programs Denominator: CMSNet data Issue: Pilot programs are not scheduled to begin until January 2012
Significance	The CCS-carve out, where coverage for CCS-related conditions is provided separately from a child or youth's other medical care needs, has been identified by an array of stakeholders including families, CCS county staff, providers, and DHCS and Healthy Families Program staff, as a barrier to effective coordination of care and possible detractor from children's and youths' health outcomes. The stakeholder process for the Title V 2010 Needs Assessment identified "modify the CCS program, with appropriate funding, to cover the whole child" as the highest priority objective. The pilot programs planned to begin January 2012 will be service models whereby all the health care for the CCS enrolled child is provided by one health care system, thus eliminating fragmentation of care for these children with chronic physically handicapping medical conditions.

SP() # 3

Performance Measure:	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.
Status:	Active
Goal	To initiate an annual CCS family satisfaction survey and increase the number of families completing the survey on their satisfaction with the program and the services received, including their assessment of their participation in decision making and linkages to support.
Definition	. **Numerator:** Number of families randomly selected by region who complete a satisfaction survey **Denominator:** Number of families randomly selected by region to complete a satisfaction survey **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	
Data Sources and Data Issues	Numerator: Data from an On-line Survey Denominator: Data from designated CCS County programs regarding number of families contacted to complete a survey Issue: Families will need access to a computer
Significance	The Title V 2010 Needs Assessment CCS stakeholder group identified several priority objectives whereby successful implementation can be assessed through a family satisfaction survey. These include: define and implement medical homes; increase family partnership in decision making and satisfaction with services; link families to information and support; and conduct regular assessments of the level of parent/patient satisfaction as part of CCS outcomes. The CCS program cannot directly measure whether children enrolled in CCS are receiving their primary care in a medical home. However, through a family satisfaction survey, CCS can assess through specific questions whether children are receiving care in a medical home. This measure allows the CCS program to evaluate family satisfaction as changes are made to the CCS program over the next 5 years.

SP() # 4

Performance Measure:	The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.
Status:	Active
Goal	To reduce the prevalence of fetal exposure to binge drinking.
Definition	The percent of women with a recent live birth reporting they had 4 or more drinks in one sitting at least once during the three months before they got pregnant with their most recent live-born infant, based on the following questions: (A) "The next questions are about drinking alcohol. By 'alcohol' we mean any kind of drink with alcohol in it. A drink is one glass of wine, one wine cooler, one can or bottle of beer, one shot of liquor, or one mixed drink. Have you had any alcoholic drinks in the past 2 years?" (B) "The next two questions are about drinking 4 or more alcoholic drinks in one sitting. By one sitting, we mean within about 2 hours. During the 3 months before you got pregnant, how many times did you drink 4 or more alcoholic drinks in one sitting?" (Response categories for these questions are not shown). **Numerator:** Number of women with a recent live birth who reported that they had 4 or more drinks in one sitting at least once during the 3 months before they got pregnant with their most recent live-born infant. **Denominator:** Number of women with a recent live birth for whom binge drinking could be determined. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	No specific HP 2010 Objective Closely related to HP 2010 Objective 16-17b: Increase abstinence from alcohol, tobacco, and illicit drug use among pregnant women. No specific HP 2020 Objective Closely related to HP2020 Objective MICH–16:4: Increase the proportion of women delivering a live birth who practiced key recommended preconception health behaviors: Did not drink alcohol prior to pregnancy.
Data Sources and Data Issues	Source: Maternal and Infant Health Assessment (MIHA), California Department of Public Health, Maternal, Child and Adolescent Health Program. Issues: Alcohol use is based on self-report. Women who did not respond to questions about alcohol use in the two prior years or binge drinking in the three months before they became pregnant with their most recent live-born infant are excluded from the analysis. Survey data are weighted to the representative number of resident California women who delivered a live birth in a given year.
Significance	Preconception drinking is predictive of alcohol use during the prenatal period, particularly for almost half of all women with an unplanned pregnancy annually. This is partly due to an unlikely change in drinking behavior before pregnancy is recognized, which may be several weeks after conception. Alcohol use during pregnancy increases the risk of miscarriage, stillbirth, prematurity and birth defects. Fetal Alcohol Spectrum Disorders (FASD) is the continuum of mild to severe birth defects that affect the brain, face, heart and other organs. Importantly, the learning, emotional and behavioral problems associated with FASD last into adulthood. The most severe alcohol-related defects have been linked to frequent and heavy drinking (i.e., binge drinking) during early pregnancy, when women are less likely to know they are pregnant, and therefore may not have changed their drinking behavior. All alcohol-related birth defects and disabilities are preventable, and no safe level of alcohol consumption during pregnancy has been established. To reduce the detrimental effects of alcohol use during pregnancy, the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend that women who are pregnant or planning a pregnancy drink no alcohol at all. CDC recommends that women who can become pregnant but are not using effective contraception, even if they are not planning a pregnancy, also abstain from alcohol consumption.

SP() # 5

Performance Measure:	The percent of cesarean births among low-risk women giving birth for the first time.
Status:	Active
Goal	To reduce non-medically indicated cesarean births.
Definition	Low-risk is defined as full-term (reater than or equal to 37 weeks gestation), singleton pregnancy, with vertex fetal presentation (head down in the uterus). **Numerator:** Number of births delivered by cesarean section to low-risk women giving birth for the first time. **Denominator:** Number of live births to low-risk women giving birth for the first time. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	HP 2010 Objective 16-9a Reduce cesarean births among low-risk women giving birth for the first time. HP 2020 Objective MICH 7.1 Reduce cesarean births among low-risk women giving birth for the first time
Data Sources and Data Issues	Source: Both numerator and denominator will be calculated using the California Birth Statistical Master file. Issues: Women for whom delivery method, gestational age, plurality and presentation cannot be determined will be excluded from the analysis.
Significance	The cesarean section rate in the United States reached 32% in 2007, the country's highest rate ever reported. In California, the rate has increased each year since 1998, reaching an all-time high in 2009 when fully 33% of all births were delivered by cesarean section. The rising trend in cesarean sections in California has been seen across all age and race/ethnic groups. Although cesarean delivery greatly improves labor and delivery outcomes when clinically indicated, high cesarean delivery rates have raised questions about the health and economic consequences of this practice. Cesarean delivery poses increased risk of maternal and perinatal morbidity, longer lengths of stay, and higher total hospital charges when compared to vaginal deliveries. Cesarean delivery with one pregnancy, increases the risk of placental uterine implantation and its associated complications for subsequent pregnancies Cesarean delivery among women giving birth for the first time also increases the likelihood of repeat cesarean delivery for subsequent pregnancies.

SP() # 6

Performance Measure:	The percent of women of reproductive age who are obese.
Status:	Active
Goal	Reduce the proportion of women of reproductive age who are obese.
Definition	Obesity is defined as a body mass index (BMI) equal to or greater than 30. BMI is calculated from self-reported weight and height by dividing the weight in kilograms by height in meters squared (kg/m2). **Numerator:** Women aged 18-44 years who have a BMI greater than or equal to 30 kg/m2. **Denominator:** Women aged 18-44 years for whom BMI can be calculated. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	No specific HP 2010 objective. Related to HP 2010 Objective 19-2: reduce the proportion of adults who are obese. Increase the proportion of women delivering a live birth who had a healthy weight prior to pregnancy. No specific HP 2020 objective. Related to HP 2020 Objective MICH 16.5: Increase the proportion of women delivering a live birth who had a healthy weight prior to pregnancy.
Data Sources and Data Issues	Source: Behavioral Risk Factor Surveillance Survey (BRFSS) Issues: Analysis limited to women of reproductive age (ages 18-44), who are not pregnant at time of the survey. Excludes women with height < 48 in. or = 84 in., women with weight < 75 lbs. or > 399 lbs or those for whom BMI cannot be calculated (missing height and/or weight information).
Significance	Obesity is the highest risk weight category. When compared to overweight, obesity is associated with more negative health outcomes for reproductive aged women, pregnant women and infants. Among women of reproductive age, obesity contributes to health conditions including asthma, metabolic syndrome, , type II diabetes, hypertension, heart disease, stroke, cancer, and infertility.1-4 Obesity during pregnancy is associated with unfavorable perinatal health outcomes, including neural tube defects, labor and delivery complications, fetal and neonatal death. Maternal complications of obesity include gestational diabetes and preeclampsia.5-9 Children of obese mothers are also more likely to be obese and develop diabetes later in life. In addition to the health outcomes for California's population, obesity has great financial impact on California's economy. The cost of adult overweight, obesity and physical inactivity was estimated at $41 billion a year in 2006. For reproductive aged women who plan to become pregnant, obesity is of particular concern, because weight loss during pregnancy is not recommended. Thus, the reduction of obesity for reproductive aged women benefits women directly and improves future pregnancy outcomes for women and their infants. Obesity reduction among the large percentage of reproductive aged women who are or will become mothers will have lasting effects on the health of their children.

SP() # 7

Performance Measure:	The percent of women whose live birth occurred less than 24 months after a prior birth
Status:	Active
Goal	To encourage women to space their pregnancies at intervals of lower risk for adverse perinatal outcomes.
Definition	. **Numerator:** Number of women with a live birth in the current year that occurred within 24 months of a previous live birth. **Denominator:** Number of women with a live birth in the current year. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	HP 2010 Objective 9.2 Reduce the proportion of births occurring within 24 months of a previous birth. Related to HP 2020 FP 5 Reduce the proportion of pregnancies conceived within 18 months of a previous birth.
Data Sources and Data Issues	Source: Birth Statistical Master file Issues: Women with birth intervals of less than five months are excluded from the analysis.
Significance	A pregnancy interval (the time between a live birth and subsequent conception) of less than six months is an independent risk factor for preterm birth, congenital malformations, and neonatal death unrelated to congenital abnormality. There is also robust evidence that interpregnancy intervals less than 18 months are associated with increased risk of poor maternal outcomes including preeclampsia and premature rupture of membranes as well as increased risk of poor perinatal outcomes when compared to longer intervals. Given the methodologic difficulty of obtaining population-based measures of conception, monitoring birth intervals (the time elapsed between an index pregnancy and the previous pregnancy) provides the most reliable estimate of pregnancy spacing. Birth intervals of at least 24 months allow for adequate interconception time to address existing physical and social risk factors and to encourage protective factors that promote maternal and infant health and reduce the risk of morbidities and mortality in the subsequent pregnancy.

SP() # 8

Performance Measure:	The percent of public school students in 9th grade reporting a high level of school connectedness.
Status:	Active
Goal	To promote the belief among students that peers and adults in their school care about them and their learning, a key protective factor that promotes positive youth development.
Definition	School connectedness is defined using a five question scale: How strongly do you agree or disagree with the following statements about your school (1) I feel close to people at this school; (2) I am happy to be at this school; (3) I feel like I am part of this school; (4) The teachers at this school treat students fairly (5) I feel safe in my school. Response options are: (1) strongly disagree, (2) disagree, (3) neither disagree nor agree, (4) agree, and (5) strongly agree. Mean school connectedness scale (SCS) scores range from 1 to 5. A high level of school connectedness is defined as a score of 3.75 or higher. **Numerator:** The number of 9th grade students enrolled in California public schools with a mean score of 3.75 or higher on the SCS. **Denominator:** Total number of California 9th grade students enrolled in public school with responses to the SCS. **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	There are no corresponding Healthy People 2010, nor Healthy People 2020 objectives for this measure. .
Data Sources and Data Issues	Source: California Healthy Kids Survey Issues: Data are available bi-annually based on the two-year survey administration schedule. In some districts, survey administration requires active parental consent, which may bias results. Respondents who answered less than four school connectedness scale questions, had insufficient response to the overall survey, or greatly exaggerated substance use reports are excluded from analysis. The CHKS survey is representative of 9th grade students enrolled in California public schools; therefore excludes adolescents who are not enrolled in school.
Significance	School-connectedness is the belief by students that adults and peers in the school care about their learning and them as individuals. It is a widely used construct for youth development, and is the focus of the Centers for Disease Control and Prevention effort to improve youth protective factors. Protective factors reduce the impact of stressors, increase the ability to avoid risks or hazards, and promote social and emotional competence for healthy development into the future. Compared to other important protective factors, such as parent-family connectedness and high academic expectations, school connectedness has been found to be the strongest protector for both boys and girls against substance use, school absenteeism, early sexual initiation, violence, and risk of unintentional injury (i.e., drinking and driving or not wearing a seatbelt). Higher school connectedness has been linked to improved academic achievement, including better grades and staying in school longer. Academic achievement is in turn an important protective factor; youth with higher grades are less likely to carry a weapon, drink alcohol, smoke cigarettes, or have sex. Educational outcomes, such as high school completion, are also linked to improved health status across the life course. Educational outcomes may also impact health outcomes in future generations because infant and child health outcomes are linked to parental education.

SP() # 9

Performance Measure:	Low-income infant mortality rate.
Status:	Active
Goal	To reduce infant mortality among low-income women.
Definition	The term "low-income individual", for purposes of this performance measure refers to an individual whose family's taxable income for the preceding year did not exceed 200 percent of the federal poverty level . Infant is defined as a live birth and under one year of age. **Numerator:** Infant deaths where the source of payment for prenatal care or delivery is indicated as Medi-Cal. **Denominator:** Live births to California state residents where the source of payment for prenatal care or delivery is indicated as Medi-Cal. **Units:** 1000 **Text:** Rate
Healthy People 2020 Objective	Addresses HP2020 Objective MICH HP2020–15: Reduce fetal and infant deaths, especially: 1.2. Fetal and infant deaths during perinatal period (28 weeks of gestation to 7 days after birth); 1.3 All infant deaths (within 1 year); 1.4 Neonatal deaths (within the first 28 days of life); 1.5 Postneonatal deaths (between 28 days and 1 year). Related to HP 2020 objective AHS-1, Increase the proportion of persons with health insurance. .
Data Sources and Data Issues	Linked Birth-Death Cohort file, California Department of Public Health. The U.S. Census identifies individuals as "low-income" if they had a family's taxable income did not exceed 150% FPL. Since family income is not reported in the linked birth-death cohort file, eligibility for MediCal was used as a proxy to define the low-income. To qualify for Medi-Cal,the ifamily's taxable income should not exceed 200% FPL. Live births and infant deaths are excluded from the denominator and numerator if prenatal care payer and delivery payer are coded as unknown. In rare instances of dual coverage (e.g., payer source is non-Medi-Cal for prenatal care services and Medi-Cal for delivery services or vice-versa), these live births are classified as having Medi-Cal as payer source. The Linked Birth-Death Cohort file is currently made available with an approximate two- to three- year lag.
Significance	Almost half of deliveries of live births in California are paid by Medi-Cal. Qualification for Medi-Cal can serve as a proxy for low income status. Social determinants influence birth outcomes and income is one dimension in the social determinants framework where infant mortality rate disparities persist. Complex relationships exist between income status,access to health care, and various other risk factors for poor birth outcomes.

SP() # 10

Performance Measure:	The percent of CCS clients who have a designated primary care physician and/or a specialist physician who provides a medical home,
Status:	Active
Goal	To increase the number of medical homes in the CCS program through tracking the number of reported medical homes and types of medical homes, over time.
Definition	. **Numerator:** Number of children in the CCS county program with a primary care physician and/or a physician that provides a medical home, as identified in CMS Net at enrollment and annual program renewal. **Denominator:** Number of children in the county CCS program **Units:** 100 **Text:** Percent
Healthy People 2020 Objective	.
Data Sources and Data Issues	Currently some identified CMS Net medical home providers are clinics, not individuals.
Significance	The Title V 2010 Needs Assessment CCS stakeholder group identified 'care for the whole child as the first objective. Coordinated care, as provided in a Medical Hom, is necessary to achieve care for the whole child. Following percentage of children with designated medical home through the currently existing CCS PM should increase awareness of Medical Home and allow CCS to move towards providing Medical Home for 100% of CCS clients.

SO() # 1

Outcome Measure:	The pregnancy-related mortality rate per 100,000 live births.
Status:	Active
Goal	To reduce the rate of pregnancy-related deaths.
Definition	The number of pregnancy-related deaths due to group cause of deaths codes 261-273 (ICD 10) as recorded in the California Death Statistical Master File divided by the number of live births, multiplied by 100,000. **Numerator:** Number of deaths to women caused by complications of pregnancy within one year of pregnancy (group cause of death codes 261-273 [ICD 10]). **Denominator:** Number of live births. **Units:** 100000 **Text:** Rate
Healthy People 2020 Objective	No specific HP 2010 objective. Related to HP 2010 Objective 16-4: Reduce maternal deaths to 4.3 maternal deaths per 100,000 live births. No specific HP 2020 objective. Related to HP 2020 Objective MICH-5: Reduce the rate of maternal mortality. For both objectives, maternal mortality includes deaths less than or equal to 42 days following parturition, whereas pregnancy-related mortality includes deaths less than or equal to 365 days following parturition.
Data Sources and Data Issues	Numerator data source: California Department of Public Health, Death Statistical Master File. Denominator data source: California Department of Public Health, Birth Statistical Master File Cases with missing/ unknown data in the following fields are excluded: cause of death or whether a woman had a pregnancy in the previous year. Completion of this field is required for the assignment of the underlying cause of pregnancy-related deaths. Failure to ascertain whether a woman was pregnant in the year preceding her death may result in an underestimate of pregnancy-related deaths. The California death certificate adopted the following in 2003, 'Was woman pregnant in the year preceding death: Yes, No, Unknown,' whereas the NCHS standard adopted by other states included response options of 'Yes<42 days, Yes 43-365 days, No, Unknown.' This difference may result in a lack of specificity in identifying late maternal deaths and differences compared to other jurisdictions.
Significance	Pregnancy-related mortality in California has increased since 1999, reversing a decades-long pattern of decline. While the rates continue to fluctuate annually, they have been as high as 19.1 in 2005, and reached 16.3 in 2008. Pregnancy-related death is considered a sentinel event; because it should be a rare, unexpected occurrence and can signal that underlying health of the target population has declined. In support of this theory, maternal morbidity is also rising in California including a 15% increase in maternal hypertension, a 43% increase in diabetes and a 50% increase in chorioamnionitis. Particularly alarming is the large, persistent, and widening disparity in pregnancy-related mortality for African-American women. African-American women are roughly four times more likely to die of pregnancy-related causes than women from other racial/ethnic groups. This disparity is among the greatest not only for maternal and child health indicators, but among all leading public health indicators in California. The leading causes of pregnancy-related deaths are preeclampsia/ eclampsia, amniotic fluid embolism and hemorrhage. Case review has shown that the factors underlying pregnancy-related death in California are not only in the domain of clinical medicine and the health care system, but are also related to factors that promote or degrade women's health and well-being across the life course.

Form Notes for Form 16

None

Field Level Notes

None

Form 17
Health Systems Capacity Indicators
Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data
State: CA

Form Level Notes for Form 17

None

Health Systems Capacity #01

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	22.9	22.3	21.9	22.0	22
Numerator	6,290	6,187	5,511	5,539	
Denominator	2,745,856	2,771,815	2,514,468	2,514,271	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012

2. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2012. Primary diagnoses of each discharge abstract were tabulated, secondary diagnoses were not included.

   Denominator:
   State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.
   Tabulations (by place of residence) were done by the MCAH Program.

   Data for 2011-2012 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010 using these updated population projections was 24.5.

3. **Section Number:** Form17_Health Systems Capacity Indicator #01
   Field Name: HSC01
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2011. Primary diagnoses of each discharge abstract were tabulated, secondary diagnoses were not included.

   Denominator:
   State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.
   Tabulations (by place of residence) were done by the MCAH Program.

   Data for 2011 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010, using these updated population projections, was 24.5.

Health Systems Capacity #02

The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	90.1	88.5	87.3	80.7	76.1
Numerator	589,251	557,757	538,894	510,203	469,920
Denominator	653,829	630,326	617,510	632,310	617,445
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Manual Indicator for 2012 based on 2011.

2. **Section Number:** Form17_Health Systems Capacity Indicator #02
   Field Name: HSC02
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: CHDP data and CMS 416 EPSDT report

Health Systems Capacity #03

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Data available from the state's SCHIP is an aggregate of the percent of children with six or more well-child visits in the first 15 months of life. State data describing the percent of children whose age is less than one year who received at least one periodic screen is not available.

2. **Section Number:** Form17_Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Data available from the state's SCHIP is an aggregate of the percent of children with six or more well-child visits in the first 15 months of life . State data describing the percent of children whose age is less than one year who received at least one periodic screen is not available.

3. **Section Number:** Form17_Health Systems Capacity Indicator #03
   Field Name: HSC03
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Data available from the state's SCHIP is an aggregate of the percent of children with six or more well-child visits in the first 15 months of life . State data describing the percent of children whose age is less than one year who received at least one periodic screen is not available.

Health Systems Capacity #04

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	79.7	79.6	79.8	79.1	79.1
Numerator	403,578	390,717	386,668	384,696	
Denominator	506,582	490,856	484,470	486,155	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2012 Birth Statistical Master File.
   Tabulations (by place of residence) were done by the MCAH Program. Birth records with missing information in prenatal care initiation or visits fields were excluded from analysis

3. **Section Number:** Form17_Health Systems Capacity Indicator #04
   Field Name: HSC04
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2011 Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Birth records with missing information in prenatal care initiation or visits fields were excluded from analysis.

Health Systems Capacity #07A

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	93.8	93.4	93.7	93.6	95.5
Numerator	3,974,016	3,718,767	3,879,778	3,817,074	4,359,806
Denominator	4,235,016	3,979,767	4,140,778	4,078,074	4,565,806
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   Numerator: All persons 1 to 21 years of age who received a service paid by the Medi-Cal program during the Federal fiscal year: October 2012-September 2013 (this is an unduplicated count), including both Fee-for-Service and Managed Care beneficiaries, as well as certified and uncertified beneficiaries (i.e., those who shared a cost for their care). Source: Research and Analytic Studies Division (RASD) Fiscal Forecasting and Data Management Branch, California Department of Health Care Services. http://www.dhcs.ca.gov/dataandstats/statistics/Pages/RASD_Default.aspx

   Denominator: Consists of the sum of two indicators: (1) An estimate of uninsured children (1-21 years old) eligible for Medi-Cal. Source: 2013 California Health Interview Survey. Estimates for the current period is unavailable from CHIS at this time; (2) All persons 1 to 21 years of age who received a service paid by the Medi-Cal program during the Federal fiscal year: October 2012-September 2013 (this is an unduplicated count), including both Fee-for- Service and Managed Care beneficiaries, as well as certified and uncertified beneficiaries (i.e., those who shared a cost for their care). Source: Research and Analytic Studies Division (RASD) Fiscal Forecasting and Data Management Branch, California Department of Health Care Services. http://www.dhcs.ca.gov/dataandstats/statistics/Pages/RASD_Default.aspx

2. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Numerator: All persons 1 to 21 years of age who received a service paid by the Medi-Cal program during the Federal fiscal year: October 2011-September 2012 (this is an unduplicated count), including both Fee-for-Service and Managed Care beneficiaries, as well as certified and uncertified beneficiaries (i.e., those who shared a cost for their care). Source: Fiscal Forecasting and Data Management Branch, California Department of Health Care Services.

   Denominator: Consists of the sum of two indicators: (1) An estimate of uninsured children (1-21 years old) eligible for Medi-Cal. Source: 2009 California Health Interview Survey; (2) All persons 1 to 21 years of age who received a service paid by the Medi-Cal program during the Federal fiscal year: October 2011-September 2012 (this is an unduplicated count), including both Fee-for-Service and Managed Care beneficiaries, as well as certified and uncertified beneficiaries (i.e., those who shared a cost for their care). Source: Fiscal Forecasting and Data Management Branch, California Department of Health Care Services.

3. **Section Number:** Form17_Health Systems Capacity Indicator #07A
   Field Name: HSC07A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Numerator: All persons 1 to 21 years of age who received a service paid by the Medi-Cal program during the Federal fiscal year: October 2009-September 2010 (this is an unduplicated count), including both Fee-for-Service and Managed Care beneficiaries, as well as certified and uncertified beneficiaries (i.e., those who shared a cost for their care). Source: Fiscal Forecasting and Data Management Branch, California Department of Health Care Services.

   Denominator: Consists of the sum of two indicators: (1) An estimate of uninsured children (1-21 years old) eligible for Medi-Cal. Source: 2009 California Health Interview Survey; (2) All persons 1 to 21 years of age who received a service paid by the Medi-Cal program during the Federal fiscal year: October 2010-September 2011 (this is an unduplicated count), including both Fee-for-Service and Managed Care beneficiaries, as well as certified and uncertified beneficiaries (i.e., those who shared a cost for their care). Source: Fiscal Forecasting and Data Management Branch, California Department of Health Care Services.

   Data reported starting 2009 should not be compared to prior years' data because of a methodological change in estimating the denominator beginning 2009. Rate for prior years' using the revised denominator estimates:; 2008=93.7 .

Health Systems Capacity #07B

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	50.0	47.6	60.3	52.6	53.3
Numerator	440,212	423,316	553,478	502,486	620,775
Denominator	880,094	889,036	918,078	955,716	1,164,862
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Final

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   This measure is the percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year. Source is the Form CMS-416: Annual EPSDT Participation report
   http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html

2. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   This measure is the percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year. Source is the Form CMS-416: Annual EPSDT Participation report
   http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html

3. **Section Number:** Form17_Health Systems Capacity Indicator #07B
   Field Name: HSC07B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: MIS/DSS Medi-Cal claims data

Health Systems Capacity #08

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	30.1	31.4	32.7	32.2	31.5
Numerator	28,253	30,123	32,788	33,062	32,845
Denominator	93,899	95,788	100,271	102,546	104,430
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form17_Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   The numerator is the no. of disabled children under 16 years of age with SSI enrolled in CCS for fiscal year 2011-12 (aid codes of 20 and 60). Numerator data source is CMS Net.

   The denominator is the no. of children under 16 years of age receiving SSI in 2012. The denominator data source is from the publication Social Security Administration Office of Policy, Children receiving SSI.

   Provisional data entered for 2012 pending SSI data.

2. **Section Number:** Form17_Health Systems Capacity Indicator #08
   Field Name: HSC08
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   This measure is the percent of SSI beneficiaries through age 15 years receiving rehabilitative services through the CCS program. Source of data for the numerator is from CMS Net and for the denominator is from the publication: Social Security Administration Office of Policy, Children Receiving SSI.

   Numerator: Children under 16 years of age enrolled in CCS with aid codes of 20 and 60 (disabled children with SSI) for FY 2010-11.

   The denominator is from the Social Security Administration Office of Policy, Children Receiving SSI under 16 years of age for 2011.

Form 18
Health Systems Capacity Indicator #05
(Medicaid and Non-Medicaid Comparison)
State: CA

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
a) *Percent of low birth weight (< 2,500 grams)*	2012	Payment source from birth certificate	6.7	6.6	6.7
b) *Infant deaths per 1,000 live births*	2011	Matching data files	5.4	4	4.8
c) *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*	2012	Payment source from birth certificate	78.4	88.3	83.8
d) *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*	2012	Payment source from birth certificate	76.1	81.7	79.1

Form 18
Health Systems Capacity Indicator #06(Medicaid eligibility level)
State: CA

INDICATOR #06 *The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.*	YEAR	PERCENT OF POVERTY LEVEL MEDICAID (Valid range: 100-300 percent)
a) *Infants (0 to 1)*	2013	250
b) *Medicaid Children* (Age range 1 to 18) (Age range to) (Age range to)	2013	250
c) *Pregnant Women*	2013	200

Form 18
Health Systems Capacity Indicator #06(SCHIP eligibility level)
State: CA

INDICATOR #06 *The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, SCHIP and pregnant women.*	YEAR	PERCENT OF POVERTY LEVEL SCHIP
a) *Infants (0 to 1)*	2013	100
b) *Medicaid Children* (Age range 1 to 18) (Age range to) (Age range to)	2013	100
c) *Pregnant Women*	2013	300

Form Notes for Form 18

Due to default limitations in TVIS which requires entry between 100 to 500% of FPL for SCHIP infant and child eligibility, an entry of 100 was entered for both. These should have been 0% as Healthy Families (California's SCHIP) stopped enrollling clients in 2013 and transitioned to Medi-Cal as part of Medicaid's expansion provision in the Affordable Care Act.

Field Level Notes

1. **Section Number:** Form18_Indicator 06 - Medicaid
   Field Name: Med_Infant
   Row Name: Infants
   Column Name:
   Year: 2015
   Field Note:
   : California Department of Health Care Services, Medi-Cal Eligibility Division (internal communications).
2. **Section Number:** Form18_Indicator 06 - Medicaid
   Field Name: Med_Children
   Row Name: Medicaid Children
   Column Name:
   Year: 2015
   Field Note:
   Source: California Department of Health Care Services, Medi-Cal Eligibility Division (internal communications).
3. **Section Number:** Form18_Indicator 06 - Medicaid
   Field Name: Med_Women
   Row Name: Pregnant Women
   Column Name:
   Year: 2015
   Field Note:
   : California Department of Health Care Services, Medi-Cal Eligibility Division (internal communications).
4. **Section Number:** Form18_Indicator 06 - SCHIP
   Field Name: SCHIP_Infant
   Row Name: Infants
   Column Name:
   Year: 2015
   Field Note:
   Source: California Department of Health Care Services, Medi-Cal Eligibility Division (internal communications. sCHIP (aka Healthy Families) was transitioned to Medicaid (Medi-Cal), as part of the Affordable Care Act's Medicaid expansion plan in the state and no longer enrolls new clients starting in 2013
5. **Section Number:** Form18_Indicator 06 - SCHIP
   Field Name: SCHIP_Children
   Row Name: SCHIP Children
   Column Name:
   Year: 2015
   Field Note:
   Source: California Department of Health Care Services, Medi-Cal Eligibility Division (internal communications. sCHIP (aka Healthy Families) was transitioned to Medicaid (Medi-Cal), as part of the Affordable Care Act's Medicaid expansion plan in the state and no longer enrolls new clients starting in 2013
6. **Section Number:** Form18_Indicator 06 - SCHIP
   Field Name: SCHIP_Women
   Row Name: Pregnant Women
   Column Name:
   Year: 2015
   Field Note:
   Source: California Department of Health Care Services, Medi-Cal Division (internal communications). Eligibility for pregnant women to the Access for Infants and Monthers is from 200% to 300% of FPL.
7. **Section Number:** Form18_Indicator 05
   Field Name: LowBirthWeight
   Row Name: Percent of ow birth weight (<2,500 grams)
   Column Name:
   Year: 2015
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2012 Birth Statistical Master File.

   Expected payer source for delivery was used. Births with unknown birth weight or births weighing <227g or >8165g were excluded when calculating percentages. Births with missing payer source are included in the Total. Tabulations (by place of residence) were done by the MCAH Program.
8. **Section Number:** Form18_Indicator 05
   Field Name: InfantDeath
   Row Name: Infant deaths per 1,000 live births
   Column Name:
   Year: 2015
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2011 Birth Cohort file.

   Expected payer source for delivery was used to compute rates. Cases with missing payer source included in Total. Tabulations (by place of residence) were

done by the MCAH Program.

9. **Section Number:** Form18_Indicator 05
Field Name: CareFirstTrimester
Row Name: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester
Column Name:
Year: 2015
Field Note:
Source: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File.

Payer source for prenatal care was used. Infant birth records with missing prenatal care initiation were excluded from analysis. Infant birth records with missing payer source included in Total. Tabulations (by place of residence) were done by the MCAH Program
.

10. **Section Number:** Form18_Indicator 05
Field Name: AdequateCare
Row Name: Percent of pregnant women with adequate prenatal care
Column Name:
Year: 2015
Field Note:
Source: State of California, Department of Public Health, Center for Health Statistics, 2012 Birth Statistical Master File.
Payer source for prenatal care was used. Birth records with missing information in prenatal care initiation or visits fields were excluded from analysis. Table reflects adequacy of prenatal care reported for women between the ages of 15 and 44 who gave birth to a live infant. Birth records with missing payer source included in Total. Tabulations (by place of residence) were done by the MCAH Program.

Form 19
Health Systems Capacity Indicator - Reporting and Tracking Form
State: CA

HEALTH SYSTEMS CAPACITY INDICATOR #09A (General MCH Data Capacity)
(The Ability of the State to Assure MCH Program Access to Policy and Program Relevant Information)

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

*Where:
1 = No, the MCH agency does not have this ability.
2 = Yes, the MCH agency sometimes has this ability, but not on a consistent basis.
3 = Yes, the MCH agency always has this ability.

Form 19
Health Systems Capacity Indicator - Reporting And Tracking Form
State: CA

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)*	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	No
Other: California Student Survey	3	Yes
California Health Interview Survey	3	Yes
California Healthy Kids Survey	3	Yes

*Where:
1 = No
2 = Yes, the State participates but the sample size is not large enough for valid statewide estimates for this age group.
3 = Yes, the State participates and the sample size is large enough for valid statewide estimates for this age group.

Notes:

1. HEALTH SYSTEMS CAPACITY INDICATOR #09B was formerly reported as Developmental Health Status Indicator #05.

Form Notes for Form 19

None

Field Level Notes

1. **Section Number:** Form19_Indicator 09A
   Field Name: BAD
   Row Name: Annual linkage of infant birth and infant death certificates
   Column Name:
   Year: 2015
   Field Note:
   Linked birth certificate and newborn screening files is only available to MCAH upon request.

2. **Section Number:** Form19_Indicator 09B
   Field Name: YRBSS_09B
   Row Name: Youth Risk Behavior Survey (YRBS)
   Column Name:
   Year: 2015
   Field Note:
   The California Youth Risk Behavior Survey (YRBS) is funded by the U.S Centers for Disease Control and Prevention. While the survey has been implemented in Los Angeles, San Bernardino, San Diego and San Francisco counties previously, the survey was implemented statewide for the third time in spring of 2013. The 2009, 2011 and 2013 surveys failed to yield a response rate of at least 60%, precluding weighting of the data to make it representative of the student population. In the2013 survey the response rate was a 50%, the highest rate of the three-years of statewide data collection efforts. Surveys are conducted in schools using a random sample of 9th through 12th graders. The YRBS was developed to monitor priority health risk behaviors that contribute the leading causes of mortality, morbidity and social problems among adolescents. The survey is part of a surveillance effort conducted by the California Department of Public Health, the California Department of Education and the Public Health Institute in cooperation with the Centers for Disease Control and Prevention. The biennial sample size for this survey is approximately 1,500 surveys.

3. **Section Number:** Form19_Indicator 09B
   Field Name: Other1_09B
   Row Name: Other
   Column Name:
   Year: 2015
   Field Note:
   CSS is a voluntary, anonymous, and confidential self-report survey of substance use, school safety, harassment and violence, youth resilience factors, and health-related behaviors. . WestEd has conducted the survey since 1989. The CA Department of Education (CDE) has been a long time state agency partner in co-sponsoring the CSS, along with the Dept. of Healthcare Services..

   The California Healthy Kids Survey (CHKS) is a voluntary, representative, biennial sample of California students, grades 7, 9, 11, and enrolled in non-traditional schools (community day schools or continuation schools). CHKS is a comprehensive youth health risk and resilience survey that includes data on tobacco use, alcohol, and other drugs. An optional tobacco module is available for use by school districts, and contains additional items related to perceived social norms about tobacco. CHKS provides trend data and provides data on current tobacco use by grade, gender, race and county through an online query system. As part of the state's effort to reduce survey burdens on the schools, the California Healthy Kids Survey (CHKS) fully integrates with the statewide biennial CSS, so that districts can combine their participation in the CSS and their own CHKS administration at the same time.

   The California Health Interview Survey (CHIS) is a telephone survey of adults, adolescents, and children from all parts of the state. Starting in 2012, CHIS transitioned from a biennial survey model to a continuous survey model, enabling a more frequent release of data; prior to 2012, CHIS was a biennial survey. CHIS is the largest state health survey and one of the largest health surveys in the United States and is able to provide statewide and local level estimates on a number of health related issues, including adolescent tobacco use.

Form 20
Health Status Indicators #01-#05
Multi-Year Data
State: CA

Form Level Notes for Form 20

None

Health Status Indicator #01A

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	6.8	6.8	6.8	6.7	6.7
Numerator	35,774	34,624	33,956	33,657	
Denominator	526,692	509,884	501,942	503,691	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012

2. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File.
   Tabulations (by place of residence) were done by the MCAH Program. Data exclude births with unknown birth weight or births weighing <227g or >8165g.

3. **Section Number:** Form20_Health Status Indicator #01A
   Field Name: HSI01A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File.
   Tabulations (by place of residence) were done by the MCAH Program. Data exclude births with unknown birth weight or births weighing <227g or >8165g. Data for 2009 should be not compared to data reported in previous years due to a change in exclusion criteria. Rates for prior years using the updated criteria: 2008 = 6.8

Health Status Indicator #01B

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	5.2	5.3	5.2	5.2	5.2
Numerator	26,470	25,949	25,182	25,253	
Denominator	509,909	493,980	485,905	488,055	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File.

   Tabulations (by place of residence) were done by the MCAH Program. Data exclude births with unknown birth weight or births weighing <227 grams or >8165 grams.

3. **Section Number:** Form20_Health Status Indicator #01B
   Field Name: HSI01B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File.

   Tabulations (by place of residence) were done by the MCAH Program. Data exclude births with unknown birth weight or births weighing <227 grams or >8165 grams. Data for 2009 should be not compared to data reported in previous years due to a change in exclusion criteria. Rates for prior years using the updated criteria: ; 2008 = 5.2.

Health Status Indicator #02A

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	1.2	1.1	1.1	1.1	
Numerator	6,066	5,791	5,721	5,623	
Denominator	526,692	509,884	501,942	503,691	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File.

   Tabulations (by place of residence) were done by the MCAH Program. Data exclude births with unknown birth weight or births weighing <227 grams or >8165 grams.

3. **Section Number:** Form20_Health Status Indicator #02A
   Field Name: HSI02A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File.

   Tabulations (by place of residence) were done by the MCAH Program. Data exclude births with unknown birth weight or births weighing <227 grams or >8165 grams. Data for 2009 should be not compared to data reported in previous years due to a change in exclusion criteria.

Health Status Indicator #02B

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	0.9	0.9	0.9	0.9	0.9
Numerator	4,428	4,286	4,246	4,225	
Denominator	509,909	493,980	485,905	488,055	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File.

   Tabulations (by place of residence) were done by the MCAH Program. Data exclude births with unknown birth weight or births weighing <227 grams or >8165 grams.

3. **Section Number:** Form20_Health Status Indicator #02B
   Field Name: HSI02B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File.

   Tabulations (by place of residence) were done by the MCAH Program. Data exclude births with unknown birth weight or births weighing <227 grams or >8165 grams. Data for 2009 should be not compared to data reported in previous years due to a change in exclusion criteria.

Health Status Indicator #03A

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	4.4	3.3	3.7	3.7	3.7
Numerator	357	267	279	281	
Denominator	8,184,071	8,199,138	7,568,037	7,554,127	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2012 Death Statistical Master File (ICD-10 Death Codes for unintentional injuries defined by CDPH, Safe and Active Communities Branch, http://www.cdph.ca.gov/HealthInfo/injviosaf/Pages/EpiCenterICD.aspx).

   Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH Program.

   Data reported for 2011-2012 should not be compared to data reported in prior years due to updates in the population projections released by the California Department of Finance (January2013) and revised ICD10 coding for deaths due to unintentional injuries. Rate for 2010 using the updated population estimate and ICD10 coding = 3.4.

3. **Section Number:** Form20_Health Status Indicator #03A
   Field Name: HSI03A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 Death Statistical Master File (ICD-10 Death Codesfor unintentional injuries defined by CDPH, Safe and Active Communities Branch, http://www.cdph.ca.gov/HealthInfo/injviosaf/Pages/EpiCenterICD.aspx).

   Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH Program.

   Data reported for 2011 should not be compared to data reported in prior years due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013) and revised ICD10 coding for deaths due to unintentional injuries. Rate for 2010 using the updated population estimate and ICD10 coding = 3.4.

Health Status Indicator #03B

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	1.8	1.0	1.1	1.4	1.4
Numerator	148	84	85	105	
Denominator	8,184,071	8,199,138	7,568,037	7,554,127	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2012 California Death Statistical Master File [The ICD-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

   Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH Program.
   Data reported for 2011-2012 should not be compared to data reported in 2010 due to updates in the population projections released by the California Department of Finance (January2013). Rate for 2010 using the updated population estimate = 1.1.

3. **Section Number:** Form20_Health Status Indicator #03B
   Field Name: HSI03B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Death Statistical Master File [The ICD-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

   Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH Program.
   Data reported for 2011 should not be compared to data reported in 2010 due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 1.1.

Health Status Indicator #03C

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	11.5	9.0	10.4	10.7	10.7
Numerator	677	539	582	604	
Denominator	5,875,809	5,969,955	5,615,748	5,623,312	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2012 California Death Statistical Master File [The ICD-10 codes for fatal MVtraffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

   Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January2013.Tabulations (by place of residence) were done by the MCAH Program.

   Data reported for 2011-2012 should not be compared to data reported in prior years due to updates in the population projections released by the California Department of Finance (January2013). Rate for 2010 using the updated population estimate = 9.

3. **Section Number:** Form20_Health Status Indicator #03C
   Field Name: HSI03C
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Death Statistical Master File [The ICD-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

   Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.Tabulations (by place of residence) were done by the MCAH Program.

   Data reported for 2011 should not be compared to data reported in 2010 due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 9.

Health Status Indicator #04A

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	192.9	186.8	191.9	193.3	193.3
Numerator	15,791	15,315	14,525	14,604	
Denominator	8,184,071	8,199,138	7,568,037	7,554,127	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2012. Principal external cause of injury codes were used (E800-E999). Data exclude cases with iatrogenic codes (adverse effects of medical care and drugs), unknown age, newborns, persons who died in the hospital, and records erroneously listing a "place of injury" code (E849.0-E849.9) as the principal code.

   Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH Program.

   Data for 2011-2012 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010 using these updated population projections was 201.4.

3. **Section Number:** Form20_Health Status Indicator #04A
   Field Name: HSI04A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2011. Principal external cause of injury codes were used (E800-E999). Data exclude cases with iatrogenic codes (adverse effects of medical care and drugs), unknown age, newborns, persons who died in the hospital, and records erroneously listing a "place of injury" code (E849.0-E849.9) as the principal code.

   Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH Program.

   Data for 2011 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010 using these updated population projections was 2014.

Health Status Indicator #04B

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	18.6	16.8	16.8	16.4	16.4
Numerator	1,523	1,376	1,270	1,240	
Denominator	8,184,071	8,199,138	7,568,037	7,554,127	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2012.Principal external cause of injury codes were used (ICD9-CM codes E810-E819). Data exclude cases of unknown age, newborns, and persons who died in the hospital.

   Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH.

   Data for 2011-2012 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010 using these updated population projections was 18.1.

3. **Section Number:** Form20_Health Status Indicator #04B
   Field Name: HSI04B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2011.Principal external cause of injury codes were used (ICD9-CM codes E810-E819). Data exclude cases of unknown age, newborns, and persons who died in the hospital.

   Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH.

   Data for 2011 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010 using these updated population projections was 18.1

Health Status Indicator #04C

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	99.1	88.9	91.4	93.7	93.7
Numerator	5,820	5,306	5,133	5,269	
Denominator	5,875,809	5,969,955	5,615,748	5,623,312	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012.

2. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2012. Principal external cause of injury codes were used (ICD9-CM codes E810-E819). Data exclude persons who died in the hospital.

   Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH Program.

   Data for 2011-2012 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010 using these updated population projections was 94.7.

3. **Section Number:** Form20_Health Status Indicator #04C
   Field Name: HSI04C
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2011. Principal external cause of injury codes were used (ICD9-CM codes E810-E819). Data exclude persons who died in the hospital.

   Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH Program.

   Data for 2011 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010 using these updated population projections was 94.7.

Health Status Indicator #05A

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	22.2	22.5	22.9	23.6	23.6
Numerator	32,987	33,440	33,860	31,994	
Denominator	1,488,207	1,488,238	1,476,421	1,358,529	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012 data.

2. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Numerator: Chlamydia, Cases and Rates by Race/Ethnicity, Gender, and Age Group, California, 2012 Provisional Data, , California Department of Public Health, STD Control Branch (data reported through 08/07/2013). Available at http://www.cdph.ca.gov/data/statistics/Documents/STD-Data-Chlamydia-Provisional-Tables.pdf. Last accessed on December 12, 2013.

   Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.

3. **Section Number:** Form20_Health Status Indicator #05A
   Field Name: HSI05A
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Numerator: Chlamydia, Cases and Rates by Race/Ethnicity, Gender, and Age Group, California, 2011 Provisional Data, , California Department of Public Health, STD Control Branch (data reported through 08/07/2012). Available athttp://www.cdph.ca.gov/data/statistics/Documents/STD-Data-Chlamydia-Provisional-Tables.pdf Last accessed on February 26, 2013.

   Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007.

Health Status Indicator #05B

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

	Annual Indicator Data				
	2009	2010	2011	2012	2013
Annual Indicator	10.0	10.6	11.4	12.3	12.3
Numerator	65,290	70,011	76,119	80,480	
Denominator	6,555,574	6,603,274	6,683,684	6,559,349	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. *(Explain data in a year note. See Guidance, Appendix IX.)*					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

1. **Section Number:** Form20_Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2013
   Field Note:
   A manual indicator is reported for 2013 based on 2012 data.

2. **Section Number:** Form20_Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2012
   Field Note:
   Numerator: Chlamydia, Cases and Rates by Race/Ethnicity, Gender, and Age Group, California, 2012 Provisional Data, , California Department of Public Health, STD Control Branch (data reported through 08/07/2013). Available at http://www.cdph.ca.gov/data/statistics/Documents/STD-Data-Chlamydia-Provisional-Tables.pdf. Last accessed on December 12, 2013.

   Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.

3. **Section Number:** Form20_Health Status Indicator #05B
   Field Name: HSI05B
   Row Name:
   Column Name:
   Year: 2011
   Field Note:
   Chlamydia, Cases and Rates by Race/Ethnicity, Gender, and Age Group, California, 2011 Provisional Data, , California Department of Public Health, STD Control Branch (data reported through 08/07/2012). Available at http://www.cdph.ca.gov/data/statistics/Documents/STD-Data-Chlamydia-Provisional-Tables.pdf Last accessed on February 26, 2013.

   Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007

Form 21
Health Status Indicators
Demographic Data
State: CA

HSI #06A - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

For both parts A and B: Reporting Year: 2012 Is this data from a State Projection? Yes Is this data final or provisional? Final

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	520,447	402,855	27,102	1,807	62,144	2,246	24,293	0
Children 1 through 4	1,993,823	1,573,125	105,755	7,414	201,102	6,312	100,115	0
Children 5 through 9	2,514,155	1,982,772	132,050	10,221	265,907	8,480	114,725	0
Children 10 through 14	2,525,702	1,992,815	143,635	10,349	265,946	8,997	103,960	0
Children 15 through 19	2,792,807	2,190,750	174,392	11,789	303,234	10,700	101,942	0
Children 20 through 24	2,830,506	2,203,151	180,293	12,523	335,035	12,099	87,405	0
Children 0 through 24	13,177,440	10,345,468	763,227	54,103	1,433,368	48,834	532,440	0

HSI #06B - Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and ethnicity. (Demographics)*

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	257,363	263,085	0
Children 1 through 4	946,575	1,047,248	0
Children 5 through 9	1,197,538	1,316,617	0
Children 10 through 14	1,237,013	1,288,688	0
Children 15 through 19	1,434,208	1,358,599	0
Children 20 through 24	1,537,318	1,293,187	0
Children 0 through 24	6,610,015	6,567,424	0

Form 21
Health Status Indicators
Demographic Data
State: CA

HSI #07A - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

For both parts A and B: Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Final

CATEGORY TOTAL LIVE BIRTHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	360	292	28	1	10	0	17	12
Women 15 through 17	10,359	8,388	712	83	192	28	534	422
Women 18 through 19	24,562	19,471	2,013	194	578	87	1,277	942
Women 20 through 34	371,976	270,048	20,664	1,864	47,640	1,672	13,210	16,878
Women 35 or older	96,455	63,564	3,833	285	20,534	342	2,533	5,364
Women of all ages	503,712	361,763	27,250	2,427	68,954	2,129	17,571	23,618

HSI #07B - Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and ethnicity. (Demographics)*

CATEGORY TOTAL LIVE BIRTHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	70	286	4
Women 15 through 17	2,103	8,098	158
Women 18 through 19	6,509	17,663	390
Women 20 through 34	181,337	182,898	7,741
Women 35 or older	57,339	35,668	3,248
Women of all ages	247,358	244,613	11,541

Form 21
Health Status Indicators
Demographic Data
State: CA

HSI #08A - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

For both parts A and B: Reporting Year: 2012 Is this data from a State Projection? No Is this data final or provisional? Final

CATEGORY TOTAL DEATHS BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	2,247	1,558	273	10	204	9	168	25
Children 1 through 4	411	297	42	1	35	2	32	2
Children 5 through 9	214	146	18	1	30	0	16	3
Children 10 through 14	279	211	32	2	17	3	11	3
Children 15 through 19	999	723	141	14	52	7	49	13
Children 20 through 24	1,934	1,414	257	18	131	21	81	12
Children 0 through 24	6,084	4,349	763	46	469	42	357	58

HSI #08B - Demographics (Total deaths) *Deaths of Infants and children aged 0 through 24 years enumerated by age subgroup and ethnicity. (Demographics)*

CATEGORY TOTAL DEATHS BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	1,076	1,159	12
Children 1 through 4	204	207	0
Children 5 through 9	96	118	0
Children 10 through 14	141	138	0
Children 15 through 19	512	485	2
Children 20 through 24	1,162	770	2
Children 0 through 24	3,191	2,877	16

Form 21
Health Status Indicators
Demographic Data
State: CA

HSI #09A - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

Is this data final or provisional? Provisional

CATEGORY Miscellaneous Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	10,346,935	8,142,317	582,934	41,580	1,098,334	36,736	445,034	0	2012
Percent in household headed by single parent	30.7	29.9	58.9	35.1	19.5	49.8	24.2	0.0	2013
Percent in TANF (Grant) families	10.9	10.6	33.7	17.1	4.0	24.5	3.5	0.0	2012
Number enrolled in Medicaid	3,914,169	3,039,617	352,843	15,448	219,124	12,600	644	273,893	2012
Number enrolled in SCHIP	954	22	2	0	5	0	0	925	2013
Number living in foster home care	54,213	38,057	11,604	462	1,056	0	2,892	142	2012
Number enrolled in food stamp program	1,951,870	1,571,789	224,992	4,862	88,476	0	53,734	8,017	2012
Number enrolled in WIC	1,722,623	606,796	123,880	648,359	88,102	10,310	189,132	56,044	2013
Rate (per 100,000) of juvenile crime arrests	1,943.0	1,904.0	5,861.0	1,849.0	457.0	2,755.0	0.0	0.0	2012
Percentage of high school drop-outs (grade 9 through 12)	13.1	8.2	22.1	18.4	5.4	15.4	9.5	37.3	2012

HSI #09B - Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by ethnicity.(Demographics)*

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
All children 0 through 19	5,072,698	5,274,327	0	2012
Percent in household headed by single parent	26.6	34.7	0.0	2013
Percent in TANF (Grant) families	8.6	13.2	0.0	2012
Number enrolled in Medicaid	1,258,813	2,466,515	188,841	2012
Number enrolled in SCHIP	940	12	2	2013
Number living in foster home care	27,728	26,343	142	2012
Number enrolled in food stamp program	652,991	1,298,879	0	2012
Number enrolled in WIC	417,231	1,305,349	43	2013
Rate (per 100,000) of juvenile crime arrests	1,973.0	1,811.0	1.0	2012

Percentage of high school drop-outs (grade 9 through 12)	10.0	16.1	27.3	2012

Form 21
Health Status Indicators
Demographic Data
State: CA

HSI #10 - Demographics (Geographic Living Area) *Geographic living area for all resident children aged 0 through 19 years old. (Demographics)*

Reporting Year: 2012 Is this data from a State Projection? Yes Is this data final or provisional? Final

GEOGRAPHIC LIVING AREAS	TOTAL
Living in metropolitan areas	0
Living in urban areas	10,119,429
Living in rural areas	227,505
Living in frontier areas	0
Total - all children 0 through 19	10,346,934

Note:
The Total will be determined by adding reported numbers for urban, rural and frontier areas.

Form 21
Health Status Indicators
Demographic Data
State: CA

HSI #11 - Demographics (Poverty Levels) *Percent of the State population at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2012 Is this data from a State Projection? Yes Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Total Population	37,912,405
Percent Below: 50% of poverty	7
100% of poverty	15.9
200% of poverty	36.5

Form 21
Health Status Indicators
Demographic Data
State: CA

HSI #12 - Demographics (Poverty Levels) *Percent of the State population aged 0 through 19 at various levels of the federal poverty level. (Demographics)*

Reporting Year: 2012 Is this data from a State Projection? Yes Is this data final or provisional? Final

POVERTY LEVELS	TOTAL
Children 0 through 19 years old	10,245,434
Percent Below: 50% of poverty	9.9
100% of poverty	22.7
200% of poverty	46.7

Form Notes for Form 21

HSI 06A & B: Source:
State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.
http://www.dof.ca.gov/research/demographic/reports/projections/P-3/. Tabulations were done by MCAH Program. White race is summed from White group and Hispanic group in this file.

HSI 07A & B: Source: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File. Tabulations (by age and race/ethnicity) were done by the MCAH Program. Women with unknown age are not included in the totals. In 2012, age was known for 503,712 women and unknown for 76 women, for a total of 503,788 live births.

HSI 08A and B: State of California, California Department of Public Health, Center for Health Statistics, 2012 California Death Statistical Master File. Calculations (by age and race/ethnicity) were performed by the MCAH Program.

HSI 11 & 12: Source: Current Population Survey, Annual Social and Economic Supplement, 2013, U.S. Census Bureau. Data extracted with online data tool, CPS Table Creator: www.census.gov/hhes/www/cpstc/cps_table_creator.html. Last accessed on January 22, 2014.

For the numerator and denominator, the "Persons in Poverty Universe" is used. The poverty status is reported for the survey year (2013), but is based upon family income in the previous year (2012).

Field Level Notes

1. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_Children
   Row Name: All children 0 through 19
   Column Name:
   Year: 2015
   Field Note:
   For the tabulation for all children 0 through 19, the data source is the State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.http://www.dof.ca.gov/research/demographic/reports/projections/P-3/

2. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_SingleParentPercent
   Row Name: Percent in household headed by single parent
   Column Name:
   Year: 2015
   Field Note:
   For the tabulation on the percent in household headed by a single parent, the data source is the U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement. Last accessed the CPS Table Creator on 01/24/2014. URL: http://www.census.gov/cps/data/cpstablecreator.html

   The Current Population Survey (CPS) household head information refers to the year the survey is taken, not a reference year prior to the survey.

   Numerator is derived by adding (1) Universe, Persons in Male-Headed Primary Families, No Spouse Present, California, Ages 0-19 and (2) Universe, Persons in Female- Headed Primary Families, No Spouse Present, California, Ages 0-19. Denominator is the Universe, Persons- All Children, California, Ages 0-19.

3. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_TANFPercent
   Row Name: Percent in TANF (Grant) families
   Column Name:
   Year: 2015
   Field Note:
   Only children ages 0-18 are eligible for CalWORKs. For the tabulation on the percent in TANF, the numerator is the number of children ages 0 to 18 in CalWORKs assistance units during FFY 2012.. The CalWORKs database groups children from 0-18 years and not as 0-19 years. The White category includes non-Hispanic White, Hispanic White and Hispanic children of unknown race. Source for the numerator; California Department of Social Services, Federal Data Reporting and Analysis Bureau. Ad hoc SAS analysis completed 02/12/14 (unpublished).

   Denominator: Number of children ages 0 to 19 in CY 2012. State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.

4. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_MedicaidNo
   Row Name: Number enrolled in Medicaid
   Column Name:
   Year: 2015
   Field Note:
   For the tabulation on the number enrolled in Medicaid, the Medicaid data included all infants and children 0-19 years enrolled in MediCal for the October 2012 month of eligibility. Age calculated is based on the difference between the eligible birth date and the first day of the eligible month. The data source is the RASS CINXMOE SAS Dataset created from the MEDS Eligible file with a 12 month reporting lag. The data source is the California Department of Health Care Services, Medical Care Statistics Section. More Than One Race Reported category included only Amerasian ethnicity code with no other codes to identify persons of more than one race. White category includes persons identified as White or Hispanic.

5. **Section Number:** Form21_Indicator 09A
   Field Name: HSIRace_SCHIPNo
   Row Name: Number enrolled in SCHIP
   Column Name:
   Year: 2015

Field Note:
For the tabulation of the number enrolled in SCHIP, the count for Asian does not include Native Hawaiian and Other Pacific Islander. The count for White includes Hispanic. The count for Asian for Title V Reporting Year 2011-12 had previously included Native Hawaiian and Other Pacific Islander in the Asian count. The HFP Monthly Enrollment Report does not include a More Than One Race Reported category. The counts for total other and unknown are combined to reflect the TVIS reporting category of other and unknown.

SCHIP stopped enrolling children in December 31, 2012.With the implementation of the Affordable Care Act and the option for MedicAid expansion, California's SCHIP participants were being disenrolled and transitioned to Medi-Cal. The table used to collect this information on enrollments changes month by month.

The data source is the Managed Risk Medical Insurance Board, HFP Monthly Enrollment Reports. Current enrolled for December 2013. Accessed January 21, 2014 at http://www.mrmib.ca.gov/MRMIB/HFP/Dec_13/HFPRpt5A.pdf

6. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_FoodStampNo
Row Name: Number enrolled in food stamp program
Column Name:
Year: 2015
Field Note:
For the tabulation on the number enrolled in the food stamp program, data represent the number of children ages 0 through 19 in CalFresh food stamp households during FFY 2012, in both public assistance and non-assistance households. No children 19 years of age were reported in the CalFresh survey sample. The count for Asian includes Native Hawaiian and Other Pacific Islander. The count for White race includes Hispanic/White and Hispanic/Unknown race. Mixed Race was added as a new race category beginning FFY 2008. Data was requested from the California Department of Social Services, Federal Data Reporting and Analysis Bureau, completed on 1/31/2014.

7. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_WICNo
Row Name: Number enrolled in WIC
Column Name:
Year: 2015
Field Note:
For the tabulation on the number enrolled in WIC, the data source is the California Department of Public Health; Women, Infants and Children Program; Research and Evaluation Section. WIC Integrated Statewide Information System (ISIS), April 2014. Unpublished data is for the period from October 2012 to September 2013.

8. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_JuvenileCrimeRate
Row Name: Rate (per 100,000) of juvenile crime arrests
Column Name:
Year: 2015
Field Note:
For the tabulation on the rate of juvenile crime arrests, the numerator data include felony and misdemeanor offenses among juveniles age 19 and younger. Data is not available for the More than One Raced Reported category.

Numerator data was requested from the State of California, Department of Justice, Bureau of Criminal Information and Analysis, Criminal Justice Statistics Center, Monthly Arrest and Citation Register, 2011. The denominator is from the State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Available at: http://www.dof.ca.gov/research/demographic/reports/projections/P-3/

9. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_DropOutPercent
Row Name: Percentage of high school drop-outs (grade 9 through 12)
Column Name:
Year: 2015
Field Note:
For the tabulation on the percentage of high school drop-outs, the 4-year adjusted cohort dropout rate is the rate of students that leave the 9-12 instructional system without a high school diploma, GED, or special education certificate of completion and do not remain enrolled after the end of the 4th year. It is calculated by dividing the number of students in the 4-year cohort that dropped out by the end of the 2011-12 school year by the number of first-time grade 9 students in Fall 2008 (starting cohort) plus students who transfer in, minus students who transfer out, emigrate, or die during school years 2008-09, 2009-10, 2010-11, and 2011-12. Due to this change in methodology in calculating the indicator compared to previous years, data currently reported should not be compared with data reported in previous years.

The percentage reported for "White" include all students whose race is reported as" Hispanic" and "White, non-Hispanic". Other and Unknown includes those identified as not reported. The data source is the California Department of Education, California Longitudinal Pupil Achievement Data System (CALPADS). Cohort Outcome Summary Report by Race/Ethnicity, Cohort Outcome Data for the Class of 2011-12, Statewide Results. Available at: http://dq.cde.ca.gov/dataquest/cohortrates/GradRates.aspx?cds=00000000000000&TheYear=2011-12&Agg=T&Topic=Dropouts&RC=State&SubGroup=Ethnic/Racial
. Last accessed on 2/20/14.

10. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_Children
Row Name: All children 0 through 19
Column Name:
Year: 2015
Field Note:
For the tabulation for all children 0 through 19, the data source is the State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Available at: http://www.dof.ca.gov/research/demographic/reports/projections/P-3/

11. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_SingleParentPercent
Row Name: Percent in household headed by single parent
Column Name:
Year: 2015
Field Note:
For the tabulation on the percent in household headed by a single parent, the data source is the U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement. Accessed CPS Table Creator on 01/24/2014. URL: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html. The Current Population Survey (CPS) household head information refers to the year the survey is taken, not a reference year prior to the survey.
Numerator is derived by adding (1) Universe, Persons in Male-Headed Primary Families, No Spouse Present , California, Ages 0-19 and (2) Universe, Persons in Female-Headed Primary Families, No Spouse Present, California, Ages 0-19. Denominator is the Universe, Persons- All Children, California, Ages 0-19.

12. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_TANFPercent
Row Name: Percent in TANF (Grant) families
Column Name:
Year: 2015
Field Note:
Only children ages 0-18 are eligible for CalWORKs. For the tabulation on the percent in TANF, the numerator is the number of children ages 0 to 18 in CalWORKs assistance units during FFY 2012. .Source for the Numerator; California Department of Social Services, Federal Data Reporting and Analysis Bureau. Ad hoc SAS analysis completed 2/12/14 (unpublished).

Denominator: Number of children ages 0 to 19 in CY 2012. State of California, Department of Finance. Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Available at: http://www.dof.ca.gov/research/demographic/reports/projections/P-3/.

13. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_MedicaidNo
Row Name: Number enrolled in Medicaid
Column Name:
Year: 2015
Field Note:
For the tabulation on the number enrolled in Medicaid, the Medicaid data included all infants and children 0-19 years enrolled in MediCal for the October 2012 month of eligibility. Age calculated based on the difference between the eligible birth date and the first day of the eligible month. The data source is the RASS CINXMOE SAS Dataset created from the MEDS Eligible file with a 12 month reporting lag. The data source is the California Department of Health Care Services, Medical Care Statistics Section.

Total Non Hispanic category includes persons grouped in the White, African American, American Indian, Asian, Native Hawaiian/ Pacific Islander and More Than One Race categories, as well as those categorized as Other. . Ethnicity Not Reported category includes persons grouped in the Unknown category, with no response or no valid data.

14. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_SCHIPNo
Row Name: Number enrolled in SCHIP
Column Name:
Year: 2015
Field Note:
For the tabulation of the number enrolled in SCHIP, the total Non Hispanic category includes persons grouped in the White, African American, American Indian, Asian, and More Than One Race categories, as well as those categorized as Other within the Other and Unknown category. The table used to collect this information on enrollments changes month by month. The data source is the Managed Risk Medical Insurance Board, HFP Monthly Enrollment Reports.

SCHIP stopped enrolling children in December 31, 2012With the implementation of the Affordable Care Act and the option for MedicAid expansion, California's SCHIP participants were being disenrolled and transitioned to Medi-Cal. The table used to collect this information on enrollments changes month by month.

The data source is the Managed Risk Medical Insurance Board, HFP Monthly Enrollment Reports. Current enrolled for December 2013. Accessed January 21, 2014 at http://www.mrmib.ca.gov/MRMIB/HFP/Dec_13/HFPRpt5A.pdf

15. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_FoodStampNo
Row Name: Number enrolled in food stamp program
Column Name:
Year: 2015
Field Note:
For the tabulation on the number enrolled in the food stamp program, data represent the number of children ages 0 through 19 in CalFresh food stamp households during FFY 2012, in both public assistance and non-assistance households. No children 19 years of age were reported in the CalFresh survey sample. The count of Total Not Hispanic or Latino includes White Not of Hispanic Origin, Black Not of Hispanic Origin, American Indian/Alaska Native, Asian/Pacific Islander, More Than One Race Reported, and Unknown. Data was requested from the California Department of Social Services, Federal Data Reporting and Analysis Bureau, completed on1/31/2014.

16. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_WICNo
Row Name: Number enrolled in WIC
Column Name:
Year: 2015
Field Note:
For the tabulation on the number enrolled in WIC, the total Not Hispanic or Latino includes White, Black/African American, American Indian/Native Alaskan, Asian, Native Hawaiian/Other Pacific Islander, More Than One Race Reported, and Other and Unknown.

Source: California Department of Public Health; Women, Infants and Children Program; Research and Evaluation Section. Unpublished data, April 2014. Data is for the period from October 2012 to September 2013.

17. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_JuvenileCrimeRate
Row Name: Rate (per 100,000) of juvenile crime arrests
Column Name:
Year: 2015
Field Note:
For the tabulation on the rate of juvenile crime arrests, the numerator data include felony and misdemeanor offenses among juveniles age 19 and younger. Data is not available for the More than One Raced Reported category. Total Not Hispanic or Latino includes White, Black/African American, Asian, Native Hawaiian/Other Pacific Islander, and Other.

Numerator data was requested from the State of California, Department of Justice, Bureau of Criminal Information and Analysis, Criminal Justice Statistics Center. The denominator is from the State of California, Department of Finance,. Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Available at: http://www.dof.ca.gov/research/demographic/reports/projections/P-3/

18. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_DropOutPercent
Row Name: Percentage of high school drop-outs (grade 9 through 12)
Column Name:
Year: 2015
Field Note:
For the tabulation on the percentage of high school drop-outs, the total count of Not Hispanic or Latino includes White, Black/African American, American Indian/Native American, Asian, Filipino, Pacific Islander, and two or more races. Total count of Ethnicity Not Reported includes only those whose race/ethnicity was not reported

The data source is the California Department of Education, California Longitudinal Pupil Achievement Data System (CALPADS). Cohort Outcome Summary Report by Race/Ethnicity, Cohort Outcome Data for the Class of 2009-2010, Statewide Results. Available at: http://dq.cde.ca.gov/dataquest/cohortrates/GradRates.aspx?cds=00000000000000&TheYear=2011-12&Agg=T&Topic=Dropouts&RC=State&SubGroup=Ethnic/Racial
. Last accessed on 2/20/2014.

19. **Section Number:** Form21_Indicator 10
Field Name: Metropolitan
Row Name: Living in metropolitan areas
Column Name:
Year: 2015
Field Note:
The data source is the United States Department of Agriculture, Economic Research Service, Population, Income, Education, and Employment State Fact Sheets: California, Population table. Last updated on January 22, 2014.Available at: http://www.ers.usda.gov/StateFacts/CA.htm. Last accessed on January 22, 2014. Data for the population living in metropolitan areas was not provided in the fact sheet.

20. **Section Number:** Form21_Indicator 10
Field Name: Urban
Row Name: Living in urban areas
Column Name:
Year: 2015
Field Note:
The data source is the United States Department of Agriculture, Economic Research Service,
Population, Income, Education, and Employment State Fact Sheets: California, Population table. Last updated on January 22, 2014.Available at: http://www.ers.usda.gov/StateFacts/CA.htm. Last accessed on January 22, 2014.

Urban and rural California population estimates were for year 2012. Urban and rural definitions are based on the Office of Management and Budget June 2003 classification. Estimated number of children living in urban areas was calculated as total population 0-19 multiplied by the percent of children living in urban counties.

Denominator Source:
State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.

21. **Section Number:** Form21_Indicator 10
Field Name: Rural
Row Name: Living in rural areas
Column Name:
Year: 2015
Field Note:
The data source is the United States Department of Agriculture, Economic Research Service, Population, Income, Education, and Employment State Fact Sheets: California, Population table. Last updated on January 22, 2014. Available at: http://www.ers.usda.gov/StateFacts/CA.htm. Last accessed on January 22, 1014.

Urban and rural California population estimates were for year 2012. Urban and rural definitions are based on the Office of Management and Budget June 2003 classification. Estimated number of children living in rural counties was calculated by multiplying the estimated number of children in the state by the percent of overall state population living in rural counties.

Denominator Source:
State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060.

Sacramento, California, January 2013.

22. **Section Number:** Form21_Indicator 10
Field Name: Frontier
Row Name: Living in frontier areas
Column Name:
Year: 2015
Field Note:
The data source is the United States Department of Agriculture, Economic Research Service, Population, Income, Education, and Employment State Fact Sheets: California, Population table. Last updated on January 22, 2014. Available at: http://www.ers.usda.gov/StateFacts/CA.htm. Last accessed on January 22, 2014. Data for the population living in frontier areas was not provided in the fact sheet..

23. **Section Number:** Form21_Indicator 09A
Field Name: HSIRace_FosterCare
Row Name: Number living in foster home care
Column Name:
Year: 2015
Field Note:
For the tabulation on the number living in foster home care, the January 2012 data presented is for a point in time (accessed on 1/24/2014) caseload for children in child welfare supervised foster care ages 0-19 years. It excludes foster care cases placed or supervised by the county probation departments, the state adoptions district offices, the Indian Child Welfare, private adoption agencies, Mental Health, the Kinship Guidance Assistance Program (KinGAP) and out-of-state agencies. The count for Whites includes Hispanics. The counts for Asian include Pacific Islanders. The data source is:

Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Putnam-Hornstein, E., Williams, D., Simon, V., Hamilton, D., Lou, C., Peng, C., Moore, M., King, B., Henry, C., & Nuttbrock, A. (2012). Child Welfare Services Reports for California. Retrieved 1/24/2014, from University of California at Berkeley Center for Social Services Research website. URL: http://cssr.berkeley.edu/ucb_childwelfare/PIT.aspx

24. **Section Number:** Form21_Indicator 09B
Field Name: HSIEthnicity_FosterCare
Row Name: Number living in foster home care
Column Name:
Year: 2015
Field Note:
For the tabulation on the number living in foster home care, the January 2012 data presented is for a point in time (accessed on 1/22/2014) caseload for children in child welfare supervised foster care ages 0-19 years. It excludes foster care cases placed or supervised by the county probation departments, the state adoptions district offices, the Indian Child Welfare, private adoption agencies, Mental Health, the Kinship Guidance Assistance Program (KinGAP) and out-of-state agencies.

The data source is:
Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Putnam-Hornstein, E., Williams, D., Simon, V., Hamilton, D., Lou, C., Peng, C., Moore, M., King, B., Henry, C., & Nuttbrock, A. (2012). Child Welfare Services Reports for California. Retrieved 1/24/2014, from University of California at Berkeley Center for Social Services Research website. URL: http://cssr.berkeley.edu/ucb_childwelfare/PIT.aspx.

ATTACHMENT 1:

Cover Letter
(Attachment to Section I-A)

State of California—Health and Human Services Agency
California Department of Public Health

RON CHAPMAN, MD, MPH
Director

EDMUND G. BROWN JR.
Governor

July 11, 2014

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

Dear Ms. Lauver:

The California Department of Public Health, Maternal, Child and Adolescent Health (CDPH/MCAH) Division is pleased to submit the FFY 2015 Title V Block Grant Application and Annual Report. We appreciate having this opportunity to showcase the many projects and programs we have underway in California to improve the health of mothers, adolescents and children, including children with special health care needs. We are grateful to you for your leadership in supporting our State Title V programs.

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

Sincerely,

Addie Aguirre
MCAH Title V Director

Maternal, Child and Adolescent Health Division/Center for Family Health
1615 Capitol Avenue, Suite 73.560, MS 8300 • P.O. Box 997420 • Sacramento, CA 95899-7420
(916) 650-0300
Internet address: www.cdph.ca.gov

ATTACHMENT 2:

Title V Public Input Received
And Previous Grant Recommendations
(Attachment to Section I-E)

Attachment to I-E. Section B: Response to Public Input Received and Previous Grant Recommendations

A. Public Input to the Draft Abridged Application/ Report and Response

The abridged FFY 2015 Title V Block Grant Report/ Application was disseminated for public comment. Below are the written comments received and grouped or subdivided by issue raised.

Comment 01 (local needs assessment process): *I have to say that I have never worked with a public entity in a manner that provides as much clarity, guidance, hand holding, tools, and resources as FHOP and CDPH have provided on this community needs assessment. I am astounded at the number of samples, templates and guides produced, and the quality of the analysis of the data. You have done everything short of doing the needs assessment for us. Not to say that I am not struggling – but that is because of time and resources. I am so appreciative and would like to pass the kudos on to anyone who needs to hear it. Thanks so much.*

Response to Comment 01:
The constructive comments we received in the previous needs assessment assisted us in crafting the materials we developed for the current needs assessment. In addition, assistance from local MCAH Directors who volunteered to pilot the Local Needs Assessment packet prior to its release helped us further refine the materials MCAH sent out to all local health jurisdictions.

Comment 02 (MCAH Partnerships and Collaboration):

- *As Immediate Past President of the American Congress of Obstetricians and Gynecologists, I wish to commend the State of California for its continued support of women's health through the California Department of Public Health, Maternal, Child and Adolescent Health Division (CDPH/MCAH) and the California Department of Health Care Services. Title V funding is critical for the health of women and as an investment in the health of the next generation.*

  During my year as ACOG President, I had the opportunity to lecture around the world. I always pointed to the collaborative efforts of ACOG with CDPH and MOD. I used the CMQCC work as I discussed maternal mortality in Chile, Colombia and Mexico. I described the importance of preconception health and the critical role the Preconception Health Council has had. And, I have used the success of our 39 week delivery efforts to point the nation forward on the National Maternal Health Initiative where we will see a reduction in maternal mortality because of our efforts, efforts modeled after the successes of California.

  Our ACOG District IX represents over 5000 physicians in California, and we support the CDPH/MCAH work as outlined in this document:
  http://www.cdph.ca.gov/programs/mcah/Documents/MO-MCAH-TitleV-AnnualApplicationReport-2013-14.pdf

  We have collaborated with our state agencies and with partners such as the March of Dimes to improve maternal health. The investment at the state level in preconception health can serve to improve maternal health outcomes and reduce maternal morbidity and mortality. This statewide collaborative is a model for the rest of the United States. Likewise, the success around reducing non-medically indicated delivery before 39 weeks has been led by California efforts, through a state collaborative. The California Maternal Quality Care Collaborative is viewed as a model both nationally and internationally as a means of reducing both maternal mortality and morbidity. The U.S. Department of Health and Human Services, Health Resources and Services Administration has introduced a National Maternal Health Initiative and the State of California is in a position to lead efforts in both quality and safety, and around well woman health care. This would not happen without the important collaboration and leadership we have seen in CDPH/MCAH.

California's 2012 preterm birth rate has dropped to 9.6%. To celebrate the reduction in our state's preterm birth rate, March of Dimes President Dr. Jennifer Howse presented the FDR Award to the State of California on March 19th, 2014. Named in honor of President Franklin D. Roosevelt who founded the March of Dimes, the FDR Award given to states who have met a challenge from the March of Dimes and the Association of State and Territorial Health Officials (ASTHO) to lower their preterm birth rates to 9.6 percent between 2009 and 2014. *Model collaborative interventions between the California Department of Public Health and March of Dimes (referenced in this application and report) have been used to help reduce the preterm birth rate and improve birth outcomes not only in this state, but across the country as well. Examples include the elimination of early elective deliveries initiative, pre/interconception health statewide council and projects and the Preterm Labor Assessment Toolkit. We greatly appreciate the hard work, vision and dedication of our Maternal Child and Adolescent Health Program (MCAH) partners at the state and local health jurisdiction level. The March of Dimes will continue to partner with the State of California to improve the health of women of childbearing age, moms and babies and advocate for restoration of its critical MCAH programs.*

March of Dimes is aware of the impact that state budget cuts are having on local MCAH Programs, including program closures, staff reductions and fewer women served. To support the work of local MCAH Programs, March of Dimes led an advocacy initiative in 2014 to get state general funds restored for the Black Infant Health (BIH) Program. More than 50 organizations supported this effort and the 2014-15 state budget included $4 million in restored state general funds for the BIH Program. This is a great success for the BIH Program and we know that there are other MCAH Programs that would greatly benefit from a similar funding restoration.

- *The RPPC coordinators are assisting with a statewide survey of hospitals regarding implementation of SB502 Hospital Infant Feeding Act. The survey will be used to inform local and state programs about best practices, and identify areas of need for breastfeeding maternity care. Data from the survey will be incorporated into the 2014 Hospital Breastfeeding Report. These efforts are very much appreciated and are an example of statewide collaboration and networking.*

  Recommendations: Recognize and support opportunities for collaboration with MCAH programs, WIC agencies, community organizations and coalitions. Efforts should include: improved familiarity with various program responsibilities and missions, opportunities for cross training and networking to improve working relationships, and strategies and goal setting for collaborative planning and outcomes-based work.

  Collaborate with WIC and community clinics to launch an education campaign regarding early and elective births. Utilize a common curriculum and messaging for patients and participants. Target areas already identified as having high rates of cesarean sections, and include materials available on the MCAH website.

  Strategic planning is needed with WIC and community clinics to identify best practices for counseling, best use of educational materials, curriculum and messaging, data collection, and opportunities to better use Registered Dietitians for counseling for Preventive Services as provided in the ACA.

Response to comment 02:

The California Department of Public Health (CDPH) aims to leverage opportunities in a changing environment, expand and strengthen collaboration and partnerships, strengthen statewide infrastructure to improve health and well-being, develop communication strategies for unified messaging, and make continuous quality improvement standard practice. To that end, CDPH and MCAH Division are leveraging opportunities to foster collaboration and planning between local MCAH and WIC programs to enhance and improve health education and health promotion activities to participating families by developing and delivering relevant, consistent health and nutrition messaging and activities.

MCAH recognizes that the collaboration between WIC and MCAH is an opportunity to support WIC and MCAH families by improving services, outreach and access to quality health and human services, along with improving chronic diseases and building healthy families for healthy communities. MCAH

recognizes that there are opportunities to leverage local MCAH staff in order to partner with community agencies to deliver services and ensure consistent messages are shared with families, medical and other service providers, and other program stakeholders.

More specifically, the collaboration between MCAH and WIC can enhance and improve health education and health promotion to participating families by developing and delivering relevant, consistent health and nutrition messaging and activities by establishing policies and procedures for MCAH's Comprehensive Perinatal Services Program (CPSP) and MCAH's local health jurisdictions.

Fostering collaboration between MCAH and other agencies is a major goal of the MCAH program. Thank you for your suggestions for further collaboration on early elective deliveries and cesarean births.

Comment 03 (Impact of Budget Reductions)

- ***"Black Infant Health Program****: Fresno continues to evaluate the BIH program. Current funding has kept the program at low staffing. The county continues to attempt to support current activities. No additional local funds are received to support BIH. Ongoing community engagement and stakeholder meeting have been held to address Infant Mortality among the African American population and enrollment in the BIH program.*

  State MCAH Staffing Reductions*: Turnover and reduction in state staffing numbers impact the local MCAH Director and staff with program technical assistance and guidance. Reductions in travel make is challenging for LHJ's at a distance to receive training and support.*

  Budget Impacts*: Fresno County MCAH Programs receive no County General Fund and very little (<12% of total budget) in Public Health Realignment. With reductions in State General Fund to MCAH and reductions in Title V, MCAH activities are greatly reduced. Fresno County has a large MCAH population, high birth rate and poor birth outcomes. The LHJ is dependent on State and Federal funding to keep MCAH program activities going. "*

- *I am speaking as AFLP/CPSP/SIDS/MCAH Coordinator plus other positions related (Cal-Learn Coordinator) that help to cover my salary. Since I began working here, five years ago, I have not seen anything else but budget cuts. I understand that as a State and as a Nation, we do not have the same funds that we used to have. I understand that as a state funded program we still have obligations to our fellow citizens, and I understand that we have to adapt to reality.*

  What I do not understand is the fact that those who decide about our state budget are not planning for the future and are not looking at the future. Cutting so much budget in prevention because it looks like we are doing "good" makes no sense. The mere fact that we are doing good and we have positive results is precisely due to the money expend in prevention.

  In my county I keep having referrals of pregnant teens every week; their parents are not teaching them about sex, the schools are not providing that education due to budget cuts, and public health is not able to help because there are not more funds. So, the money "saved" by those cuts will be nothing compared to the money the state will have to spend in medical care for the teen and a baby with a high risk to be born premature or be neglected. More money will have to be used to help the families with low resources having problems already and now with the burden of a new baby. Money will be spend because many of those teens will not finish high school and their families will ask for some cash-aid or if they work they will have a very low paid work and will enroll in welfare. In the end, saving a "little here" and a "little there" on prevention will result in expending more money in medical and social problems.

- *The California MCAH Directors leadership organization, MCAH Action, is comprised of public health professionals in 61 California health jurisdictions. Our programs develop, deliver, support, and monitor comprehensive public health systems and services for women, infants, and children in our urban and rural communities. We maintain a special emphasis on at-risk populations including low income families, pregnant*

and parenting teens, and children with special health care needs. MCAH programs and services provided at the local level have demonstrated their effectiveness as evidenced by California achieving and maintaining low rates of teen pregnancy, prematurity and infant mortality. Unfortunately, over the past seven years, repeated State and Federal budget cuts have greatly reduced funding for the local programs and services that support our at-risk populations. Simultaneously, some programs that addressed serious public health problems, such as gestational diabetes, have been completely eliminated. As a result, this has significantly limited our ability to fully provide critical services for those most in need.

The complete elimination of our State MCAH funding in 2009 has further impacted our ability at the local level to draw matching Federal Title XIX funding, which had been used to enhance our programs and services. The financial impacts on California's Title V funding threaten to create additional strain on local MCAH capacity. While we welcome potential improvements in access to health care promised by implementation of the Affordable Care Act, without effective MCAH services and leadership at the local level, many infants, children, and mothers will not experience these benefits. We are at a critical point in California. The number of children living in poverty is increasing, and yet, our community MCAH resources are declining. We have made many positive strides in California in reducing teen pregnancy, and improving birth outcomes. We cannot go backwards. Please increase levels of Title V funding to secure and augment the gains achieved through California's valuable MCAH programs and services.

- *It is remarkable to see the work that local MCAH, BIH, and AFLP programs have done in spite of the limited funding across all jurisdictions. Great strides have been made to improve maternal and child health in California and in Santa Clara County. Although our county's residents experience overall good health, disparities exist among our most vulnerable populations. Reduction in Title V and its matched funding has greatly reduced our ability to maintain key staff in our programs. As a result, our residents, families and communities have been greatly impacted. Services to our childcare community have decreased as well as our work focusing on child abuse and injury prevention and SIDS/SUIDS outreach and education.*

  Staffing cuts to our BIH program has limited our ability to provide necessary outreach to this vulnerable population of women who need our services most. Disparities continue to exist in California in pregnancy-related death, preterm birth, and fetal and infant mortality among our African American population regardless of socioeconomic level. With the continued reduction in funding, we are limited in providing necessary services for African American women. Stress due to negative life experiences (i.e.: high cost of housing, economic instability and the experience of racism) accentuates the risk for many of these maternal complications including, diabetes and other diseases.

  Although our teen birth rates have decreased, we are seeing a rise in other health disparities in our youth. Reduction in AFLP funding will be devastating to aid the necessary support and resources for a healthy birth; a healthy baby; and a healthy family. Santa Clara County is affluent and the cost of living continues to rise county-wide. With 45% of our residents paying 30% or more of their household income on housing; leaves restricted funds for health and wellbeing. Investment in these areas provides critical medical assessment, health education and outreach opportunities that would otherwise be lost.

***Response to Comment 03*:**
MCAH has taken steps to mitigate the impact of funding cuts over the last five years. Working with local MCAH Directors and the MCAH Action Executive Committee, we have streamlined processes for implementing local MCAH programs. Our efforts are focused on core priorities to meet the requirements of Federal Title V and State mandated activities, such as case finding, referrals, patient/client education, and community awareness activities. We continue to have ongoing discussion with Health Resources and Services Administration (Dr. Michael Lu, Associate Administrator) regarding inequitable MCH Title V Block Grant funding to California.

MCAH recognizes the burden on Local Health Jurisdictions (LHJs) related to budget reductions to BIH and AFLP programs since 2009. The recent restoration of State General Funds for FY 2014-15 for BIH will allow MCAH to allocate increased funds to LHJs utilizing a methodology based on health status indicators for each BIH site. BIH LHJ programs will also continue to utilize Title V funding to support programmatic activities with the primary goal of reducing low birth weight for African American babies. LHJs that are able to contribute local funds will also be able to draw down Title XIX funds for eligible activities.

AFLP agencies continue to provide services without general fund assistance and subsequent Title V cuts since 2009. In 2009, AFLP was significantly cut from over $19.2 million in FY 2008-09, serving 11,320 clients to $5.3 million in FY 2012-13 serving 3,144 clients. The capacity of agencies to provide needed services for this vulnerable population has decreased with cuts in funding and resulted in the closure of some of the state's AFLP programs.

MCAH continues to move toward a process that aligns allocations with local need based on health status indicators in each county. Title V Block Grant funding will continue for AFLP to support positive outcomes for expectant and parenting teens. In addition, grant funds from the U.S. Department of Health and Human Services, Office of Adolescent Health will continue to support the positive youth development project for AFLP.

Comment 04 (Funding Support for MCAH)

- *The Regional Perinatal Programs of California have worked with our region's hospitals to improve the quality of care provided to pregnant women and their babies by disseminating quality improvement tools to assist them in doing so. Our local county MCAH program has partnered with us and other entities to provide a seamless transition from pregnancy care to postpartum, serving the highest risk population including those women of color, low socioeconomic status, and those with limited access to health care and health education. By doing so, they have attempted to decrease the disparities among this population. County programs such as breastfeeding, oral health, and preconception health have optimized health outcomes for both mothers and their newborns and have provided the foundation for a healthier community. One in eight babies born in the US is born in California and as such we are one of the leading states in the number of infants, children, and women of reproductive age and we continue to grow in numbers. The rate of maternal mortality and morbidity is increasing in California, and several organizations including ACOG are trying to determine strategies to improve maternal outcomes. The MCAH programs are vital in bringing these ideas and strategies to fruition and reducing these adverse outcomes by enabling the early identification and reduction of health risks that would otherwise result in preterm birth, birth defects, chronic disease, and maternal/infant death and disability. Continued funding is vital to ensure that these programs that improve the quality of care provided to women and children remain intact.*
- *Title V funding for MCAH remains a vital resource for addressing numerous public health priorities for mothers, infants and children at the community level. There are significant and persistent challenges to promoting health equity and improving life course trajectories for our substantial MCAH population that is adversely impacted by poverty, late prenatal care, poor birth outcomes, teen births, obesity, and many other negative conditions. Title V allows us to provide essential programs and services that effectively respond to these needs. Title V also supports professional expertise within local public health programs to both provide necessary MCAH program oversight and to guide the development and coordination of community collaboratives that have the capacity to focus attention, leverage community resources, and achieve collective impact on a wide range of local MCAH priorities.*

  While we welcome the many benefits that will be afforded by ACA implementation, many of these critical MCAH issues will remain unresolved without continued investment in the MCAH Block Grant. Unfortunately, Federal, State, and local funding cuts are hindering the ability of MCAH programs to serve California's mothers, infants, children, and families—even while the demand for services continues to rise.

  Furthermore, compared to other states, California has the greatest number of annual live births and far greater numbers of infants, children, and reproductive age women. According to recent U.S. Census data, the poverty

rate for California's children ages 0 -18 years is 29% (higher than the national average). However, California ranks near the bottom in per person Title V funding for the maternal, infant, child, and adolescent population. Efforts to restore prior levels of Title V funding for California using a more equitable allocation formula are critical in order to ensure that we are able to protect and improve the health of even more of California's mothers, infants, and children in need.

- *Title V MCAH funding is essential to the continued efforts of local health jurisdictions and the State of California to continue to provide essential programs and services to improve the health and well-being of infants, children, and families in our low income and underserved communities. Funding supports local coordination of high quality comprehensive perinatal services for low income pregnant women and vulnerable populations.*

***Response to Comment 04*:**
This comment correctly identifies the contributions of the Regional Perinatal Programs of California and county MCAH programs toward reducing disparities and improving health outcomes for California women and their infants. While maternal mortality across the country is not decreasing, California has experienced a decrease over the past couple of years. We believe this is due in part to the development and broad promotion of the California Maternal Quality Care Collaborative toolkits. These toolkits are designed to improve health care response to pregnancy related issues, such as Reduction of Early Elective Deliveries Less Than 39 Weeks Gestation, Hemorrhage, and Preeclampsia. Soon to be released is another toolkit in that series addressing Cardiovascular Disease in Pregnancy.

We agree that continuing funding in the Title V Block Grant funding is critical to our programs. We would welcome a more equitable award based on number of live births.

Comment 05 (Funding support for local BIH Program)
"Fresno continues to evaluate the BIH program. Current funding has kept the program at low staffing. The county continues to attempt to support current activities. No additional local funds are received to support BIH. Ongoing community engagement and stakeholder meeting have been held to address Infant Mortality among the African American population and enrollment in the BIH program."

***Response to Comment 05*:**
MCAH recognizes the burden on Local Health Jurisdictions (LHJs) related to budget reductions to BIH programs since 2009. The recent restoration of State General Funds for FY 2014-15 will allow MCAH to allocate increased funds to LHJs utilizing a methodology based on health status indicators for each BIH site. BIH LHJ programs will also continue to utilize Title V funding to support programmatic activities with the primary goal of reducing low birth weight for African American babies.

Comment 06 (Funding Support for local AFLP Program)
Fresno County Economic Opportunities Commission (Fresno EOC) operates the Adolescent Family Life Program (AFLP) through our Sanctuary Youth Services. The Fresno EOC AFLP is partially funded as a contractor under County and Title V funding, which has helped Fresno EOC AFLP provide essential services to teen parents in Fresno County.

Since 1988, the Fresno EOC AFLP program has been providing comprehensive case management services to address the social, health, educational, and economic consequences of adolescent pregnancy. Using the evidence-based Positive Youth Development model, we work to improve the health of the pregnant and parenting teens, thus supporting the health of the baby; improve graduation rates; reduce repeat pregnancies; and improve linkages and create networks for pregnant and parenting teens.

While California's teen pregnancy rate has been declining in recent years, Fresno County continues to remain

among the counties with the highest teen birth rates. Fresno County has a Hispanic Population of 50.3%, and it is especially important to note that the Hispanic population experiences the highest of all teen birth rates, at 77.3 births per 1,000 being females ages 15-19.

- *Parenthood is the leading reason that teen girls drop out of school. More than 50% of teen mothers never graduate from high school.*
- *About 25% of teen moms have a 2nd child within 24 months of their first baby.*
- *Less than 2% of teen moms earn a college degree by age 30.*

In Fresno County, there are large waiting lists of expectant and parenting teens waiting to get into AFLP. Fresno EOC AFLP services are essential in assisting teen parents to ensure a safe, positive and healthy future for them and their baby, and in avoiding repeat pregnancies. In addition to parenting skills, Fresno EOC AFLP teen parents learn important life skills such as maintaining a budget and a healthy lifestyle, free of alcohol and drugs. They receive assistance and encouragement in completing high school graduation requirements and pursuing secondary education. Without these essential services, many teen parents in Fresno County face an uncertain future.

We urge the continuation of Title V funding for this important service to help address issues of teen pregnancies, thus alleviating some of the contributing factors to the cycle of poverty and social dysfunction, and instead leading to a healthy and productive life for young families and the community.

***Response to Comment 06*:**
MCAH recognizes the burden on local communities from previous budget reductions to AFLP. MCAH continues to move toward a process that aligns allocations with local need based on health status indicators in each county. Title V Block Grant funding will continue for AFLP to support positive outcomes for expectant and parenting teens. In addition, grant funds from the U.S. Department of Health and Human Services, Office of Adolescent Health will continue to support the Positive Youth Development project for AFLP.

Comment 07 (Access to MCAH Services)
"In general, MCAH program provides a very comprehensive care to its population. However, not every county has all the services in place. Some counties lack many services that are crucial to their citizens. For example, Lake County does not have many of the services provided by MCAH program. In addition, it is geographically isolated from big cities, and it has high percentage of low income. Therefore, it is difficult for clients to obtain needed services due to lack of transportation/gas money, unable to take time off from work, etc. This issue puts burden on clients, adding more stress, and can lead to high rate of missed appointments. With any kind of services, it is not only important that they are available, but they also need to be accessible. Improving the accessibility of services such as having local services in place for the clients not only has the potential to improve maternal and child health in the long run due to improving compliance, but also saving money from having less missed appointment, travel expense reimbursements, and time spend by healthcare providers (i.e. doctors, nurses, and home visiting nurses) coordinating the out-of-county appointments.

Another way to improve accessibility is to bring the services to the clients. Home Visiting Program is a great way to make this possible. However, MCAH home visiting nurses (HVNs) are limited in what they can offer their clients due to the limitation of their scope of practice. Providing the HVNs with education and training on certain health topics and expanding their scope of practice has the potential to reduce some barriers.

We need to change our tactic in reaching out to clients. Instead of thinking how to get clients to the needed services, we need to think of ways to get services to clients."

***Response to Comment 07*:**
CDPH/MCAH understands the challenges that rural counties experience in promoting accessibility of services to clients. Thank you for documenting this issue. Please continue to inform your stakeholders of this need as well.

CDPH/MCAH, through the California Home Visiting Program (CHVP), funds 22 two home visiting programs in 19 local health jurisdictions (LHJs). The two home visiting programs are Nurse-Family Partnership and Healthy Families America. Other LHJs offer home visiting or case management services to their high-risk populations through their local MCAH programs. All MCAH Directors and staff may use the training opportunities and webinars located on the CHVP website at: http://www.cdph.ca.gov/programs/mcah/Pages/HVP-HomePage.aspx The University of San Francisco, Family Health Outcomes Project (FHOP), contracts with CDPH/MCAH to provide training and information on health issues that affect the MCAH population. FHOPs intervention planning resources and tools are located at: http://fhop.ucsf.edu/fhop/htm/prods/IPinformational.htm. CDPH/MCAH will continue to offer opportunities for education on health topics and emerging issues.

Comment 08 (Expanding MCAH Services to the General Population)
"The women's support group such as their partners, families and friends are very important because they have some influence in the women's decisions. If the MCAH program can expand its program to include providing education to this group of people and not just the MCAH population, then the women's decisions to improve her health and the health of her children can be strengthen because she will have more support in her decisions. Media campaign through television, radio, and internet can be a great way to reach many people to provide them with education on the importance of topics like breastfeeding, immunization, prenatal care, preconception health and healthcare, drug abuse, nutrition, and any information that does not require clients to have a one-on-one conversation with healthcare providers."

***Response to Comment 08*:**
CDPH/MCAH recognizes the importance of and is working to increase awareness of the support systems for women and children, including increasing attention to fathers, partners, families, and friends of our target population. We are incorporating best-practice and/or evidence-based activities into our programs and future planning that involve a woman's sphere of influence.

Comment 09 (Mental Health Services)
"Thank you for the opportunity to review and provide public comment on California's MCAH Title V Block Grant.

In reviewing the 2015 proposals, I am concerned that activities that would enhance access to mental health services for children, teens, young adults and families (new mothers and fathers in particular) seem to be missing. If they are embedded under programs, it is not obvious in this report to MCHB, that maternal mental health, in particular is a top priority for many counties across California. In my opinion, it would be important to demonstrate that just as a mother and infant are a dyad, so should behavioral and physical health. Many of our programs measure physical health indicators, but the association with mental health cannot be left out.

If you have any questions, please do not hesitate to contact me and thank you again for this opportunity!"

***Response to Comment 09*:**
MCAH programs address mental health needs and access to mental health services as part of a comprehensive approach to health. MCAH acknowledges that there has been a push to screen women for depression, both during pregnancy and the postpartum period. For this reason, our programs deliver enhanced services that include nutrition, psychosocial and health education, in addition to standard obstetrical services. Many of our direct service programs (i.e., California Home Visiting Programs, AFLP & BIH) use the validated Edinburgh Postnatal Depression Scale (EPDS) to identify women with postpartum depression. Although the EPDS is typically used at a single time point to identify women with probable depression, many of our programs are now using the EPDS to routinely screen pregnant and postpartum women. Women with high EPDS

scores are referred to a mental health provider for further evaluation.

More specifically, the Adolescent Family Life Program (AFLP) is a case management-based program that offers services to pregnant and/or parenting youth throughout 30 California counties and 32 local agency sites. The program addresses the mental health needs of its pregnant and/or parenting youth through several screening tools. Upon entering the program, participants complete the Comprehensive Baseline Assessment (CBA). The CBA asks six questions designed to alert case managers to immediate mental health issues. Following the CBA, program participants complete one of the following depression screenings: Patient Health Questionnaire (PHQ-9); PHQ-9 Modified for teens; or the Edinburgh Postnatal Depression Scale screening tool. AFLP also screens for substance use using CRAFT from the National Center for Mental Health Checkups at Columbia University. Case managers will refer clients with mental health needs to the appropriate community resources available in the county, based on the results of their screening.

Finally, many local health jurisdictions address perinatal mood and anxiety disorders (PMAD), including screening and linkage to appropriate services as part of their priorities. Statements on PMAD and access to appropriate services are found throughout the report.

Comment 10 (MCAH successes and challenges)

- *Great strides have been made in infant mortality, teen births, health insurance coverage for children, and preterm births - efforts that highlight the partnership between state and local government, as well as the broader healthcare, social service, and non-profit systems. But we continue to have stalled progress in areas of low birth weight and very low birth weight births, maternal morbidity and mortality, and the Black/White ratio for infant mortality. Findings of an increasing rate of unintentional injuries and injury deaths among children/youth/young adults, especially due to motor vehicle crashes, is also quite concerning.*

- *The funding cuts experienced during the Great Recession stretched our county's ability to service the MCAH and CYSHCN populations. In particular, State General Fund reductions to MCAH, BIH, and the Adolescent Family Life Program (AFLP), as well as reductions in other federal and local funding sources, resulted in San Mateo County discontinuing social support groups for pregnant/parenting teens, case management services for fathers, and involvement in many county collaborative groups serving MCAH populations. San Mateo County discontinued involvement in State AFLP due to the drastically reduced funding, although a local version of the program continues.*

***Response to Comment 10*:**

In 2012, infant mortality rate (IMR) was 4.5 infant deaths per 1,000 live births, down from 4.8 in 2011. However, the African American infant mortality rate remains high, dropping to 9.8 infant deaths per 1,000 live births in 2012, from 10.5 in 2011. The IMR disparity persists in California as well as in the nation, with African American infant deaths occurring two and a half times more often than White infant deaths. This remains a challenge. Beginning in 2010, MCAH has implemented a group intervention model with complementary case management in the Black Infant Health Program (BIH). Evaluation of data from this revised BIH approach will help inform ongoing interventions that address the disparity. The contribution of racism and its impact on infant health and birth outcomes has been incorporated into MCAH program activities and in the collection of data from surveys such as the Maternal Infant Health Assessment. Ongoing research on disparities will assist us in developing evidence-based, data-driven interventions.

The percent of low birth weight (LBW) and very low birth weight (VLBW) births has not gone up over the past several years. The percent of LBW births fell to 6.7% in 2012 from 6.8% in 2011; the percent of VLBW births remained at 1.1% for both 2011 and 2012. As we continue our prematurity prevention efforts, we implement interventions that impact LBW and VLBW births. We have made significant

progress in decreasing the percent of premature births and will continue to follow the trend for LBW and VLBW.

There are continuing efforts to address preterm births through application of the March of Dimes Preterm Labor Assessment Toolkit and the protection of the impacted infants through the use of Antenatal Corticosteroid Treatment if it appears that the infant will be born between 24-34 weeks gestation.

Regarding Maternal Mortality and Morbidity, the following toolkits are an outgrowth of the Maternal Mortality Reviews: "Improving Healthcare Response to Obstetric Hemorrhage" and "Improving Healthcare Response to Preeclampsia." A third toolkit, "Improving Healthcare Response to Cardiovascular Disease in Pregnancy," is under development. We have seen improvement in maternal mortality in California as a result of the implementation of these toolkits and their associated learning collaboratives. We plan to address maternal morbidity and mortality through review of non-medical issues during pregnancy.

Comment 11(Diabetes Program during Pregnancy)

As I looked through the list of offerings, I did not see high risk pregnancy, diabetes and pregnancy or diabetes prevention programs. I hope the Health Department will realize that leaving out preconception care for women with Type 1 DM may lead to more birth defects and that ignoring GDM will lead to more diabetes and obesity.

I thought the State had more money now. Why do they not reinstate the diabetes and pregnancy outreach program? Webinars are nice and useful but they do not address the individualized needs of each diverse community. Site visits are essential to discover areas of need.

Also, who will be running what is left of the Sweet Success system?

***Response to Comment 11*:**
The Title V Annual Report includes the California Diabetes and Pregnancy Program (CDAPP) Sweet Success program on pages 13, 18, 25, 39, 41.

MCAH continues as lead for the CDAPP Sweet Success Program. As of July 1, 2014, a new contract for the CDAPP Sweet Success Resource and Training Center was awarded.

The new contractor will continue to manage the CDAPP Sweet Success Resource and Training Center activities to provide educational materials and monthly webinar trainings for CDAPP Sweet Success Affiliates and health care providers. The CDAPP Sweet Success Affiliates provide the direct patient care to the pregnant women with diabetes in California.

Comment 12 (Breastfeeding Program Support)
"I am writing to state that I am deeply concerned with any funding cuts that will affect breastfeeding support to mothers of California. The health risks to mothers and infants would be costly without funding to establish and continue services that provide lactation support. Scientific evidence based research affirms the long range benefits of breastfeeding, such as reducing risks to Type II Diabetes, obesity, lower incidence of SIDS, and ear infections. African American women continue to rank lowest in California's exclusive breastfeeding rates, and programs such as Black Infant Health are desperately needed to bridge the gaps in healthcare disparities among this group. Please fund this grant!"

- *"It is my understanding that the Title V application and progress report needs input for breastfeeding. I feel that breast feeding education and encouragement is part of core public health services. The State of California supports programs that promote breastfeeding such as BIH and NFP. Part of maternal engagement and bonding comes with breastfeeding. Education to support and encouragement of breastfeeding promotes health*

on several levels and helps to narrow the gap of various social determinants of health. Women with a higher level of education are more likely to breast feed. Breastfeeding can contribute to resistance to certain infant health issues, promotes healthy weight and attachment. Breastfeeding of infants can help those of more impoverished circumstances improve their baby's life. "

- *"Breastfeeding Summits -We credit the initial Breastfeeding Summit with providing us an opportunity to invite a local pediatrician to attend with us, and then become a breastfeeding champion within our local hospital environs. We have continued to invite other local partners, with good results, and look forward to the Summit each year as a motivational event.*
- *Birth and Beyond- It is unfortunate that this program was defunded. Our local hospital is attempting to train its staff "in-house." The BBC would have been so much more comprehensive, authoritative, and reliable. At the time it was offered here, there was seemingly no administrative consciousness with regards to lactation."*

***Response to Comment 12*:**

MCAH recognizes that breastfeeding benefits society as a whole. MCAH is aware that research has demonstrated that breastfeeding benefits infants, mothers and communities. MCAH acknowledges that breastfeeding contributes to a more productive workforce since mothers miss less work to care for sick infants. Employer medical costs are also lower. Moreover, breastfeeding is also better for the environment. There is less trash and plastic waste compared to that produced by formula cans and bottle supplies.

With this in mind, MCAH programs and initiatives use data-driven strategies to educate and promote breastfeeding. Additionally, MCAH encourages exclusive breastfeeding, in particular among our low income and priority populations. For example, CDAPP: Sweet Success, AFLP, CPSP, and BIH promote and encourage exclusive breastfeeding for at least 6 months among program participants. More specifically, programs like BIH address disparities in breastfeeding as it contributes to other disparities, such as higher infant mortality, asthma rates and obesity among African American children.

MCAH acknowledges that for infants, formula feeding is associated with an increased risk of otitis media, gastroenteritis, and pneumonia, as well as elevated risks of childhood obesity, type 1 and type 2 diabetes, leukemia and sudden infant death syndrome (SIDS). For mothers, failure to breastfeed is associated with an increased incidence of premenopausal breast cancer, ovarian cancer, retained gestational weight gain, type 2 diabetes and metabolic syndrome. For this reason, MCAH endorses the use of the 2011 American Academy of Pediatrics (AAP) recommendations to educate parents and the public to reduce the risk of all sleep-related infant deaths, including SIDS. Breastfeeding is one of the important messages addressed in the infant safe sleep and SIDS risk reduction recommendations.

MCAH is committed to improving overall maternal and child health. We will continue to work towards improving breastfeeding activities and collaboration among our national, state and local partners.

Comment 13 (Breastfeeding Program Recommendations)

- *"Some needs for the perinatal and breastfeeding/postpartum mothers/families:*
  1)Expand/continue the Home Visitation Program to include follow up with a Lactation Specialist (IBCLC) from 3-4 days post-delivery. Many mothers are unable to travel to appointments immediately after birth or have other children to care for – a home visit is easier on the baby and mother.

  2) Streamline access to quality electric breast pumps for breastfeeding moms. The system is so very complicated – the ACA states that mothers can obtain lactation services free of charge, including access to

pumps. When I have tried to obtain a breast pump for mothers who have MediCal – there are many roadblocks: need a prescription, referral from the OB, not allowed, etc.

3) Continue/expand the BBC (Birth and Beyond Program) – which should include assisting more hospitals to become Baby Friendly.

4) Work with hospitals to assist Labor and Delivery staff to become IBCLCs

5) Assist current IBLCLCs to become licensed (similar to licensing RNs)

6) Work with local communities to ensure access to Lactation Rooms that are not a bathroom and adequate for using (chair, table, sink, private)

7) work with employers to ensure HR departments understand the Pregnancy Related-disability programs and FMLA laws – prevent antidiscrimination towards nursing mothers when they return to work

8)Collaborate with California 1st 5 programs to promote breastfeeding to prenatal mom and postpartum mothers

9) Work with child care providers to ensure breastfeeding is supported in day/child care settings

10) Promote breastfeeding as the "First Food" for infants and work with legislators to prohibit hospitals from distributing/marketing formula discharge bags to mothers when they deliver.

11) Develop a preconception/interconception health program/campaign with a focus on breastfeeding "until at least one year" or longer.

12) Develop a method of billing for local health departments/clinics to incorporate lactation services as part of their core "Public Health Nursing" programs – which could allow "outpatient lactation services" to be established in local health clinics.
I would be happy to sit on a state Task Force that works towards any of these projects."

- *"Fresno County continues to struggle with exclusive breastfeeding rates when leaving the hospital and those rates greatly decline by 6 months post- partum. Fresno County received a Community Transformation Grant that had utilized a portion of the award to fund the "Baby Friendly Hospital Initiative" the funds have paid for education of all maternal child hospital staff to adopt the Baby Friendly feeding policy guide and also had funded a part-time coordinator to assist with moving policy and education changes for breastfeeding. When CTG funds were decreased local MCAH funds supported the project. Increased MCAH dollars would assist to improve breastfeeding rates when leaving the hospital and broaden the effort to child care providers and workplaces for breastfeeding policies."*
- *On behalf of the CA Breastfeeding Coalition (CBC), we applaud MCAH for the many accomplishments to increase breastfeeding rates in California. We ask that MCAH continue to focus efforts on increasing breastfeeding rates in the following ways:*

- *Continue as an in-kind sponsor of the annual CA Breastfeeding Summit. If funds become available, please provide funds to CBC for the coordination of the summit as it directly serves the MCAH population and focuses on removing systemic barriers to breastfeeding for all women. Recommend or require LHJs to send MCH staff to the annual California Breastfeeding Summit. Adapt the Vermont BBC curriculum that was originally from CA and make it appropriate for CA by changing photos and update for California Hospitals to conduct nurse education training. Update the Model Breastfeeding Policies to align with the Baby-Friendly Tens steps and to include language to comply with the WHO Code. Collect hospital contacts and disseminate to local breastfeeding coalitions Ensure that CPSP services are maintained and available for women transitioning into Medi-Cal managed care. Develop a three hour breastfeeding education training for physicians serving the MCAH population through the Breastfeeding Technical Assistance program. Continue to provide assistance to the DHCS's Breastfeeding Task Force to increase breastfeeding rates among women receiving Medi-Cal as*

part of the DHCS Strategy for Quality Improvement. On behalf of Breastfeed LA, we wish to add the following comments with respect to the Title V block grant and breastfeeding:

We recommend that:

1. *1. All the Local Health jurisdictions be required to send staff to the CA Breastfeeding summit. 2. Consider updating the Model Breastfeeding Policies to align with the Baby-Friendly Tens steps or to include language to comply with the WHO Code.*

   3. Collect hospital contacts and disseminate to local breastfeeding coalitions. 4. Continue to partner with the California Breastfeeding Coalition to plan the CA Breastfeeding Summit. 5. Ensure that CPSP services are maintained and available for women transitioning into Medi-Cal managed care.

1. *6. Develop a three hour breastfeeding education training for physicians serving the MCAH population.*

   7. Engage the Office of the Patient Advocate [http://www.opa.ca.gov/Pages/Home.aspx] to ensure that the Affordable Care Act, Women's Preventive Services, Breastfeeding Support, Supplies and Services is being implemented by all California Insurance Payers. 8. Consider funding an update to the Birth and Beyond California curricula to include updated research and evidence and to support acquired skills in adopting the Ten Steps to Successful Breastfeeding. 9. Continue to advocate for workplace lactation support, by engaging the Labor Commissioner to issue better employer guidelines for the lactation accommodation laws.

- *Although a final report from CDPH-COPP is pending for this project, it was evident at the close of the project, that the 15 clinics accomplished, in just one year, huge improvements in their breastfeeding policies and practices and most are now billing for lactation support and sustaining their programs. While California WIC Association and California Breastfeeding Coalition developed the project tools, provided the technical support, and leadership for the development of a pending document for breastfeeding friendly clinics and offices, this project was an excellent example of collaboration between MCAH, COPP, community organizations and statewide volunteer experts. The project also has provided important information for strategies and challenges for increasing breastfeeding rates in the postpartum period for low-income mothers, and opportunities for collaboration as part of health care reform.*

  Recommendation: CDPH-COPP needs to publish the Steps/Guidance/Criteria document for breastfeeding friendly clinics and medical offices. CDPH should also publish a toolkit for clinics and medical offices to use to implement breastfeeding policies and practices. CDPH should seek funding opportunities to either further develop the existing clinics and/or start new sites, given the various models of service delivery. Recommendation: Funding opportunities to either further develop breastfeeding support in the existing clinics and/or start new sites, given the various models of service delivery, should be pursued. California has an opportunity to be a national model for implementing community continuums of care for low-income breastfeeding mothers, and incorporating the key organizations involved in health care reform.

  Recommendation: Work with a breastfeeding coalition, specifically the Inland Empire Breastfeeding Coalition as original authors, to update the California Model Hospital Policies to parallel the Baby Friendly Hospital Policies.

  Expanding breastfeeding support in MCAH programs is an excellent idea, but should be done thoughtfully and strategically with other programs, especially with the WIC program that provides extensive breastfeeding support and training, and has the largest workforce of lactation consultants, educators and peer counselors. With shrinking budgets and an era of innovation and reform, now is the time to work very closely to expand effective breastfeeding support. Additionally health plans and the Dept. of Health Care Services also need to be involved in the planning process.

Recommendation: CDPH-MCAH and WIC should be working closely with DHCS, to tap the Preventive Services opportunities to provide nutrition and breastfeeding counseling. Public health Registered Dietitians, the majority which are employed in WIC, should be tapped for innovative service delivery models of the Preventive Services through cross program staffing and health reform innovations for billing.

Response to Comment 13

As outlined in CDPH's strategic map, we are aiming to leverage funding and program opportunities to expand and strengthen collaborations and partnerships; strengthen statewide infrastructure to improve health; develop communication strategies for unified messaging, and make continuous quality improvement a standard. To that end, CDPH is working with several programs, such as Medi-Cal, to support our Medi-Cal providers in offering preventive services to their pregnant clients. Our goal is for women and families to receive seamless services while always utilizing funding appropriately and efficiently.

In addition, MCAH, Department of Health Care Services (i.e., CCS), and WIC have continuously met since 1993 to plan, coordinate and collaborate on delivering standardized health and wellness messages and service delivery to promote nutrition (including breastfeeding) and physical activity among MCAH programs and initiatives, and community agencies. In addition to our collaboration with state managed care, we provide technical assistance to local county Perinatal Services Coordinators (PSCs) to ensure that local managed care plans include CPSP services (including nutrition and breastfeeding) when negotiating their contracts. This will ensure adequate reimbursement to providers serving pregnant and postpartum women.

Breastfeeding:
Local health jurisdictions complete their Title V needs assessment this year. Based on their findings, they are encouraged to select MCAH Division recommended objectives. For breastfeeding, MCAH has developed model objectives that will encourage partners (i.e., community, maternity and children's health centers) to implement the Breastfeeding-Friendly Guidelines as developed with funding through the California Obesity Prevention Program.

California Home Visiting Program promotes and supports breastfeeding. Making International Board Certified Lactation Consultant (IBCLC) services available when needed would be a great addition to the home visiting program. While many of the local programs have acquired additional lactation education for members of the home visiting team, there are times when then the expertise of an IBCLC is needed. To increase the success rate of the mothers participating in this program, having an IBCLC who could make home visits and provide continuing education to staff would be a great benefit. Should funding be available, it will be seriously considered.

MCAH was the lead in writing the California Food Guide's "Infant Feeding" section where breastfeeding is promoted as normal infant feeding. This guidance is followed in all MCAH programs that work with perinatal women and young children. The Regional Perinatal Program of California (RPPC) works with labor and delivery hospitals and promotes breastfeeding, including the requirements of the Infant Feeding Act (having an infant feeding policy) and SB402 (hospitals will comply with the guidelines of the Baby Friendly Hospital Initiative or the California Model Hospital Breastfeeding Policies).

Currently, all MCAH materials aimed at interconception care and health promotion promote breastfeeding. The most prominent interconception care campaign - the Interconception Care Project of California - promotes breastfeeding on all of the clinical modules and patient materials. The Every Woman California website links to breastfeeding information. A new easy-to-read fact sheet is in development for the Every Woman California website that will promote breastfeeding among women

who have not yet had a baby. This preconception health-focused breastfeeding material is aimed at increasing breastfeeding intention, which is linked to actual rates of breastfeeding initiation and duration.

Before the ruling on women's preventive care coverage came out, CDPH provided the only state testimony for what should be included. MCAH wrote the nutrition, physical activity and breastfeeding comments:

CDPH/DHCS Testimony for IOM Committee on Preventive Services for Women. The issue is huge as each insurance provider defined what the coverage is. Last summer, the USBC put this web page up - http://www.usbreastfeeding.org/NewsInfo/NewsRoom/201307ModelPayerPolicy/tabid/345/Default.aspx - to provide some assistance. HealthCare.gov offers only this information: https://www.healthcare.gov/what-are-my-breastfeeding-benefits/. DHCS will convene an advisory group on this topic. MCAH will continue to support the convening of this advisory group and will be available to participate if asked.

Local health jurisdictions complete their Title V needs assessment this year. Based on their findings, they are encouraged to select MCAH Division-recommended objectives. For breastfeeding, MCAH has developed model objectives that include:

- Labor and delivery hospitals to implement the model hospital policies or the Baby- Friendly USA™ Hospital requirements to comply with the Infant Feeding Act [Health And Safety Code Section 123360-123367]; and
- Postpartum breastfeeding women returning to work at the Public Health Department (PHD) will breastfeed as long as desired and/or a lactation accommodation policy will developed and implemented; and
- African American mothers participating in MCAH program(s) will be encourage to exclusively breastfeed until six months of age; and
- CDPH will establish a plan to support breastfeeding and other forms of infant feeding, including, during emergencies.

MCAH will consider breastfeeding education training for physicians and other health care providers serving the MCAH population. MCAH has several online resources, such as "Going Back to Work or School" website, which includes sections for parents, employers, CDPH, child care workers, community leaders and international reports.

MCAH will continue to encourage and enquire within DHCS to develop guidance on lactation services that support the Affordable Care Act. MCAH will be available to participate on any advisory committee that DHCS forms to develop breastfeeding service guidelines.

Baby Friendly Initiatives:
The funding for CA Birth and Beyond project was cut several years ago due to decreased funding for Title V activities. In the last few years in Los Angeles County, First Five awarded $10 million to assist hospitals to become baby friendly. Pending funding availability, MCAH may consider next steps for building upon early work of the Birth and Beyond Program.

MCAH has no control over hospitals' decision to train their nurses to become IBCLCs, which involves extensive classroom and internship hours. MCAH programs can provide resources for labor and delivery staff to become IBCLCs. MCAH will continue to educate on the IBCLC certification on the CDPH breastfeeding web page. In addition, the MCAH web page will link to the United States Lactation Consultant Association, which includes information on the cost effectiveness of the use of lactation consultants in the primary care practice and IBCLC staffing recommendations.

The Vermont Birth and Beyond curriculum is well done and the photos are helpful. The PowerPoint method to go along with their slides requires training for all those who use it. Pending funding availability, MCAH will consider next steps for building upon the adaptation of BBC completed by Vermont.

The model hospital policies were developed as an alternate set of policies for hospitals that were resistant to working on the Baby-Friendly Hospital Initiative (BFHI). Over the years, that resistance has waned so that we now have over 60 hospitals certified as breastfeeding friendly. Acknowledging that SB 402 refers to these policies and that there are still hospitals resistant to the BFHI and pending funding availability, MCAH will consider steps for updating the Model Breastfeeding Policies to align with the Baby-Friendly Ten Steps and include language to comply with the WHO Code.

Childcare Nutrition:
MCAH is currently working with the State of California Emergency Medical Services Authority (EMSA) to develop standards for the training required by AB 290 (Alejo) Child day care: childhood nutrition training. The bill will add one hour of required nutrition training to the current seven-hour Preventive Health and Safety Practices Course required for licensees of child care homes and centers. The new training will allow child care providers to be educated on childhood nutrition, including breastfeeding. The standards will be developed to provide guidance to EMSA's training directors who must develop the curricula used for the training and who oversees the training throughout the state. The bill goes into effect January 1, 2016.

California Obesity Prevention Program
The California Obesity Prevention Program of the California Department of Public Health and partners, with supplemental funding to the obesity grant from the Centers for Disease Control and Prevention, was funded to implement a breastfeeding friendly healthcare provider certification program to increase breastfeeding duration rates in California communities of color. Efforts were focused on enhancing the capacity of community safety-net health clinics that offer direct health care services to provide professional breastfeeding support to mothers after they return home from the hospital. Health centers implemented systems to provide and bill for professional breastfeeding support services and pumps as required by the Affordable Care Act. Fifteen community clinics serving families in high-risk ethnic groups and communities that have chronically low breastfeeding duration rates were selected and funded in 2013 to:

- Participate in a statewide collaborative to develop model policies that will be used to designate a community clinic as breastfeeding-friendly certified, in similar fashion to the designation of a hospital as baby friendly, and pilot test these model policies.
- Improve staff skills in lactation support and in billing Medicaid for pumps and other lactation support services through training and technical assistance to the recipient clinics, enabling them to sustain continuation of these activities beyond the term of the grant.

Next steps under the leadership of the California Obesity Prevention Program will be to:

- Disseminate the materials developed through the collaboration and pilot test the policies and billing process, thus encouraging other community clinics to undertake breastfeeding-friendly certification and obtain reimbursement for lactation services
- The information gathered from this program will be used to inform California state efforts in promoting and developing guidelines for the breastfeeding provision of the women's preventive services regulation.

Comment 14 (Availability of online Breastfeeding Data)

- *We feel certain that publicizing the breastfeeding data by County and Hospital of Occurrence has given our local efforts a strong boost. Our county ranks at third from the bottom. We think these publicized statistics have started to "sink in" and we have been able to counter initial reactionary excuses and minimizing comments, so that we can get down to what is really true, which is that our local hospital has not sufficiently trained its staff to manage lactation, either in the maternity department, or elsewhere in the hospital system where a nursing mother may need care, such as in the ED.*

- *Sharing of, and familiarity with, breastfeeding data across programs, is critical for developing goals for health outcomes and meeting federal benchmarks. This is even more important with the rollout of the ACA and implementation of Electronic Medical Records. Much work is needed to ensure breastfeeding data is collected, quality assurance is established, and collaborative program planning occurs. MCAH plays an important role in this with WIC and DHCS.*
  Recommendation: Continue collaboration with the state programs for breastfeeding data collection, AND include the EMR companies, clinics and provider offices/Independent Physician Groups. There are many existing gaps in the collection of breastfeeding data and planning for data collection and quality assurance is a critical need.

  Infant feeding data collected on the Newborn Screening Form by GDS and managed by MCAH has been critical in the provision of the hospital breastfeeding report, state and county fact sheets. These reports, now published since 2006, have been instrumental tools to help breastfeeding experts, hospital staff and local decision makers improve hospital breastfeeding policies and ultimately rates. These reports have also drawn national attention, including the CDC, as an effective strategy for improving maternity care.
  Recommendation: Continue to collect and manage hospital breastfeeding data. Hospital data is especially important in order track post-discharge data.

  The county and regional mPINC reports were also used in the hospital breastfeeding report, which bolstered the credibility of the report by using multiple data sources, including use of federal data.
  Recommendation: Continue to use the federal mPINC data to make available these useful tools for high-need counties and regions.

***Response to Comment 14*:**
We are pleased to hear that breastfeeding data posted on the MCAH website is being used extensively and has drawn national attention. The set of breastfeeding related measures provide rates at the local level to help communities track and demonstrate impact of programs and policies developed to promote breastfeeding.

Comment 15 (CCS Strengths and Needs)
"1115 Waiver, Promoting Organized Systems of Care for Children with Special Health Care Needs (CSHCN): The CCS program pilot projects have not been implemented as planned. Orange, San Diego and LA have not implemented at all due to funding and other issues not resolved with State. The CCS Program future remains hazy. Not sure how decisions can be made for another model to revise CCS when pilots have not been implemented and evaluated.
Child Health Insurance Coverage: The transition from Healthy Families to Medi-Cal was smooth in Fresno County based on CCS and CHDP Admin experience.
High-Risk Infants: Fresno CCS authorizes HRIF services to Children's Hospital Central CA. No issues that we are aware of. We have a good working relationship.
Pediatric Palliative Care: Fresno currently has 9 children enrolled in PPC. Hinds Hospice is the only approved provider for PPC services. Implementation of the program is extremely time consuming with requirements for "End of Life Nurse Education Course" (ELNEC) training for CCS nurses involved in the program, approximately 30 page Family Care Plan (FCAP) to be completed by the providing agency every 6 months which must be reviewed by MD and CCS Nurse along with other forms."

***Response to Comment 15*:**

Comment 16 (Inclusion of Local Data in Annual Report/Application)

"Fresno County is located in the center of the state of California. It has an area of over 6,000 square miles in central California, and is the sixth largest county. Being located near the center of the San Joaquin Valley is a distinct physical feature. Fresno County is the number one agricultural county in the state with production of $6,886,213,700 in 2011. Top private sector employers are Health care, Manufacturing, Agricultural Product processing, Telecommunications, Insurance, Auto & Real Estate Sales. Public sector employers include Education, County & Municipal Government, Health Care, and Air Quality Regulation. Fresno County has only 5.5 recreation facilities available for every 100,000 residents compared to 9 for the state of California. This places Fresno County as 47th of the 56 California counties ranked for access to recreation facilities. Within the city of Fresno, the most populated city in Fresno County, parkland totals 1,511 acres. Only 1.4 playgrounds exist for every 10,000 resident and the city spends, on average, $59 per resident for parks and recreation centers. In Fresno County, nearly 40% of teens and adults have not visited a park, playground, or open space within the last month. Fresno County ranks 46 out of 57 counties in the State on its health rankings. When data is combined with the entire state of California to report to HRSA on health and outcomes indicators it dilutes the areas of the state that are higher in poverty and those which have the poorest health outcomes. Many of these counties are located in the Central San Joaquin Valley.

I would recommend that regional reports on outcome data also be shared with HRSA in order to provide a clearer picture of the areas of need around the state. Although numbers in many areas look improved there are still many counties and regions that struggle with High Infant Mortality, Preterm deliveries, teen pregnancy and poor access to health care. A more comprehensive picture may provide a different perspective."

***Response to Comment 16*:**

The annual report/application is structured to only allow reporting of state-level data. If the reporting requirements change to allow inclusion of regional data, California will comply with the new requirement.

Comment 17 (CCS care coordination and program evaluation):

- *The level of care coordination in the medical home for CYSHCN seems to be getting worse in California based on national surveys, despite the availability of CCS services for low-income children and those in the CCS MTUs.*
- *San Mateo County is also the one CCS Demonstration Grant (CCS Pilot) currently operating under the California Medicaid Section 1115 Waiver - a Medi-Cal Managed Care pilot through Health Plan of San Mateo (HPSM). This pilot is allowing HPSM and San Mateo County CCS to provide whole-child care, enhanced care coordination with a comprehensive assessment and service plan to be shared with the family and primary care provider, increased family participation in program oversight, and additional community resources. While we are pleased to pilot this partnership under the 1115 Waiver, we are disappointed that SCD does not appear to be pursuing a formal evaluation of this pilot through their previously planned agreement with the UCLA Center for Health Policy Research. Lack of a rigorous evaluation will make it much harder to determine the ideal system of care for CYSHCN in California. We are, nonetheless, excited to test this new way to serve our population of CYSHCN.*

Response to Comment 17:

Comment 18 (Public Input Document)

I also believe that if the State wants input on such a huge document, they should pay professionals to give input. Do the State employees volunteer their time or do they get paid?

***Response to Comment 18*:**
Thank you for the suggestion. We deeply appreciate the time and energy that our stakeholders contribute to provide their perspective.

Comment 19 (WIC State Plan)
Below are comments, relevant to MCAH, submitted by California WIC Association, regarding the California WIC Program State Plan.

Regarding Objective1: Work with the Department's Maternal, Child and Adolescent Health (MCAH) Program to provide coordinated services to WIC participants, ensuring a continuum of care to include baby behavior intervention.
Recommendation: Through many targeted small programs such as Black Infant Health, Home Visiting, and Adolescent Family Life, MCAH provides evidence-based care to high-risk mothers and families, including case management, health education, support and empowerment, and coordination of health and psycho-social care for individuals with many life challenges. These targeted MCAH programs often – if not exclusively -- depend on WIC intake and screening for the identification and proper referral of patients that make up their small but high-need caseloads. To put it simply, MCAH looks to WIC to populate MCAH's specialized interventions, not the other way around. It is unrealistic and highly unlikely to expect that MCAH staff, already stretched thin, will somehow discover and enroll large numbers of potentially eligible but un-served WIC participants in the community.

WIC eligibility, education and referral services should be provided by WIC staff, and high-risk mothers and children identified through WIC should continue to receive more intensive services through MCAH's family of programs. While there is always room for improvement and innovation, our experience is that these programs are generally well-coordinated, particularly in county health departments who administer both WIC and MCAH contracts.

Regarding Objective II: Work through the Department's MCAH Program to establish a nutrition community coordinator position at each local health jurisdiction to take advantage of existing community connections to provide enhanced services to WIC participants who have been determined to be at high risk.

Recommendation: It is duplicative (and a questionable use of taxpayer funds) to deploy MCAH staff to provide direct nutrition and referral services to WIC participants, including "enhanced" WIC services for high-risk participants. How would MCAH document these services in WIC ISIS as required and how would WIC staff avoid providing the same services over again to the same participants?

WIC is a public health nutrition program that provides secondary prevention services that are clearly defined in federal regulations and guidance. In WIC, participants at higher nutritional risk, or those in need of intensive breastfeeding counseling, already have ready access to WIC Registered Dietitians and WIC Breastfeeding Peer Counselors and/or International Board Certified Lactation Consultants. Participants found to be at high risk for other health or psychosocial problems are required to be referred to other community providers, including MCAH in many cases. Moreover, direct provision of other services such as immunizations, actual enrollment (beyond screening and referrals) into CalFresh, Medi-Cal or Covered California, psychological counseling, oral health care, substance abuse treatment, family planning, domestic violence, housing counseling, or other primary health care are not WIC-allowable costs under federal law.

While it makes very little sense to set up a parallel nutrition and breastfeeding direct service delivery system within MCAH's already stretched infrastructure, a WIC-funded community coordinator position at each local health jurisdiction could be strategically deployed to outreach and educate community health and service providers about WIC's valuable nutrition and breastfeeding resources, and to share WIC's robust and evidence-based health education strategies and patient education tools with them in an effort to create uniform and common health messages and better-quality patient counseling around breastfeeding, healthy infant feeding behaviors, complementary feeding, diabetes prevention and weight gain during pregnancy. Like a pharmaceutical sales rep, a WIC community coordinator could provide "detail marketing" visits to the "frequent flyer" (highest sources of WIC referrals) OB and pediatric providers, to improve understanding and strengthen linkages between WIC and the medical community.

Moreover, a well-trained and knowledgeable WIC community coordinator could provide critically needed medical and community clinic partner "inreach", which could truly help WIC staff troubleshoot frequent misunderstandings and correct widespread misperceptions about WIC's eligibility and benefit requirements, especially (but not limited to) the reasons for federal blood-work requirements, benefits of "Breastfeeding-Friendly" medical provider clinics, and the how to streamline ongoing challenges around the provision of non-contract brand and/or medically unnecessary (and very costly) special formulas, medical foods, and other clinical nutrition issues.

This community coordinator role would require a significant investment in training to empower the staff to be able to answer questions related to the WIC program, which is a complex program. Local vendor and regional breastfeeding liaisons, are examples of staff positions with community interface that have been successful, but only with thoughtful planning and extensive training on WIC program details.

Regarding Objective III: Engage other programs that currently have access to the WIC participant demographic in order to collaborate and strategize the promotion of the WIC program and to ensure retention of existing participants.

Recommendation: We welcome the Department's vision of leveraging WIC and other programs serving low-income young parents, infants and children more strategically towards achieving specific and concrete health outcomes. Local WIC programs partner on myriad community health efforts, working in both local health departments and other primary care systems. Although local WIC and MCAH agencies have a long history of collaborative strategies and agreements, this collaboration could always use some strengthening across the state using a "collective impact" approach. In fact, last November CWA staff offered, without success, to convene an initial WIC-MCAH stakeholder group to prioritize common health outcome objectives, metrics, strategies and barriers.

In our conversations with county MCAH Directors since then, we have discovered that they are just as puzzled as we are by the lack of clarity and information about this proposal, and equally frustrated by the lack of consultation with local providers who will be expected to carry it out. In the strongest possible terms, we urge the Division not to proceed with this plan without extensive and meaningful joint consultation and input from both WIC and MCAH providers from a broad cross-section of California regions, which will increase the likelihood of success and useful outcomes.

***Response to Comment19*:**

MCAH and WIC have been long-term partners in providing critical quality services to families. However, the environment is changing. Since California's WIC participation has declined, MCAH has the capacity and infrastructure to increase and retain WIC's participation by enabling the target population (women and children up to 5 years old) to select healthy foods and beverages and increase physical activity to improve the birth and pregnancy outcomes among WIC and MCAH participants.

To that end, CDPH is leveraging opportunities across programs to support consistent messages, improve service delivery, and strengthening partnerships. The collaboration between WIC and MCAH will ensure better outcomes for California families. CDPH's focus is on the family, which may receive services or hear messages from multiple venues. The goal is for the families to receive consistent messages and seamless services while always utilizing funding appropriately and efficiently.

MCAH and WIC have had a long-term reciprocal relationship where both programs benefit from each other's referrals to reach their target populations, in particular to reach low-income priority populations. MCAH and WIC services and resources provide California families an opportunity to maximize collective impact on nutrition (including breastfeeding) and physical activity. MCAH has been instrumental in referring women and families to WIC to ensure they have food on the table every night. Through MCAH programs, families have remained WIC participants beyond their child's first year.

Based on the Maternal and Infant Health Assessment (MIHA) data, we also know that many women still

think they don't qualify for WIC. For example, low-income women without Medi-Cal may not know they qualify for WIC. In addition, women intending to breastfeed think WIC is for formula only; or simply don't understand the value of WIC services. Among WIC-eligible women, 15.4% (51,300 out of 332,900) did not enroll in WIC during pregnancy. Women whose incomes fall close to the cut-off may not think they are eligible because they make too much money.

MCAH and WIC will foster collaboration to enhance and improve health education and health promotion to participating families by developing and delivering relevant, consistent health and nutrition messaging and activities by establishing policies and procedures for MCAH's Comprehensive Perinatal Services Program (CPSP) to:

- Establish a perinatal health community coordinator at each local health jurisdiction to coordinate and provide consist health and nutrition messages and activities among MCAH (i.e., CPSP providers) and WIC programs. In addition, the perinatal health community coordinator will be charged with building community relationships.

- Provide consistent health and nutrition messages and activities between MCAH and WIC programs and their respective community partners.

- Increase and enhance outreach efforts and activities to increase participation and retention among WIC participants and eligible non-participants.

- Coordinate and improve efforts between CPSP providers and the WIC program in securing timely and accurate biochemical (including hemoglobin and/or hematocrit values), results from WIC participants to establish WIC eligibility.

- Reduce costs related to the number of therapeutic formula authorizations and distribution requests among WIC participants by educating health care professionals and the public about pediatric nutrition, feeding practices, tolerance and qualifying medical conditions.

Comment 20 (information about the Home Visiting Program): *I was hoping there might be more about CHVP – maybe that is reported elsewhere?*

Response to comment 20:
CDPH/MCAH houses both Title V and the California Home Visiting Program (CHVP) funded by the Maternal Child Health Bureau (MCHB). The Title V application/ report is primarily focused on reporting the progress of Title V-funded programs and presenting brief information about other programs that Title V programs collaborate with. More information about CHVP is described in two annual progress reports submitted annually to MCHB: the Formula Grant Progress Report and the Competitive Grant Progress Report. These reports document yearly programmatic progress, budgetary expenditures/allocations and evaluation efforts. CHVP also submits two Annual Benchmark Reports each year that document the 35 federally-mandated constructs: the Formula Grant Benchmark Report and the Competitive Grant Benchmark Report. These data reports consists of individual level outcome data aggregated by site and by grant.

Comment 21 (correction to the abridged draft report):
- *Correction to page 10 re: CMQCC should be "The next QI toolkit for release will address cardiovascular disease in pregnancy targeting obstetricians, family medicine and ER staff.//2015//*
- *I noticed on p. 11 of the abridged version that maybe an introduction is missing for BIH: "The report recommended…" I think this could perhaps be revised as: "A 2007 report by UCSF recommended …"*

Response to comment 21:
Thank you for the suggested corrections. The correction has been made in the final version of the document.

B. Stakeholder Input on MCH Transformation 3.0 (video available at http://mchb.hrsa.gov/blockgrant/index.html)

California's Title V circulated the MCH Transformation 3.0 video, together with the video transcript and slide set, to its stakeholders. Comment was provided by 22 individuals. Generally, those who provided comment welcomed the changes outlined and provided constructive suggestions on refining or retooling the "straw person" measures proposed. A 33-page compilation of the comments and recommendations received was inserted throughout the different sections of the transcript and was sent electronically to MCHTransformation@hrsa.gov on January 22, 2014.

Our effort spurred the Lucile Packard Foundation for Children's Health, one of our stakeholders, to compile comments it received from 12 additional individuals. The 14-page compilation of comments was electronically sent on January 17, 2014. An electronic copy of both compilations is available upon request.

C. Public Comments Reviewed from Print Media

MCAH reviews comments from the public about MCAH-related news articles, editorials and opinion pieces from major dailies in California. There were 338 public comments that were reviewed by MCAH from select MCAH-related articles and opinion pieces. To illustrate this point, select public comments from an article printed in the Los Angeles Times is shown below. This is followed by a listing of the number of comments reviewed by printed article for the current reporting period.

1. ***Thirty four (34) comments reviewed from:***

Gorman, A. (2013, September 29). For Black infants, a precious start in life. Los Angeles Times. Retrieved from http://www.latimes.com/local/columnone/la-me-c1-black-babies-20130909-dto,0,1311885.htmlstory#axzz2o39I5HYO. Last accessed on February 6, 2014. (Select comments are provided below)

A commenter posted at 3:43 PM, September 11, 2013:
"Thank you so much for sharing your family's special story of LIFE, Samantha and Antoine. (It touched me so much that I created an account just to leave a comment.) What a precious, precious gift you have in your little Adris! A happy 14 months to you tomorrow!"

A commenter posted at 12:49 PM September 9, 2013
"…The mother's that were interviewed for this story are educated, married and solid middle-class, yet their rates of miscarriage and early term births are higher than white women. Geneticists have found that if a person has suffered starvation and extreme circumstances that this will make changes in DNA, which results in future generations with health problems
(some of which include obesity & cancer). The Dutch did a study on women that had been starved during WWII and have followed those descendants (they are
known for keeping track of their citizens via medical charts) and how future generation are still being affected. I can see why Black people are still being 'haunted' by the past even in their genes."

A commenter posted at 12:25 PM September 9, 2013
"Very nice story, very thorough, well-investigated and written. I appreciate these efforts to honestly address social problems like this. They are too frequently ignored because no one wants to talk about them. Kudos, Times. ."

A commenter posted at 12:11 PM September 9, 2013
If you're broke with no insurance how do you get prenatal care?

A commenter posted at 12:06 PM September 9, 2013
"You can blame the parents or lobby for laws to punish irresponsible parents. But all this punishing the parents doesn't help the black babies. If you were to see a helpless baby on the street by herself, you'd probably help her in some ways, because that's the moral thing to do. If you were to see a helpless baby with her irresponsible mom, would you feel you've achieved an adequate moral standard if all you've done is chastise the mom?"

A commenter posted at 8:28 AM September 9, 2013:
"Black women are more likely to be poor, have less education, lack health insurance and have chronic conditions such as diabetes and obesity. All reasons not to have a baby UNTIL you can afford it and are healthy enough - they never seem to think beyond the "I want a baby" and it is not society's responsibility to take care of your kid(s) either."

A commenter posted at 12:05 PM September 9, 2013:
"…This article is about how even with insurance, a black-family will still have more difficulties and for a multitude of reasons."

1. Six (6) comments reviewed from:
Kumeh, T. (2013 July 13). State teen birthrate dropped to lowest level in 20 years. Los Angeles Times, Los Angeles, CA. Retrieved from: http://articles.latimes.com/2013/jul/17/local/la-me-ln-california-teen-birth-rate-20130717. Last accessed on February 6, 2014.

2. Six (6) comments reviewed from:
Lee, S. M. (2013, October 29). Breastfeeding push gives rise to risky sites. San Francisco Chronicle, San Francisco, CA. Retrieved from http://www.sfgate.com/health/article/Breast-feeding-push-gives-rise-to-risky-sites-4937429.php#page-2. Last accessed on February 6, 2014.

3. Forty seven (47) comments reviewed from:
Orenstein, N (2013, November 1). Report highlights racial disparities in Berkeley health. Berkeleyside. Retrieved from http://www.berkeleyside.com/2013/11/01/report-highlights-racial-disparities-in-berkeley-health/. Last accessed February 6, 2014.

4. Two (2) comments reviewed from:
Tuan, L. (2013, November 19). Researchers find high rate of teenage pregnancy among foster youth. The Daily Californian. Retrieved from http://www.dailycal.org/2013/11/19/researchers-find-high-rate-teenage-pregnancy-among-foster-youth/. Last accessed on February 6, 2014.

5. Three (3) comments reviewed from:
Kaplan, K. (2013, November 30). Obesity may be a side effect of PTSD in women, study finds. Los Angeles Times. Retrieved from http://www.latimes.com/science/sciencenow/la-sci-sn-ptsd-obesity-link-

women-20131120,0,7750483.story#ixzz2sa90Ly8L. Last accessed on February 6, 2014.

6. Nineteen (19) comments reviewed from:
Healy, M. (2013, December 2). Fat and healthy is a myth, new study says. Los Angeles Times. Retrieved from: http://www.latimes.com/science/sciencenow/la-sci-fat-healthy-myth-20131202,0,5532717.story#ixzz2saB45atg. Last accessed on February 6, 2014.

7. Three (3) comments reviewed from:
Harris, J. (2013, December 3). Soda of future designed to trick taste buds into sweet submission. Los Angeles Times. Retrieved from http://www.latimes.com/food/dailydish/la-dd-pepsi-soda-taste-modifiers-s617-20131203,0,1737126.story#ixzz2saA8sP00. Last accessed on February 6, 2014.

8. Sixty four (64) comments reviewed from :
Alexander, K. (2014, February 2) California abortion rate lowest in decades. San Francisco Chronicle Retrieved from http://blog.sfgate.com/stew/2014/02/03/california-abortion-rate-lowest-in-decades/. Last accessed on February 6, 2014.

9. One (1) comment reviewed from:
Henry, J. (2014, February 7). Mental health, obesity top list of San Gabriel Valley health problems. San Gabriel Valley Tribune. Retrieved from: http://www.sgvtribune.com/health/20140207/mental-health-obesity-top-list-of-san-gabriel-valley-health-problems Last accessed on June 11, 2014.

10. Twenty (20) comments reviewed from:
Early, D. (2014, February 11). Poll: obesity overtakes drug use as top health worry about California's kids. San Jose Mercury News. Retrieved from: http://www.mercurynews.com/bay-area-news/ci_25116997/poll-obesity-overtakes-drug-use-top-health-worry. Last accessed on June 11, 2014.

11. Two (2) comments reviewed from:
Terhune, C. (2014, March 2). Rate of babies delivered early at U.S. hospitals drops sharply. Los Angeles Times. Retrieved from: http://www.latimes.com/business/la-fi-hospital-early-deliveries-20140303-story.html#panel=comments. Last accessed on June 11, 2014.

12. Nineteen (19) comments reviewed from:
Florido, A. (2014, March 3). Why do black infants die so much more often than white infants? Southern California Public Radio 89.3 KPCC. Retrieved from: http://www.scpr.org/news/2014/03/03/42483/why-do-black-infants-die-so-much-more-often-than-w/ . Last accessed on June 11, 2014.

13. Six (6) comments reviewed from:
Tracy, J, Moder, C. and Gilmore, J. (2014, March 13.) Hunger, obesity connections stems from limited food options. U-T San Diego. Retrieved from: http://www.utsandiego.com/news/2014/mar/13/hunger-obesity-diabetes/. Last accessed on June 11, 2014.

14. Six (6) comments reviewed from:
Healy, M. (2014, March 17). Habits that feed child obesity are widespread, study finds. Los Angeles Times. Retrieved from: http://www.latimes.com/science/sciencenow/la-sci-sn-child-obesity-parenting-20140317-story.html Last accessed on June 11, 2014.

15. Seventeen (17) comments reviewed from:
Cohen, D. (2014, March 19). Obesity epidemic: standardized portion sizes in restaurants could help solve

public health crisis. Mercury News. Retrieved from: http://www.mercurynews.com/opinion/ci_25376015/obesity-epidemic-standardized-portion-sizes-restaurants-could-help?source=rss. Last accessed on June 11, 2014

16. Five (5) comments reviewed from:
Smith, T. (2014, April 30). Student workers union reaches tentative agreement on gender neutral restrooms, lactation stations. The Daily Californian. Retrieved from: http://www.dailycal.org/2014/04/30/student-workers-union-reach-tentative-agreement-access-gender-neutral-restrooms-lactation-stations/ . Last accessed on June 11, 2014.

17. Forty-six (46) comments reviewed from:
Knoll, C. (2014, May 18). For lactating mothers, jury duty poses logistical challenges. Los Angeles Times. Retrieved from: http://www.latimes.com/local/la-me-breastfeeding-jurors-20140518-story.html# Last accessed on June 11, 2014.

18. Thirty two (32) comments reviewed from:
Hoppin. J. (2014, May 22). Dominican Hospital draws protest for termination of lactation consultant Janet Hoover. Santa Cruz Sentinel. Retrieved from http://www.santacruzsentinel.com/news/ci_25810965/dominican-hospital-draws-protest-termination-lactation-consultant-janet#disqus_thread. Last accessed on June 11 2014.

D. Public Input from a Survey

Leapfrog, Inc. conducted a survey of about a thousand California registered voters in late Fall 2013 to assess the public's perception of the greatest threats to the health of children in California. The survey results are presented below.

About the Survey

Population surveyed:	**California registered voters.**
Data collection method and sample sizes:	**Telephone interviews with 1,002 registered voters conducted in English and Spanish. In order to cover a broad range of issues, some of the questions were asked of a random subsample of either 465 or 537 registered voters statewide.**
Interviewing period:	**November 14 – December 5, 2013.**
Auspices:	**Conducted by *The Field Poll* on behalf of The California Endowment.**
Sampling error estimates:	**Findings from the overall sample have a maximum sampling error of +/- 3.2 percentage points at the 95% confidence level, while results from each random subsample have a sampling error of +/- 4.5 percentage points.**

E. Response to the 2014 (Previous Year's) Review Recommendations

There were strengths, weaknesses and recommendations made in the review of California's 2014 Block Grant application and annual progress report. The following weaknesses and recommendations were noted:

Weakness 1: Significant budget reduction has had a dramatic effect on State capacity over the past several years. This is reflected in all program areas, some more impactful than others. Given this challenge, the MCH/CCS program has demonstrated remarkable resilience and durability.

California Response:
MCAH Program thanks you for your comment. MCAH has taken steps to mitigate the impact of funding cuts over the last five years, but recognizes the great burden that funding reductions have placed on LHJs ability to address the needs of the MCAH population.

We are aware that the struggle remains and are in ongoing discussion with Health Resources and Services Administration (Dr. Michael Lu, Associate Administrator) regarding inequitable MCH Title V Block Grant funding to California.

Weakness 2: Public input is not as apparent in the application as it could be. Despite wide distribution, public input appears limited. Because the next Needs Assessment is already being planned, there is an opportunity to incorporate innovative strategies to obtain input from non-traditional or non-responding stakeholders. Perhaps the Title V program could utilize key informant interviews to ensure input from key stakeholders who traditionally do not provide significant input into the process.

California Response:
MCAH has posted the report on our Web site and broadly disseminated a request for input. We will continue to explore ways to engage our communities to provide input.

Weakness 3: Strong activities around dental services/oral health for children are occurring, but a data source has been lacking since 2005 to reflect the impact of these activities.

California Response:
Unlike in prior years, data for the current report is the percentage of Medi-Cal beneficiaries ages 6-9 who are eligible for Early and Periodic Screening, Diagnostic, and Treatment, (EPSDT) for 90 continuous days, receiving a sealant on a permanent molar tooth. The data is from the Center for Medicaid and Children's Health Initiative Program (CHIP) Services, EPSDT, CMS Form 416.

Weakness 4: Implementation of the 1115 Waiver Bridge to Reform will require that SCD/CCS be clear about its role with both waiver-enrolled and non-waiver enrolled children and families, and the roles that SCD will play with CSHCN and potentially CSHCN who are not enrolled in the CCS program.

California Response:

Recommendation 1: During the 2015 needs assessment planning, it is recommended that thought be given to identifying innovative strategies for gaining and incorporating input from not only current stakeholders, but a wider range and number of constituents, maybe using key informant interviews. It would be great to see a more robust description of public input, and how that input is analyzed and taken into consideration in program planning. Since much of the public input may occur through the LHJs, and thus may not be as robustly reflected in the block grant application, consideration could be given to providing one or more LHJ vignettes that demonstrate their level and quality of public input.

California Response:
Thank you for your suggestion. We are developing a stakeholder questionnaire that we will use in the 2015 Needs Assessment to obtain public input.

Recommendation 2: It is suggested that a data mechanism or plan be identified or developed for capturing the impact of oral health activities on access to oral health care for children in California.

California Response:
Medi-Cal routinely collects and prepares an annual report on enrolled children receiving a dental sealant, oral health and dental diagnostic services by age group. In addition, the biennial California Health Interview Survey collects child and teen data on the length of time since the last dental visit and reasons for not visiting a dentist. The California Children's Dental Disease Prevention Program tracks data from school children in 32 counties who received fluoride supplementation, plaque control, oral health education and dental screening.

MCAH also tracks national oral health data reports. Examples include the 50-state report on dental sealants published by the Pew Charitable Trusts (www.pewstates.org/dental-sealants) and the Catalog of Surveys and Archive of Procedures Related to Oral Health (http://drc.hhs.gov/catalog.htm) published by the Dental, Oral and Craniofacial Data Resource Center.

Recommendation 3: The applicant organization may want to consider developing and providing in the 2014 Application a chart/table, listing major MCAH programs in each of the State priority areas, with an indication of how long programs have been in place, whether evaluation activities are in place for those programs, whether impact data are available, and the nature of impact.

California Response:
Thank you for your suggestion. MCAH Program has a table with some of this information in the current report. We will consider adding a table in the future.

Recommendation 4: The applicant organization should consider continuation of monitoring the impact of the
CCS 1115 Waiver, Bridge to Reform, for the CCS population and provide preliminary data in the 2014 Application.

California Response:

Needed

Recommendation 5: *The newly named SCD is encouraged to fully embrace its new vision and its responsibility not only to the whole child, which has been a State priority for several years, but also for the entire population of CSHCN in the State, not simply those it serves directly. This recommendation would be particularly important while conducting the five-year needs assessment which provides a unique and critical opportunity to advocate for all children and families as the State implements the Affordable Care Act; as the 1115 waiver demonstration project results are revealed; and as access, quality and cost issues loom large for families.*

California Response:

Recommendation 6: MCAH and SCD may want to craft a shared vision, particularly going forward, for all of Title V in the State. Changing culture, history and behaviors is difficult but worthwhile work, and each will benefit through positive collaborations with the other on key issues such as systems development initiatives, including the needs assessment.

The two Title V Divisions - SCD and MCAH - are encouraged to continue to work on points of common interest as they build a more cohesive relationship going forward. Developing, and ideally implementing, a shared plan for the five-year, statewide, population-based, comprehensive needs assessment is not only imperative but is a huge educational opportunity. Given that there is a request for technical assistance around increasing the visibility of the Title V programs as a resource for the evolving healthcare system, it seems propitious to have this opportunity to provide clear leadership in assessing and documenting needs, engaging partners in priority setting, and then serving as the clearly accountable focal point for all children and families in the State.

California Response:
SCD and MCAH have meetings scheduled every other month to work on points of common interest and build a more cohesive relationship. In addition, both programs have worked closely on engaging and presenting our programs to our shared stakeholders.

ATTACHMENT 3:

Overview
(Attachment to Section III-A)

ATTACHMENT TO SECTION III

A. State 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 through2020.

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, Filipino and Vietnamese. Within each Asian group is variation in language and culture. While the largest numbers of Asians reside in the large population centers of Southern California in Los Angeles (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//

/2013/ > Economy

In 2011, the state faced a $26.6 billion budget shortfall due to unprecedented level of debts, and

budgetary obligations accumulated over the prior decade. The 2011 budget made substantial progress in returning to state fiscal stability by substantially shrinking the state's ongoing deficit and rejected over-reliance on one-0time solutions. The latest estimates suggest that the state faces $15.7 billion budget problem for 2012-13. This was a result of reduced revenue outlook, higher costs to fund schools and decisions by the federal government and courts to block budget cuts. To restore fiscal balance more cuts to state programs and the state workforce are proposed. //2013//

>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, proportion of children ages 0-5 who are Hispanic are expected to continue to increase through 2020, while the proportion that is White are 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 are expected to decline to 32%. Other groups are expected to remain somewhat stable. Of particular interest are the youngest women of reproductive age, who demonstrate increased risks and poorer birth outcomes compared to their older counterparts. [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 MCAH status 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.[11] 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.[12]

> 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.//2013//

>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. [13]

>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 to18.9% in 2008. [14] 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%). [15] 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.[16] /2012 In 2009, the graduation rate increased to 70%.[18] //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. [19] Among children under age 18 the rate is higher: 16% of the population is in poverty, or approximately 1.6 million children. [20] 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. [20] 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. [21] [22] 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. [22]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. [23] /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. [24] While employment grew in 2010, the unemployment rate also increased to 12.4%, the third highest rate in the U.S. [25] 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%. [26] //2012// /2013/ The percent of public school students eligible for free or reduced price lunch increased to 56.7% in 2011. [27]//2013//

>Housing

California's high housing costs create a burden for families, resulting in less income available for other resources needed to maintain health. [28] 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. [28] 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. [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

CDPH is the lead state entity in California providing core public health functions and essential services. The Department has five centers to provide detection, treatment, prevention and surveillance of public health and environmental issues. The 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 provides 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 provides 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 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/ CCS addresses the health service needs of 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 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.//2013// /2014/ The Office of Health Equity will play a key leadership role to reduce health and mental health disparities to vulnerable communities through the building of cross-sectoral partnerships. //2014//

/2013/In May 2012, the Governor established the Get Healthy California Task Force to be composed of individuals representing patients and consumers, healthcare providers, health plans, employers, community-based organizations, foundations, and organized labor. Its mission is to reduce the individual, social, and economic burdens of preventable and chronic conditions and improve the health of Californians. By December 2012, the task force will develop a report that includes, the baseline data and targets for reducing diabetes, asthma, childhood obesity,

hypertension, and sepsis-related mortality; reducing hospital readmissions within 30 days of discharge; and increasing the number of children receiving recommended vaccines by age three. The report shall also include recommendations for achieving these targets without additional government spending and standards for measuring improvement over a 10-year period.

> 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//

/2014/Starting October 2013, "Covered California, the state-run health insurance market, will qualify low-income individuals and families for free health insurance through Medi-Cal and moderate-income families to premium subsidies to make private health coverage affordable. It

provides consumer protections set forth by the ACA including the ten Essential Health Benefits. These include (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management and (10) pediatric services. Covered California and each health plan selected are committed to ensuring high quality of care for all enrollees. Specifically, each plan must ensure that each enrollee has had a preventive health and wellness visit during the first year of enrollment; identify and proactively manage all "at-risk" enrollees; determine enrollee's health status and proactively develop a plan to manage their individual health care needs; promote the use of best practice models for continuity of care and care coordination that are proven to improve quality of care; be transparent about plan performance at the point of enrollment, specifically regarding standard measures of prevention, access, and clinical effectiveness; and, be certified by the National Committee for Quality Assurance or URAC (formerly known as the Utilization Review Accreditation Commission) to meet quality standards.//2014//

/2015/California continues to lead the way in embracing and implementing health care reform enrolling nearly a quarter of all exchange enrollees nationwide. Covered California enrolled about 625,000 individuals between October 1, 2013 and January 15, 2014. Challenges exist in enrolling Latinos, younger adults and in vastly improving customer service for consumers and those trying to enroll them. There have been challenges over billing and paperwork exchanges between Covered California and private insurance companies. Actions taken to mitigate these issues include hiring additional bilingual staff, expand the capacity of its serve centers and further investments in marketing and advertising campaigns targeting Latinos and young adults.//2015//

B. 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 (CSHCN)

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 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 of the 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 the 1115 Waiver Pilot Projects. Five projects were selected with four different models of care through which CCS children will have all their health care needs met by 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// /2014/MCMC, the 1115 Waiver Model, began April 2013 in San Mateo County while the Accountable Care Organization model will begin later

in 2013.//2014//

>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 Child Health and Disability Prevention Program (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//

/2014/ The combined HF and Medi-Cal enrollment for fiscal year (FY) 2010 was 6,188,788. The California Health and Human Services Agency (CHHSA), MRMIB and DHCS developed a transition plan for HF enrollees to Medi-Cal. Medi-Cal established the Targeted Low Income Children's Program which expands child eligibility to 250% of FPL. The transition, implemented in phases, began in January 2013. HF will continue to serve families until they are transitioned to Medi-Cal, including Access for Infants and Mothers (AIM)-linked infants. In addition, children continue to be pre-enrolled into Medi-Cal through the CHDP Gateway.//2014//

> 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 Regional Perinatal Programs of California (RPPC) in L.A. to develop a report on BBC pilot project findings and provide technical assistance (TA) 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//

/2014/ MCAH is collaborating with the Office of Emergency Preparedness to develop an infant feeding plan.

MCAH continues to collaborate with hospitals to promote evidence-based infant feeding and maternity care policies.

MCAH collaborated with the California Breastfeeding Coalition, the California WIC Association and State programs to host the 3rd Annual California Breastfeeding Summit on January 31 –

February 1, 2013. This summit brought together professionals throughout California who are working in their communities to improve infant, family, and community health. There was an overwhelming response to the summit that clearly demonstrates commitment to implementing evidence-based maternity policies and practices that support breastfeeding and to fostering productive partnerships between hospitals and community agencies so that mothers are supported at every level of care. The summit focused on training participants to 1) utilize hospital breastfeeding data to measure the effectiveness of maternity care practice and improve patient outcomes, 2) interpret how breastfeeding can mitigate social determinants of poor health outcomes, and 3) employ the changing paradigm of public health action on breastfeeding from one of individual behavior to collective responsibility, with particular emphasis on the role of the health care system to provide more support.

MCAH took a lead to develop a webpage with resources and author a letter to hospitals from WIC and MCAH providing them with resources and notification regarding California Health & Safety Code §123366, the Hospital Infant Feeding Act, which requires that: 1) all California hospitals providing maternity care services have an infant feeding policy, 2) policies need to promote breastfeeding and utilize guidance from the Baby-Friendly Hospital Initiative or the CDPH Model Hospital Policy Recommendations, 3) policies must be clearly posted and routinely communicated to staff.

MCAH took a lead to author a letter from WIC and MCAH to CDC to support the continuation of mPINC, a national survey of maternity care practices and policies conducted every 2 years by the CDC.

The infant feeding sections of the AFLP Nutrition and Physical Activity Guidelines, the CDAPP Sweet Success Guidelines for Care and the CPSP Steps to Take Guidelines were updated with more current and accurate breastfeeding information. MCAH continues to have a representative on the USBC. She participates in the following workgroups: Emergency Preparedness, the Media/Public Relations and the Reduce Infant Formula Marketing.

To increase breastfeeding duration rates in California's high risk communities, MCAH is collaborating with the California Obesity Prevention Program (COPP) to enhance the capacity of community safety-net clinics to provide quality breastfeeding services. Utilizing CDC funding, this statewide pilot project focuses on increasing breastfeeding duration rates in California's low-income communities of color. Community health centers have been funded to create an environment that promotes and supports mothers' decision to breastfeed prenatally, as well as their intention to sustain breastfeeding post-hospital-birth discharge. Beginning in January 2013, one-time competitive grant funds were provided to 15 clinics for specified local breastfeeding support and promotion services to low-income mothers and infants receiving primary health care in community health centers. This includes nonprofit free and community clinics, federally qualified health centers (FQHCs), FQHC "look-alikes", hospital out-patient clinics, county public health department clinics, Indian Health Service clinics and Rural Health Services clinics.

Grantees are receiving training, technical assistance, and resources to assist them in two key strategies: 1) implementation of "breastfeeding-friendly" environmental and policy changes in selected clinic sites, and 2) provision of direct breastfeeding services, reimbursable through Medi-Cal, to the target population. Successful pilot strategies will be highlighted and shared in

an effort to build evidence base and momentum for all community clinics statewide to adopt specific model “breastfeeding-friendly” clinic policies and practices.

MCAH developed a Systems and Environmental toolkit to support optimal nutrition, physical activity, and breastfeeding through fostering partnerships between local health jurisdiction's Maternal, Child, and Adolescent Health (MCAH) Programs and existing organizations to promote healthy environmental changes. The resources that this toolkit links to were chosen as they appear to be feasible projects for MCAH Program involvement. This is not a comprehensive toolkit; however, it does provide concrete examples of environmental change projects that are specific for supporting optimal breastfeeding within the maternal, child and adolescent population. On December 13, 2012, a webinar introducing the toolkit was provided to the local health jurisdictions’ MCAH programs. It featured Richard Jackson, MD, MPH from the UCLA Fielding School of Public Health who specializes in designing healthy communities and a rural and urban MCAH leader with experience in environmental change.//2014//

>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 outdated. The data collection requirements also were not standardized, limiting the ability to measure the program's effectiveness.

The 2007 report by UCSF 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, ,/2013/lessons learned from our previous model, staff and partner expertise//2013// 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//

/2014//In 2012, all of the sites with the exception of Los Angeles had implemented the revised BIH model. By the end of 2012, all sites who had implemented the revised model had also been trained in the new MCAH BIH-MIS, and entered their backlog data into the system by early 2013. In August 2012 LHJs submitted site profiles, which were analyzed and have been used to

provide information about aspects of the model across sites, and inform necessary levels of funding and staffing for sites in order for the revised model to be effective. The site profiles also provided insight into which areas require more state technical assistance in sites, such as recruitment and retention and case management. In early 2013, a fidelity toolkit was presented to sites. The toolkit was designed to help sites maintain fidelity to the new model through assessments of the overall program and specific areas in group and case management. For the remainder of 2013 and into 2014, work will continue with improvements to the revised model. By early 2014, MCAH and partners at UCSF will be releasing to LHJs; an updated evaluation plan and report, revised curriculum, updated policies and procedures, a recruitment toolkit and additional reports in the BIH-MIS. LHJs will also be provided regionalized trainings regarding case management and data entry/quality.//2014//

>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. /2014/ The CDC preconception health initiative launched the national "Show Your Love" campaign on February 14, 2013 to popularize the term "preconception health" to the public and provide targeted messaging to women 18-44 who were considered planners (considering a pregnancy in the next two years) or non-planners (not considering a pregnancy during the same time period).//2014//

The PHCC is the 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// /2014/Due to the high prevalence and increasing trend of gestational diabetes among Asian and Pacific Islander women in California, MCAH partnered with Orange County to translate the gestational diabetes handout to Vietnamese and to includeculturally-appropriate images.//2014//

MCAH LHJs 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// /2014/In 2012, MCAH collaborated with local partners to train almost 200 Preconception Peer Educators (PPE) in the San Joaquin Valley and developed statewide training and outreach resources online. MCAH participates on the Office of Minority Health PPE Advisory panel to restructure and update the PPE program curriculum.//2014//

>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// /2014/As of February 2013, 67 of 69 HRIF programs are reporting online with 5170 HRIF Program Referrals/Registrations and 1550 HRIF Program Standard Core Visits for 2012. HRIF summary reports provide information on the follow-up status of enrollees, demographic/social risk information, status of medical and special service needs, neurological examination outcomes and developmental outcomes. Feedback and reports from HRIF Program staff are obtained in the annual quality audit report.//2014//

>Neonatal Quality Improvement Initiative

MS 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 January 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 Pediatric Intensive Care Units (PICUs) beginning July 2012. The goal is to have approved insertion and maintenance bundles for central lines in all NICU/PICU's. //2013//. /2014/The collaborative ends mid-2013. It has sustained gains with an overall CLABSI rate of 0.65/1000 central line-days.

CCS began a new NICU CLABSI prevention collaborative that integrates QI routinely. This new collaborative funded by the American Hospital Association is linked to a NICU CLABSI prevention collaborative in 14 other states. Of the 180 NICUs in this national collaborative, 68 are CA NICUs. The ultimate goal is to enroll all 132 CA NICUs in ongoing QI projects led by CCS.//2014//.

>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// /2014//In 2013, two CCS Community PICUs were approved, while the RCA is being developed. The VPS California PICU database was developed to be the standard for all PICU's in California. This dataset will be representative of nearly all CSHCN in California.//2014/

>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 two 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// /2014/The Pediatric Palliative Care Waiver was renewed effective through March 2017 with UCLA conducting the program evaluation. Preliminary results show high levels of program satisfaction and significant program savings. As of December, 2012, there were 84 children enrolled in the program in nine counties, served by one of ten participating agencies.//2014//

>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.//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 slightly declined to 4.5 pregnancy-related deaths among African-American for every pregnancy-related death among White women.//2013//.

/2014/The MQI contractors have developed a composite morbidity indicator to help explain the trajectory of maternal morbidity among women entering pregnancy with different risk profiles. The workgroup has also examined and compared the feasibility of three methods to track elective deliveries: 1) vital statistics/patient discharge data, 2) electronic medical records, and 3) a targeted maternity care quality improvement project.//2014//

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 perinatalogists 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// /2014/Due to funding cuts, the Local Assistance for Maternal Health (LAMH) project was reduced to providing technical assistance through the RPPC program.//2014//

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 three 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 preexisting 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.//2013// /2014/The toolkit “Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age was relicensed in 2013 as part of MCAH’s commitment to make publicly available a guide to help physicians, nurses and care teams promote practices that eliminate elective inductions and C-sections before 39 weeks gestation. Multi-state, hospital-based quality improvement programs, implemented this toolkit to guide changes in early term delivery practices. The rate of elective early term deliveries in a group of 25 participating hospitals fell significantly from 27.8% to 4.8% during the one-year project period.//2014// 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// /2014/ The toolkit to Improve the Health Care Response to Preeclampsia was released in April 2013. The translation of the OB Hemorrhage Toolkit into Spanish has been delayed.//2014//

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 chloropleth 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// /2014/A detailed report on WIC participation around the time of pregnancy using data from 2010 was given to WIC in 2012. In 2013, WIC program data were linked to the 2011 birth file. MCAH will update reports annually to track WIC participation over time. In 2012-2013, MCAH has also started to examine the association between WIC and MCAH outcomes, such as pre-term birth.//2014//

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// /2014/Updated county, regional and statewide tables, maps, charts and reports using 2011 data will be posted online in 2013. Beginning with 2013 births, the sample design has been revised to produce county-level estimates for the 35 counties with the most births.//2014//

/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// /2014/ In 2013, MCAH collaborated with CDC and UCSF on a Morbidity and Mortality Weekly Reports that used combined MIHA-PRAMS data to estimate how many women were eligible but not enrolled in WIC during pregnancy across 27 states and New York City. Out of all eligible women in California, 83.3% participated in WIC, the highest coverage rate in any state examined. Characteristics of WIC participants and eligible nonparticipants were also presented.//2014//

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// /2014/Eight workshops to improve birth data quality are scheduled for 2013.//2014//

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.

/2014/With the support of RPPC,//2014// /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// /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%.

>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//. /2014/Two cross-cutting areas of focus include positive youth development and healthy relationships.//2014// **/2015/MCAH convened its first adolescent sexual health annual meeting in 2013 to enhance the knowledge, skills, and capacity across its primary and secondary teen pregnancy prevention programs.//2015//**

>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 School-Age 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.//2012// /2013/MCAH awarded 11 local sites for piloting the new positive youth development case management intervention with integrated life planning to promote reproductive life planning and build youth resiliency.//2013// /2014/MCAH re-applied for the U.S. Department of Health and Human Services (HHS), Office of Adolescent Health funding of the Pregnancy Assistance Fund Program for four years, beginning 2013-2014.//2014/

/2013/ The goals of the program focus on secondary teen pregnancy prevention. 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. 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// /2012/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//

/2014/MCAH re-applied for the U.S. Department of Health and Human Services (HHS), Office of Adolescent Health funding of the Pregnancy Assistance Fund Program for four years, beginning 2013-2014.//2014//

/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. /2014/Twenty-one local sub-awardees began start-up activities in July 2012 and included delivery of evidence-based program models by January 2013.//2014//

>Information and Education (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. CDPH is designated as the single State entity to oversee and administer home visiting funds on behalf of California. To receive funding from HRSA and the Administration of Children and Families (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 /2014/began the enrollment of clients in//2014// mid-year 2012.

Two evidence-based models, Nurse-Family Partnership (NFP) and Healthy Families America (HFA), were selected to meet the needs of the 22 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 California Home Visiting Program (CHVP) Request for Supplemental Information.//2013//

The overarching goal of the 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, CDPH/State and Local Injuries Control/2014/, American Indian Infant Health Initiative, California WIC Program, California Domestic Violence Leadership Group, Center for the Study of Social Policy, and the California Department of Housing & Community Development//2014//. 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/> 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.//2013//

/2014/ Since April 2014, MCAH and CMS have been meeting monthly to improve information exchange between the programs.//2014//

>Strategic Map

/2013/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.//2013/ /2014/In Winter 2013, the Office of Quality Performance and Accreditation was created to provide leadership and coordinate department initiatives that seek to improve the quality and performance of programs and processes within CDPH. //2014//

/2015/Implementation of CDPH's Strategic Map consists of two separate, but complementary tracks. Track One focuses on implementation of activities, interventions and tactics identified with the six priority objectives on a Department-wide basis. Track Two implementation activities are at the program level and roll up to the Strategic Map.

For Track Two implementation, CDPH programs were encouraged to select several Strategic Map objectives reflective of their work. Additionally, programs involved in one or more of the 21 objectives in the Internal Operations and Performance Plan were asked to identify those performance measures they continue to monitor and would transition into a Strategic Map objective. As part of the over-all goal to achieve health equity and eliminate health disparities, MCAH is taking the lead in reducing the infant mortality rate ratio for live births with a Medi-Cal payer source over a live birth with a non-Medi-Cal payer source.

CDPH has been working to finalize documentation for Public Health Accreditation Board submission. Efforts include compiling feedback from Policy Committee Executive Review, reaching out to programs to obtain additional information as well as receiving technical assistance from the Association of State and Territorial Health Officials. On February 6, 2014, submitted documentation on the e-PHAB system.//2015//

ATTACHMENT 4:

Agency Capacity Tables
and Additional Agency Capacity Narrative
(Attachment to Section III-B)

ATTACHMENT TO SECTION III-B. AGENCY CAPACITY

Title-V Programs	Agency Affiliation	Primary Target Population				
		Infants	Pregnant Mothers	Children and Adolescents	CSCHN	Community-based services
Adolescent Family Life Program (AFLP)	MCAH		x	x		x
Black Infant Health (BIH)	MCAH		x			x
Breastfeeding Program	MCAH/ CMS	x	x		x	x
California Birth Defects Monitoring Program (CBDMP)	MCAH	x	x			
California Children's Services (CCS) Program	CMS				x	x
California Diabetes and Pregnancy Program (CDAPP)	MCAH	x	x			x
California Early Childhood Comprehensive Systems	MCAH			x		
California Perinatal Transport System (CPeTS)	MCAH	x	x			x
California Personal Responsibility Education Program (CA PREP)	MCAH			x		x
Child Health and Disability Prevention Program (CHDP)	CMS	x		x		x
Comprehensive Perinatal Services Program (CPSP)	MCAH	x	x			x
Family-Centered Care	CMS				x	x
Fetal Infant Mortality Review Program (FIMR) and BIH FIMR	MCAH	x	x			x
Genetically Handicapped Persons Program (GHPP)	CMS				x	x
Hearing Conservation Program	CMS			x		x
Health Care Program for Children in Foster Care (HCPCFC)	CMS	x		x		x
High Risk Infant Follow-up (HRIF)	CMS	x				x
Home Visiting Program	MCAH	x	x	x	x	
Human Stem Cell Research Program	MCAH		x			
Information and Education (I&E)	MCAH		x	x		x
Local Health Department Maternal Child and Adolescent Health Program (LHDMP)	MCAH	x	x	x		x
MCAH Toll Free Hotline	MCAH	x	x	x		x
Medical Therapy Program (MTP)	CMS				x	x
Newborn Hearing Screening Program (NHSP)	CMS	x				x
Oral Health Program	MCAH	x	x	x		
Pediatric Palliative Care Waiver Program	CMS				x	x
Preconception Health and Health Care	MCAH		x			x
Regional Perinatal Programs of	MCAH	x	x			x

California (RPPC)						
Sudden Infant Death Syndrome (SIDS) Program	MCAH	x	x			x

Major Title-V Collaboratives, Task Forces and Advisory/Work Groups	Agency Affiliation	Primary Target Population				Quality Improvement effort
		Infants	Pregnant Mothers	Children and Adolescents	CSCHN	
Adolescent Sexual Health Work Group (ASHWG)	MCAH		x	x		x
California Maternal Quality Care Collaborative (CMQCC)	MCAH	x	x			x
California Perinatal Quality Care Collaborative (CPQCC)	MCAH	x	x			x
Children's Regional Integrated Services Systems (CRISS)	CMS				x	
Maternal Quality Indicator Workgroup	MCAH		x			x
Neonatal Quality Improvement	CMS	x				x
Perinatal Substance Use Prevention	MCAH		x			
Preconception Health Council of California (PHCC)	MCAH		x			x
Transition Workgroup	CMS				x	

Capacity Building Business Partners	Agency Affiliation	Primary Target to Provide Technical Assistance		
		State	Local	
Branagh Information Group	MCAH	x	x	
California Adolescent Health Collaborative	MCAH	x	x	
California State University, Sacramento	MCAH	x	x	
Childhood Injury Prevention Program	MCAH		x	
Family Health Outcomes Project at UCSF	MCAH/ CMS	x	x	
Health Information Solutions	MCAH		x	
Perinatal Profiles at UCB	MCAH		x	
Public Health Institute	MCAH	x		
Maternal and Infant Health Assessment Survey with UCSF	MCAH	x	x	
Center for Health Policy at UCLA	MCAH	x		

C. Additional Agency Capacity Information

Family Voices

FVCA represents more than 20,000 families of CSHCN across the state. FVCA identifies the following key issues for California's CSHCN and their families: family professional partnership at all levels; access to coordinated comprehensive care within a medical home; improved access to mental health services; adequate access to private and/or public insurance to pay for needed services; preservation of CCS Program's services and standards; early and continuous screening for special health needs; organization of community services for easy use; and youth transition to adult health care work and independence.

FVCA's May 2013 Annual Report noted local County Member Agencies (CMAs) provided over 7,000 families with culturally and linguistically competent, individualized information and support in local communities. Languages included English, Spanish, Cantonese and Mandarin. Other CMA activities included workshops, trainings, and presentations to families and providers. In addition, FVCA developed a new pilot funded by Lucile Packard Foundation for Children's Health (LPFCH) called "Project Leadership" to increase the number of family members of CSHCN who are prepared and supported to become advocates for health care policy and service improvements. The trainings offered to families in the San Diego/Imperial Counties region began September 2013 with a second series to start in early 2014

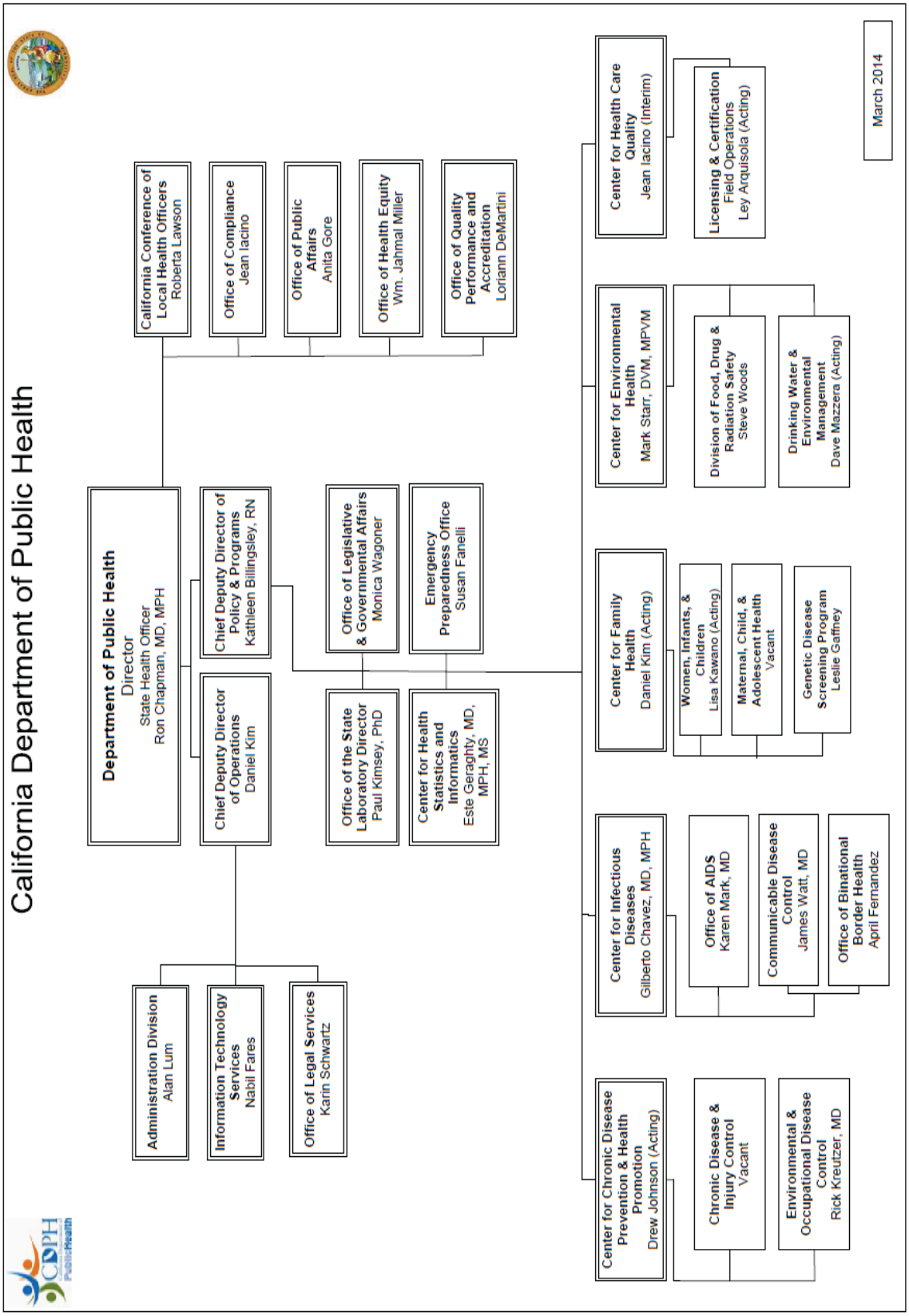
HRIF SSDI grant

The SSDI grant supports SCD collaboration with the CCS/California Perinatal Quality Care Collaborative (CPQCC) HRIF Quality of Care Initiative (QCI) to manage a web-based HRIF Reporting System to collect data for the CCS HRIF Program. The web-based Reporting System allows the State and each NICU to track longer term morbidities and outcomes (evolving morbidities whose severity and extent may not be apparent on discharge from the NICU) of each NICU's HRIF patients in relation to all other NICUs in the state - - from follow up rates to all CCS standard visits, re-hospitalizations, medication and equipment use, outpatient service utilization and unmet needs, neurologic and developmental challenges, and other important longer-term endpoints; allows the state to assess site-specific successes; and supports real-time case management in identifying infants who might develop CCS-eligible conditions after discharge from a CCS-approved NICU. The CCS HRIF reports and database inform the state about high risk infants that require CCS follow-up services and resources and identifies barriers to service access. CCS intends to work with CPQCC to use the data to estimate the extent of long-term consequences and challenges that face the high-risk infant and family. The CCS Program ensures there is an authorization in place for each HRIF eligible infant. The HRIF referral rate page for specific HRIF-eligible infant categories as a quality indicator on the CPQCC online NICU reports was implemented in 2013, linking the CPQCC with the CPQCC-CCS HRIF database, and will appear in the CCS Annual Report. The Reporting System, collecting data on high risk infants enrolled in the CCS HRIF Program will add value to the current CPQCC data already collected.

In 2013, CCS updated HRIF Program policy letters to clarify issues of medical eligibility criteria to assure all eligible infants have access to diagnostic services. HRIF QCI developed a provider resource directory to motivate communication between the NICU and HRIF Programs. The HRIF QCI data system update reported >33,100 total referrals/registrations for birth years 2009-2013.

ATTACHMENT 5:

MCAH Organization Chart
(Attachment to Section III-C)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Maternal, Child, & Adolescent Health
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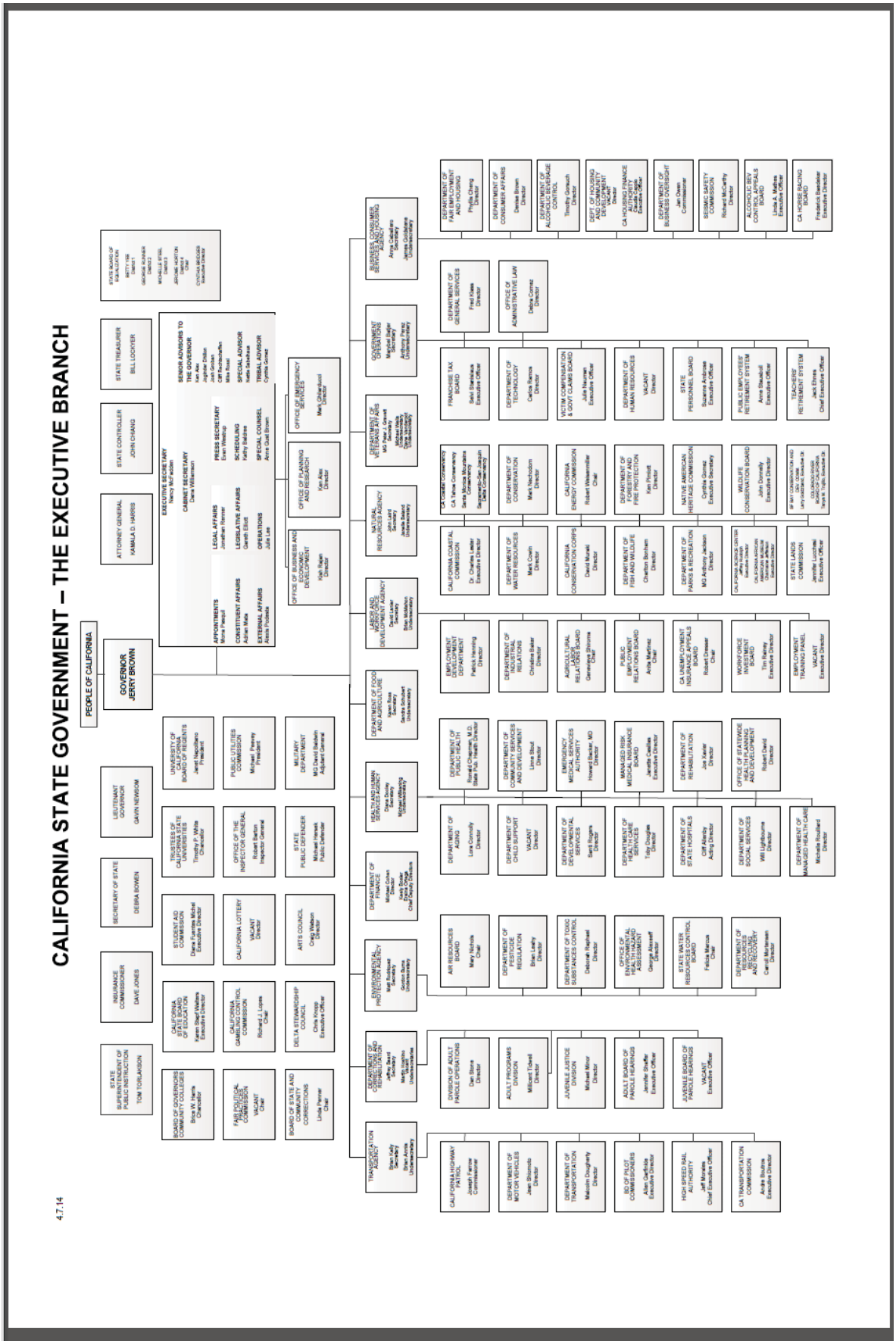
Office of AIDS
Karen Mark, MD
Communicable Disease Control
James Watt, MD
Office of Binational Border Health
April Fernandez
Center for Chronic Disease Prevention & Health Promotion
Drew Johnson (Acting)
Chronic Disease & Injury Control
Vacant
Environmental & Occupational Disease Control
Rick Kreutzer, MD
March 2014
CDPH
Public Health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Undersecretary
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Undersecretary
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FAIR POLITICAL PRACTICES COMMISSION
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Executive Officer
STUDENT AID COMMISSION
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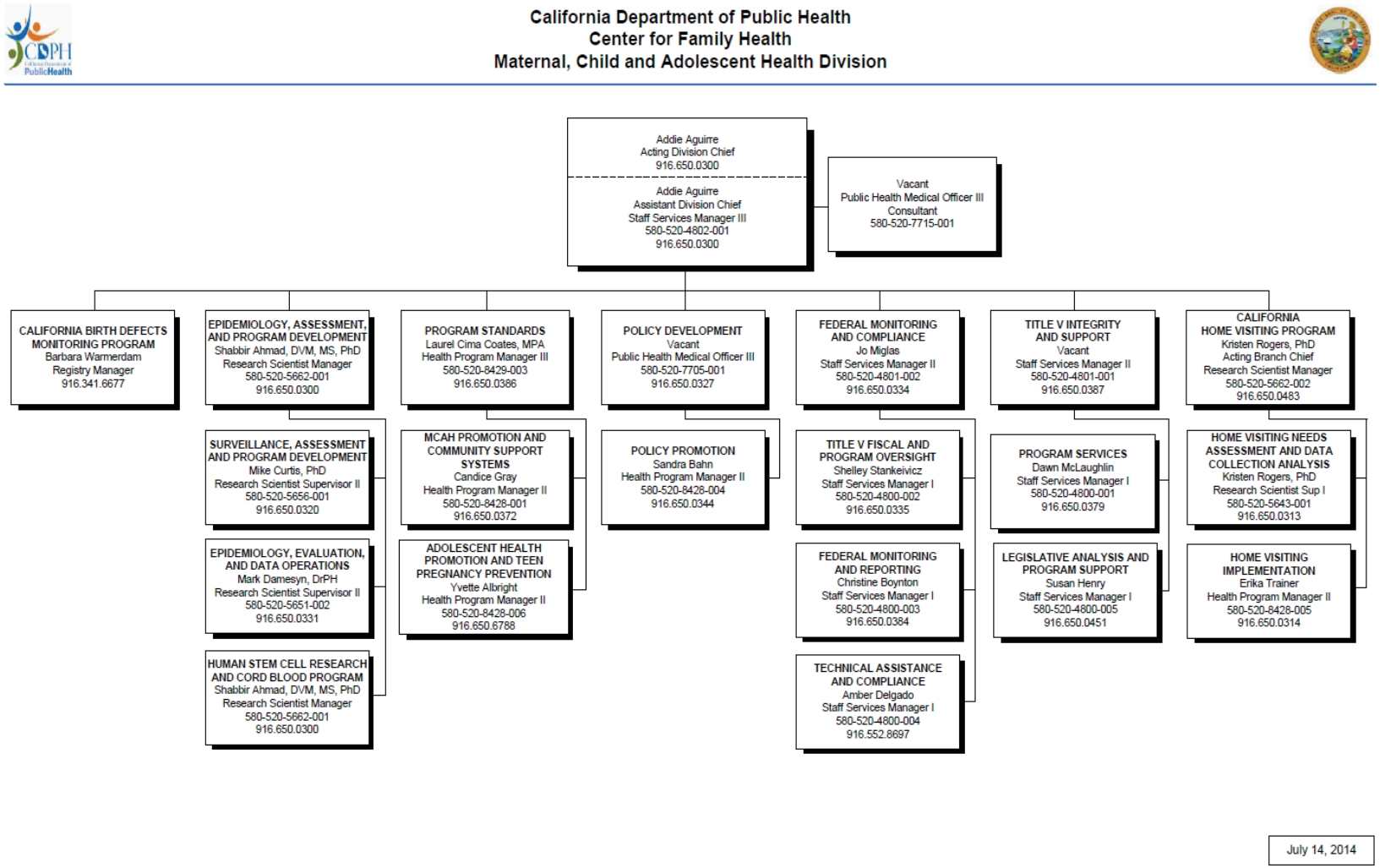
California Department of Public Health
Center for Family Health
Maternal, Child and Adolescent Health Division
Addie Aguirre
Acting Division Chief
916.650.0300
Addie Aguirre
Assistant Division Chief
Staff Services Manager III
580-520-4802-001
916.650.0300
Vacant
Public Health Medical Officer III
Consultant
580-520-7715-001
CALIFORNIA BIRTH DEFECTS MONITORING PROGRAM
Barbara Warmerdam
Registry Manager
916.341.6677
EPIDEMIOLOGY, ASSESSMENT, AND PROGRAM DEVELOPMENT
Shabbir Ahmad, DVM, MS, PhD
Research Scientist Manager
580-520-5662-001
916.650.0300
SURVEILLANCE, ASSESSMENT AND PROGRAM DEVELOPMENT
Mike Curtis, PhD
Research Scientist Supervisor II
580-520-5656-001
916.650.0320
EPIDEMIOLOGY, EVALUATION, AND DATA OPERATIONS
Mark Damesyn, DrPH
Research Scientist Supervisor II
580-520-5651-002
916.650.0331
HUMAN STEM CELL RESEARCH AND CORD BLOOD PROGRAM
Shabbir Ahmad, DVM, MS, PhD
Research Scientist Manager
580-520-5662-001
916.650.0300
PROGRAM STANDARDS
Laurel Cima Coates, MPA
Health Program Manager III
580-520-8429-003
916.650.0386
MCAH PROMOTION AND COMMUNITY SUPPORT SYSTEMS
Candice Gray
Health Program Manager II
580-520-8428-001
916.650.0372
ADOLESCENT HEALTH PROMOTION AND TEEN PREGNANCY PREVENTION
Yvette Albright
Health Program Manager II
580-520-8428-006
916.650.6788
POLICY DEVELOPMENT
Vacant
Public Health Medical Officer III
580-520-7705-001
916.650.0327
POLICY PROMOTION
Sandra Bahn
Health Program Manager II
580-520-8428-004
916.650.0344
FEDERAL MONITORING AND COMPLIANCE
Jo Miglas
Staff Services Manager II
580-520-4801-002
916.650.0334
TITLE V FISCAL AND PROGRAM OVERSIGHT
Shelley Stankeivicz
Staff Services Manager I
580-520-4800-002
916.650.0335
FEDERAL MONITORING AND REPORTING
Christine Boynton
Staff Services Manager I
580-520-4800-003
916.650.0384
TECHNICAL ASSISTANCE AND COMPLIANCE
Amber Delgado
Staff Services Manager I
580-520-4800-004
916.552.8697
TITLE V INTEGRITY AND SUPPORT
Vacant
Staff Services Manager II
580-520-4801-001
916.650.0387
PROGRAM SERVICES
Dawn McLaughlin
Staff Services Manager I
580-520-4800-001
916.650.0379
LEGISLATIVE ANALYSIS AND PROGRAM SUPPORT
Susan Henry
Staff Services Manager I
580-520-4800-005
916.650.0451
CALIFORNIA HOME VISITING PROGRAM
Kristen Rogers, PhD
Acting Branch Chief
Research Scientist Manager
580-520-5662-002
916.650.0483
HOME VISITING NEEDS ASSESSMENT AND DATA COLLECTION ANALYSIS
Kristen Rogers, PhD
Research Scientist Sup I
580-520-5643-001
916.650.0313
HOME VISITING IMPLEMENTATION
Erika Trainer
Health Program Manager II
580-520-8428-005
916.650.0314
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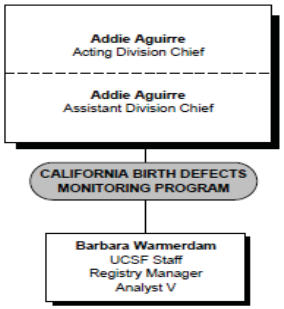

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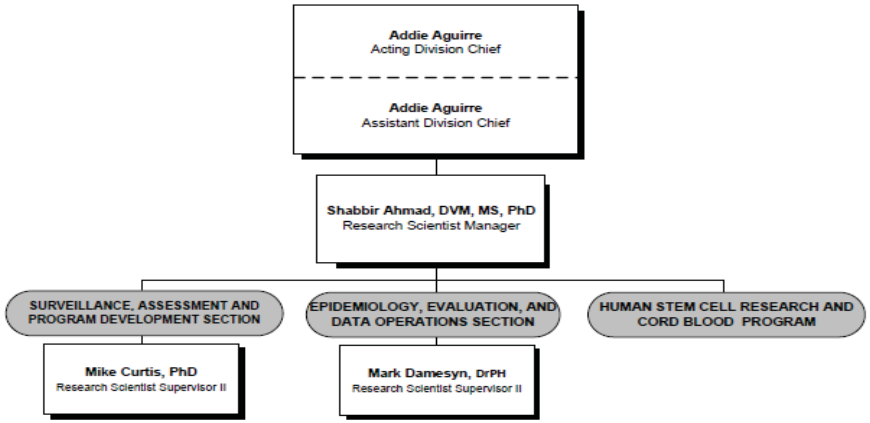

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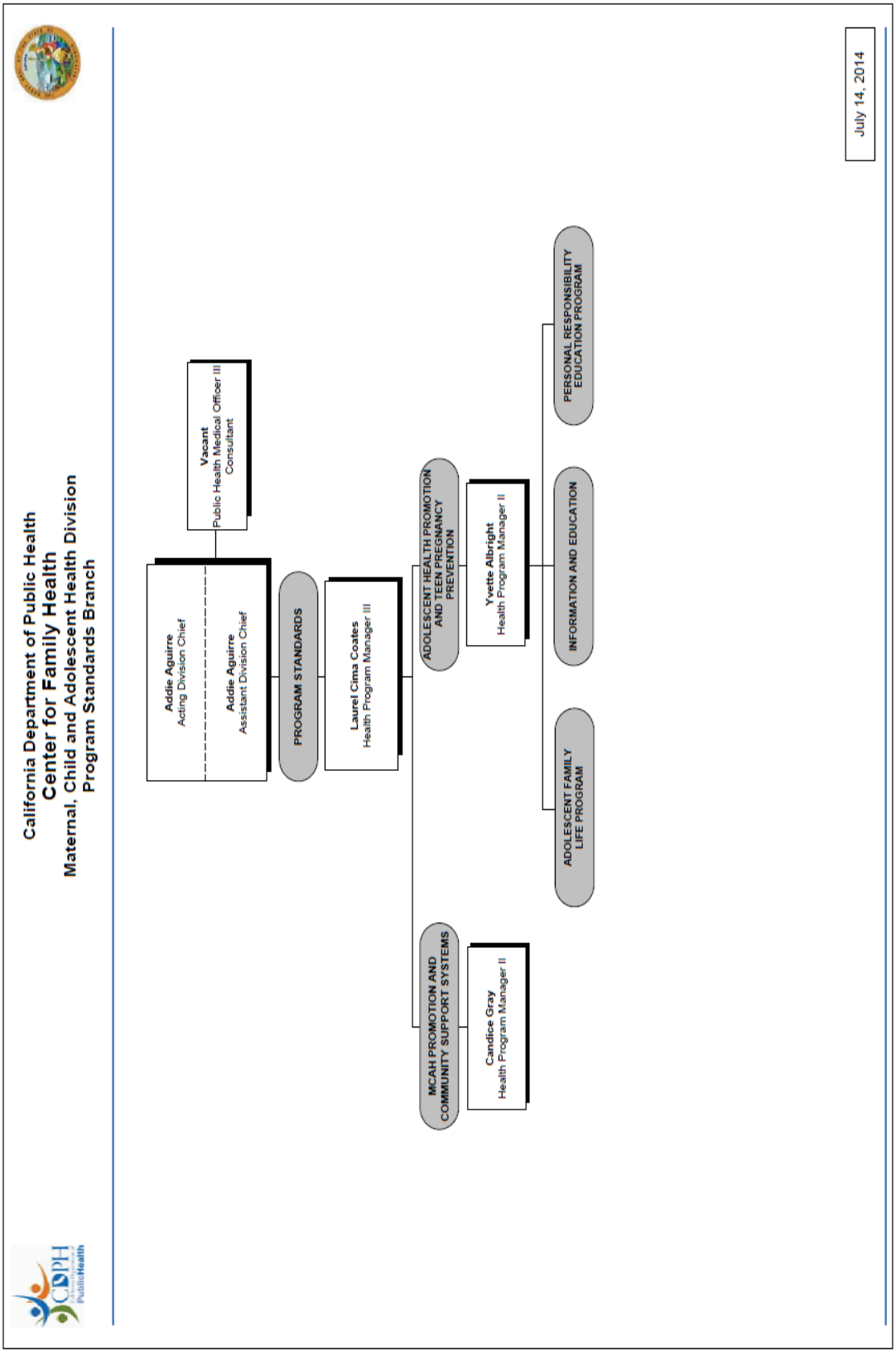
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Addie Aguirre
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Addie Aguirre
Assistant Division Chief
Vacant
Public Health Medical Officer III
Consultant
PROGRAM STANDARDS
Laurel Cima Coates
Health Program Manager III
MCAH PROMOTION AND COMMUNITY SUPPORT SYSTEMS
Candice Gray
Health Program Manager II
ADOLESCENT HEALTH PROMOTION AND TEEN PREGNANCY PREVENTION
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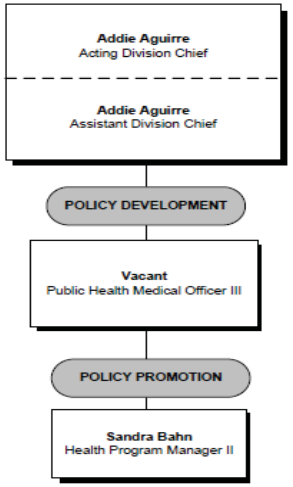

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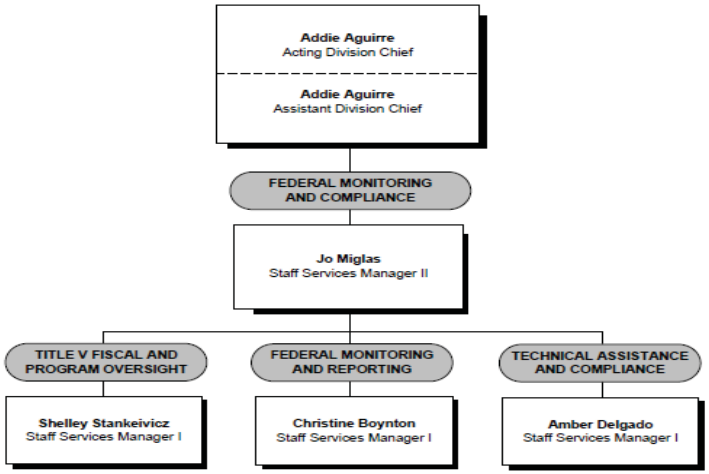

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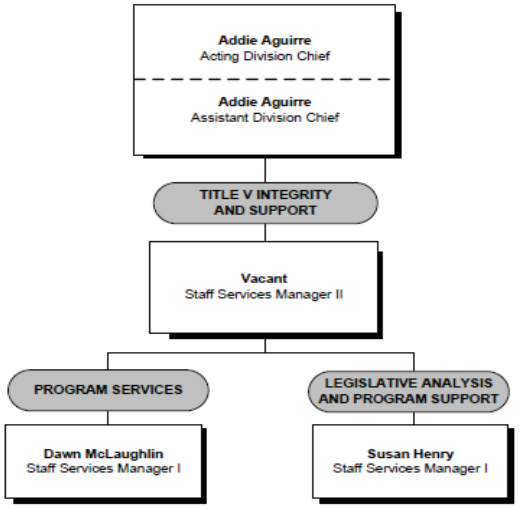

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Center for Family Health
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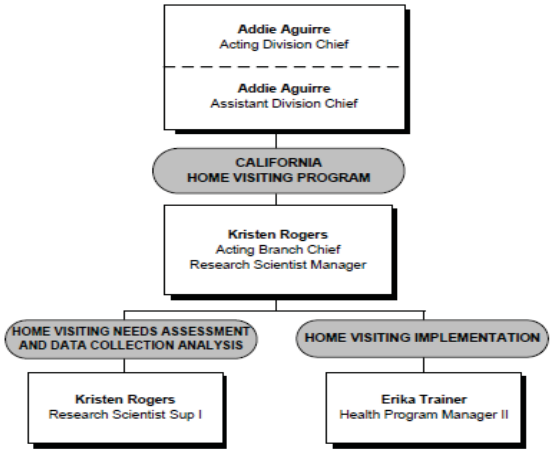
California Home Visiting Program



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ATTACHMENT 6:

Endnotes and Glossary of Acronyms and Abbreviations
(Attachment to Section VIII)

ATTACHMENT TO SECTION VIII.
Glossary of Acronyms, Abbreviations and Endnotes

Glossary of Acronyms and Abbreviations

A	AAP-CA	California District of the American Academy of Pediatrics
	AB	Assembly Bill
	ABCD	Assuring Better Child Health and Development
	ACA	Affordable Care Act of 2010
	ACF	Administration of Children and Families
	ACIP	Advisory Committee on Immunization Practices
	ACOG	American Congress of Obstetricians and Gynecologists
	ADP	Alcohol and Drug Program
	AFLP	Adolescent Family Life Program
	AI/AN	American Indian or Alaskan Native
	AIDS	Acquired Immune Deficiency Syndrome
	AIIHI	American Indian Infant Health Initiative
	AIM	Access for Infants and Mothers
	ALIP	AIM Linked Infants Program
	AMCHP	Association of Maternal and Child Health Programs
	ARB	Air Resources Board
	ASHWG	Adolescent Sexual Health Work Group
	ASPHN	Association of State Public Health Nutritionists
	ASRH	Adolescent Sexual and Reproductive Health
	ASTPHND	Association of State and Territorial Public Health Nutrition Directors
B	BBC	Birth and Beyond California
	BIH	Black Infant Health
	BMI	Body Mass Index
C	CA	State of California
	CAA	Certified Application Assisters (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
	CBDMP	California Birth Defects Monitoring Program
	CBO	Community Based Organization
	CCDPHP	Center for Chronic Disease Prevention and Health Promotion
	CCG	Community Challenge Grant
	CCHA	California Children's Hospital Association
	CCHD	Critical Congenital Heart Disease Screening
	C-CHIP	County Children’s Health Initiative Program
	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
	CHVP	California Home Visiting Program
	CIPPP	Center for Injury Prevention Policy and Practice
	CLABSI	Central Line Associated Blood Stream Infections
	CLPP	Childhood Lead Poisoning Prevention program
	COPP	California Obesity 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
	CSUS	California State University, Sacramento
	CTCP	California Tobacco Control Program
	CVS	Chorionic Villus Sampling
	CWA	California WIC Association
	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
	ELL	English Language Learner
	EPSDT	Early and Periodic Screening, Diagnosis and Treatment

F	Family PACT	Family Planning, Access, Care & Treatment
	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
	FMCO	Fiscal Management and Contract Operations
	FPL	Federal Poverty Level
	FQHC	Federally Qualified Health Clinic
	FRC	Family Resource Center
	FTE	Full-time equivalent
	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	HBV	Hepatitis B vaccine
	HBEX	Health Benefit Exchange
	HCC	Hearing Coordination Center
	HCG	Human Chorionic Gonadotropin
	HCP	Hearing Conservation Program
	HCPCFC	Health Care Program for Children in Foster Care
	HEDIS	Health Plan Employer Data and Information Set
	HF	Healthy Families -- California's State Children's Health Insurance Program
	HeAPA	Health-e-App Public Access
	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
	HV	Home Visiting Program
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
	LAMH	Local Assistance to Maternal Health
	LAPSNC	Los Angeles Partnership for Special Health Care Needs Children
	LBW	Low Birth weight (<2500 grams)
	LHDMP	Local Health Department Maternal Child and Adolescent Health Program
	LHJ	Local Health Jurisdiction
M	MCAH	Maternal, Child, and Adolescent Health
	MCHB	Maternal and Child Health Bureau (Federal Agency)
	MCMC	Medi-Cal Managed Care
	MEDS	Medi-Cal Eligibility Data System
	MHF	Maternal Health Framework
	MHSA	Mental Health Services Act
	MIG	Medicaid Infrastructure Grant
	MIHA	Maternal and Infant Health Assessment
	MIS	Management Information Services
	MOD	March of Dimes
	MPINC	Maternity Practices in Infant Nutrition and Care Survey
	MQI	Maternal Quality Improvement
	MRMIB	Managed Risk Medical Insurance Board
	MTP	Medical Therapy Program
N	NBS	Newborn Screening
	NCHS	National Center for Health Statistics
	NHSP	Newborn Hearing Screening Program
	NICU	Neonatal Intensive Care Unit
	NIPT	Non-Invasive Prenatal Testing
	NPM	National Performance Measure
	NQI	National Quality Improvement
	NT	Nuchal Translucency
	NTD	Neural Tube Defect
O	OCAP	Office of Child Abuse Prevention
	OFP	Office of Family Planning
	OHAC	Oral Health Access Council
	OHC	Other Health Coverage
	OHU	Oral Health Unit
	OPG	Obesity Prevention Group
	OSHPD	Office of Statewide Health Planning and Development
	OTech	Office of Technology Services
	OT	Occupational Therapy

	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
	PCC	Pediatric Critical Care
	PCP	Primary Care Physician
	PDD	Patient Discharge Data
	PDN	Private Duty Nursing
	PDS	Program Development Section
	PDHC	Pediatric Day Health Care
	PedNSS	Pediatric Nutrition Surveillance System
	PFC	Partners For Children
	PHCC	Preconception Health Council of California
	PHHI	Preconception Health and Healthcare Initiative
	PHL	Parent Health Liaison
	PHN	Public Health Nurse
	PHP	Partnership Health Plan
	PICU	Pediatric intensive care unit
	PKU	Phenylketonuria
	PPC	Pediatric Palliative Care
		Pediatric Palliative Care Waiver
	PPE	Preconception Peer Educators
	PQIP	Perinatal Quality Improvement Panel
	PRAMS	Pregnancy Risk Assessment Monitoring System
	PRISM	Pediatric Risk of Mortality
	PSA	Public Service Announcement
	PSS	Program Support Section
	PSU	Provider Services Unit
	PT	Physical Therapy
	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
	RTT ELC	Race to the Top Early Learning Challenge

S	SAC	Safe and Active Communities
	SARs	Service Authorization Requests
	SCCs	Special Care Centers
	SCD	Systems of Care Division
	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
	SOW	Scope of Work
	SPM	State Performance Measure
	SPS	Statewide Programs Section
	SSC	State Screening Collaborative
	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 Supplemental Nutrition Program
	WHO	World Health Organization
Y	YSHCN	Youth with Special Health Care Needs

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