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

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DRAFT

Maternal Child and Adolescent Health Program

Center for Family Health

Department of Public Health

Children's Medical Services Branch

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A. Overview

Geography

California is the most populous state and, in terms of total land area, the third largest state in the nation. Covering over 156,000 square miles California is home to numerous mountain ranges, valleys and deserts.[1] It is bordered by Oregon to the north, Mexico to the south, Nevada and Arizona to the east, and the Pacific Ocean to the west. Depending on how urban and rural areas might be classified, as much as fifteen percent of California could be designated as rural.[2]

There are 58 counties in the state with a land area ranging from 47 square miles in San Francisco to 20,053 square miles in San Bernardino. Most counties cover an area greater than 1,000 square miles. The regions with the largest land area include Inyo, Kern, and Riverside Counties. Each of these counties covers an area greater than 7,000 square miles. The smallest regions – those with less than 600 square miles of land area – include Santa Cruz, San Mateo, San Francisco, and Amador Counties.[1]

Population

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

California's diversity is shaped by the multitude of racial and ethnic sub-groups across the state. For example, California's Asian population, the largest in the nation, demonstrates substantial diversity. The largest Asian sub-groups in California are Chinese, 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]

Age Distribution

California accounts for one in eight births in the U.S. As with the overall population in California, the MCAH population will continue to grow in numbers and diversity over the next 10 years. The population of

children 0-18 years of age has increased to 10.6 million in 2010 from 9.8 million in 2000, and is projected to reach 11.5 million by 2020. Similar increases are expected among women of reproductive age (18-44).

Among each of the MCAH populations, the largest racial/ethnic group in 2010 was Hispanic. Over the next 10 years, the proportion of the population that is Hispanic is expected to continue to increase for all population groups. The White population proportion is expected to continue to decline. Other racial/ethnic groups are expected to remain stable.

For instance, 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 (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.*

In 2011, the population of children and reproductive age women increased. By race/ethnicity, the Hispanic proportion increased while the White proportion decreased.[3]

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%), American Indian/Alaska Natives (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]

In 2009, the drop-out rate increased to 21.5% and increased across racial/ethnic groups.[16] *In 2009, the graduation rate increased to 70%.*[17]

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 federal poverty level in 2008 was $21, 200 for a family of four. African Americans, Hispanics, and American Indians have the highest rates of poverty in California.[18][18]*Among children under age 18 the rate is higher: 16% of the population is in poverty, or approximately 1.6 million children.*[19] *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.* [20]

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. [19]

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]

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]

Housing

California's high housing costs create a burden for families, resulting in less income available for other resources needed to maintain health.[27] *Lack of affordable housing also forces families to live in conditions that negatively impact MCAH outcomes: overcrowded or substandard housing or living in close proximity to industrial areas increases exposure to toxins such as mold and lead, as well as increased stress, violence, and respiratory infections.*[27] *It also exposes families to urban desert, i.e., neighborhoods lacking sidewalks, public parks, grocery stores and parks.*

In 2010, the fair market rent in California ranged from $672 in Tulare County to $1,760 in San Francisco Bay Area counties.[28] *Even for working families, the high cost of fair market rent is out of reach. In California, on average, one wage earner working at minimum wage would have to work 120 hours per week, 52 weeks per year in order to afford a two-bedroom apartment at fair market rent.*[29]

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.[30] *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.[31] *Homelessness in children has been linked to behavioral health problems,*[27] *and negatively impacts educational progress.*[31]

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. [32]

Public Health System

The California Department of Public Health (CDPH) is the lead state entity in California providing core public health functions and essential services. 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 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 which provide surveillance, early detection and prevention education related to cancer, cardiovascular diseases, diabetes, tobacco cessation, injury and obesity; the Center for Environmental Health which is responsible for identifying and preventing food borne illnesses and regulates the generation, handling and disposal of medical waste; the Center for Health Care Quality which licenses and inspects healthcare facilities to ensure quality of care, inspects laboratory facilities and

licenses personnel; and the Center for Infectious Diseases which provide surveillance, health education, prevention and control of communicable diseases.

To facilitate health planning and coordination and delivery of public health services in the community, California is divided into 61 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 AFLP, BIH, CPSP, the Sudden Infant Death Syndrome (SIDS) education and support services, and Fetal and Infant Mortality Review (FIMR).

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, SF, and Los Angeles.

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 California Department of Health Care Services (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. Given this multifaceted approach, California's Title V major state initiatives include the following:

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

California's Medicaid Section 1115 waiver for hospital financing and uninsured care expires on August 31, 2010. The need to submit a new waiver application presents 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

Work groups (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 (American Academy of Pediatrics, 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 Medi-Cal Managed Care 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.

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

>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, California's low cost insurance for children and teens who do not qualify for Medi-Cal, to continue providing health care coverage to current enrollees.

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

>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 RPPC in L.A. to develop a report on BBC pilot project findings and provide technical assistance for all other RPPC regions for 2 years. To date, 20 hospitals fully participated and 2 of the funded RPPC regions have obtained other funds to continue the BBC work. BBC curricula and tools will be posted on the MCAH breastfeeding website.

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.

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 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 AIM 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. This Collaborative ended

October 8, 2011. The goal of improving by 25% any breastfeeding at discharge for <1500gm infants was met.

>Comprehensive Black Infant Health (BIH) Program assessment

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

In 2006, MCAH contracted with the University of California, San Francisco (UCSF) Center on Social Disparities in Health to complete an assessment report of the BIH Program that was released in 2008. The conclusions from the literature review of the report found no definitive scientific evidence showing the best path to decrease disparities, but current knowledge suggests promising directions by addressing: (1) health and social conditions (including stress) across the life course, (2) social support, (3) empowerment/capacity building of individuals and communities, and (4) group-based approaches. The report also found that the current BIH program models lacked standardization across sites and were out-dated. The data collection requirements also were not standardized, limiting the ability to measure the program's effectiveness.

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

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

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

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 TA and training, to begin implementation in November 2011.

> 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.

The Preconception Health Council of California (PHCC), established in 2006 through a partnership between MCAH and the March of Dimes, 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.

California MCAH has also worked to incorporate preconception health messaging into other existing programs by including preconception curriculum content in the Black Infant Health program and the trainer module for California Diabetes and Pregnancy Program.

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 (HRSA)/MCHB to implement a preconception health social marketing campaign. California's data indicated that the lowest prevalence of daily folic acid use was among Latinas, and the lowest prevalence of healthy body mass index and smoking abstinence were among African Americans.

California's project will test "preconception health" and "reproductive life planning" 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.

MCAH staff continues to participate in a number of national preconception health–related workgroups including the national preconception health indicators workgroup and the CDC's preconception health consumer workgroup.

The PHCC serves as a coordinating hub for preconception health activities across the state such as the Interconception Care Project of California, an American Congress of Obstetrics and Gynecologists (ACOG), Region 9 project funded by March of Dimes 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 ways to improve their health status and plans for future children.
Local MCAH health jurisdictions have also undertaken activities related to preconception health. The L.A. Collaborative to Promote Preconception/Interconception Care has produced a curriculum for public health providers; published a data brief on preconception health in LA County; established a website; held a second preconception health summit for providers in the county; and developed an evaluation framework for the collaborative. It also oversees local preconception health projects that have had promising results such as the California Family Health Council's effort to develop and introduce a pre/interconception care curriculum into nearly 80 Title X clinics and the Public Health Foundation Enterprises WIC's WOW project (WIC Offers Wellness) which extended its integration of interconception health into WIC from one center to 61 centers throughout L.A. and Orange County.

>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 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. 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.

>Neonatal Quality Improvement Initiative

CMS and the California Children's Health Association (CCHA) sponsored a statewide QI Collaborative, partnering with CPQCC, to decrease Central Line Associated Blood Stream Infections (CLABSIs) in NICUs using the Institute for Healthcare Improvement (IHI) model for QI. Thirteen regional NICUs participated in 2006-07, reducing CLABSIs by 25 percent for all weight groups. In the second year, all 22 Regional NICUs

participated, aided by a Blue Shield Foundation grant. The CLABSI rate in 2008 was 2.33 per 1000 line days and 3.22 in 2007, but some of this reduction was due to a CDC definitional change for CLABSIs beginning Jan. 1, 2008. After the grant extension ended June 30, 2009, 14 regional NICUs continued the CLABSI prevention collaborative and for 2010 they are adding bloodstream infection (BSI) prevention. For 2009 the CLABSI rate for the 14 NICUs was 2.05 for all weights, and competing priorities have been the greatest barrier to infection prevention. 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.

>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. There are 22 PICUs; PRISM III data are collected.

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. Work is progressing on the comprehensive severity-adjusted PICU database and finalizing standards for Community Level PICUs.

>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. A request for amendment was submitted to CMS and approved to add the service: 'pain and symptom management' (by hospice providers) in October 2010. Year 2 has started in Marin, Orange, SF, and Sonoma counties and is projected to expand to Fresno and LA counties this fall; these (including the first 5) are the targeted 11 counties.

>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. In 2008, maternal mortality dropped slightly to. However, the disparity ratio for African –American mothers continued to rise to. 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 Maternal Infant Health Assessment (MIHA) and California Women's Health Survey (CWHS). MCAH conducts the California Pregnancy- Associated Mortality Review (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. 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. The Maternal Quality Indicator Work Group (MQI) trends maternal morbidity data and tests methods for monitoring national obstetric quality measures in California. Just as for mortality, the MQI group has found significant change in maternal morbidity with increased rates of diabetes, maternal hypertension and

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. 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." 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. The projects in San Bernardino and Los Angeles counties 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.

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 3 phases of a life course perspective: prior to pregnancy, during pregnancy and following pregnancy to restore a mother to health should a health complication arise during pregnancy. The MHF is being shared with all local health jurisdictions and external stakeholders as an example of an application of life course theory to real world public health policy and program planning.

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

with the goal of maximizing health during pregnancy.

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

Finally, in Phase III, MCAH provides programs and services to address common complications of pregnancy. CDAPP recruits, educates and provides consultation and technical assistance to providers who deliver comprehensive health services for high-risk pregnant women with pre-existing diabetes or women who develop diabetes while pregnant. CMQCC has developed two QI toolkits: one to reduce morbidity of obstetrical hemorrhage, a common complication of pregnancy and one to reduce elective inductions of labor prior to 39 weeks gestation which appears to be associated with higher rates of cesarean delivery.

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. Analyses were completed for linked 2008 data during the past year. Choropleth maps and hot-spot analyses were completed for specific counties and used by WIC to target resources in a funding announcement. Choropleth maps were then generated and disseminated to other WIC program areas for local planning and outreach. Data for 2009 were also linked and will get analyzed in 2011 for similar resource allocation and planning purposes. MCAH also provided training and technical assistance to State WIC staff as well as local WIC providers and agencies on how to interpret and use choropleth maps; trainings included several hands on sessions at the 2011 California WIC Association Conference.

Second, California's Maternal and Infant Health Assessment (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.

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 May 2011 and MCAH and WIC are working to identify priority analyses and applied uses of these data.

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.

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.

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.

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.

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 Local Health Jurisdiction (LHJ) data books, which are 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. 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.

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

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> AFLP PYD

On September 29, 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 Department of Education Cal-SAFE Program. 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.

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.

Grant funding is being made available to counties identified with the highest need and service gaps through a competitive process. 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. 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.

> Home Visiting Program

The Maternal, Infant and Early Childhood Home Visiting Program was established on March 23, 2010 by the Affordable Care Act (ACA) 0f 2010, which amended Title V of the Social Security Act by adding Section 511. MCAH is designated as the single State entity to oversee and administer home visiting funds on behalf of California. To receive funding from HRSA and ACF, MCAH began working in partnership with the California Department of Social Services (CDSS), California Department of Alcohol and Drug Programs (CDADP), the California Head Start State Collaboration Office (CHSSCO) of the California Department of Education (CDE), and local stakeholders from each of California's 61 Local Health Jurisdictions 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). MCAH anticipates implementation of home visiting programs in California in late 2011 or early 2012, depending on the availability of awarded funds. MCAH is anticipating the implementation of up to 30 home visiting programs in California, depending on the amount of awarded funds from HRSA and ACA.

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

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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, family resource centers, 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 the California Early Childhood Comprehensive Systems (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 MOUs 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

C. Agency Capacity

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

MCAH and CMS Programs

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

>Adolescent Family Life Program (AFLP)

AFLP aims to promote healthy development of adolescents and their children, healthy lifestyle decisions, including immunization and pregnancy prevention and continuation of adolescents' education. It uses a case management model to address the social, medical, educational, and economic consequences of adolescent pregnancy, repeat pregnancy and parenting on the adolescent, her child, family, and society.

It also links clients to mental health, drug and alcohol treatment, foster youth, family planning and dental care services and direct services available through Medi-Cal and CalWorks. AFLP targets services to pregnant and parenting teens and is providing services to approximately 6000 adolescents in 38 programs

throughout the State. In many counties, AFLP is the only case management program available for pregnant and parenting teens. The caseload for 2010 was 8,902 clients in 37 programs.

>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 in 2009 and reduced to 15 programs in 2010. BIH include a client-centered, strength-based group intervention with case management.

>California Birth Defects Monitoring Program (CBDMP)

CBDMP collects and analyzes data to identify opportunities for preventing birth defects and improving the health of babies. The 2006 birth year information was recently linked to vital statistics live birth and fetal death information, creating a database of more than 129,000 pregnancies affected with birth defects from a base population of 6.25 million births. Birth year 2007 linkage will be completed soon.

>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. The CCS caseload for FFY 2009 is 179,306 including 136,504 (76.1%) enrolled in Medi-Cal; 25,606 (14.3%) in HF, and 17,196 (9.6%) in state-only CCS.

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.

>California Early Childhood Comprehensive Systems (ECCS)

ECCS promotes universal and standardized social, emotional and developmental screening. ECCS collaborative efforts provide the Child Health and Disability Prevention (CHDP) Program 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, which served as the stakeholders in the ABCD project.

ECCS is partnering with Alameda County to develop early childhood programs of care for children 0 to 8 years of age California Project Launch. 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.

>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, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment.

>Comprehensive Perinatal Services Program (CPSP)

CPSP provides comprehensive perinatal care including obstetrical, nutrition, health education, and psychosocial services from qualified providers to Medi-Cal eligible women. There are 1566 active CPSP providers in California, and 1592 for 2010. MCAH develops standards and policies; provides technical assistance 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 monitor CPSP service delivery, recruit new providers and offer technical assistance and consultation to potential and approved providers in the implementation of CPSP program standards.

>Fetal Infant Mortality Review Program (FIMR)

Sixteen local health jurisdictions 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, identifies factors associated with these deaths, and determines if these factors represent systems problems. Recommendations from the Case Review Team are presented to a Community Action Team that develops and implements interventions that lead to positive changes.

>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 1,750 clients for 2008-2009 and 1,800 for 2009-10.

> 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.

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

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

>High Risk Infant Follow-up (HRIF)

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

The HRIF program continues to provide three multidisciplinary outpatient visits to identify problems, institute referrals, and monitor outcomes. The QCI developed a web based reporting system to collect HRIF data for quality improvement activities. Statewide trainings were provided to all NICU and HRIF Program staff before implementation and a follow-up training was held in February 2010 and spring 2011.

>Home Visiting Program (HVP)

HVP is designed to improve coordination of activities and services for at risk communities. It promotes improvements in maternal and infant health, school readiness, reduction of child maltreatment, improved community referral systems, and reductions in crime and domestic violence.

>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 human stem cell research.

>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.

>Maternal Quality Indicator (MQI) Workgroup

The MQI workgroup conducts trend analysis of maternal morbidity rates, chronic conditions that compromise maternal health and suggests strategies for surveillance and monitoring of quality benchmarks for obstetric hospitals.

>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 (25,556 in 2009).

>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 and 259 hospitals as of December 2009.

>Pediatric Palliative Care Waiver Program

This program allows for the provision of expanded hospice type services and curative care concurrently. This program is designed to improve the quality of life for children with life limiting or life threatening conditions, and their family members. It is anticipated that cost neutrality will be achieved by reduced hospital stays, medical transports and emergency room visits in addition to other costs avoided while the child is enrolled in the program.

>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. CPeTS maintains a web-based bed availability list, locate beds for high-risk mothers and infants and provide transport assistance, transport data reports, and perinatal transport quality improvement activities, including emergency triage and transport in the event of a disaster. Maternity hospitals can obtain information 24 hours a day, 7 days a week to facilitate transfers. The 2011-2014 contract will be drafting hospital Maternal Levels of Care.

>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.

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 the Birth and Beyond California 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.

>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 local MCAH programs collaborate on various community tasks forces involving oral health issues; this decreased to 21 in 2010. Further, direction has been provided by updating oral health educational components in the CPSP "Steps to Take" Guidelines, BIH prenatal and postpartum curriculumscurricula, AFLP "Infant Feeding" Guidelines and CDAPP's Sweet Success Guidelines. MCAH is disseminating perinatal clinical oral health guidelines to assist providers deliver oral health services.

>Preconception Health and Healthcare

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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. Reproductive life planning concepts and tools are being integrated into BIH and AFLP programs.

Major Collaboratives

MCAH and CMS value the input provided by its stakeholders across communities and has actively fostered collaboratives, task forces and advisory/work groups to address MCAH and CSCHN health issues. These collaborative, 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 youth providers and educators, integrated data tables (available at: http://www.californiateenhealth.org/download/ASHWG_Integrated_Data_Tables.pdf) and positive 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; for 2011, there were 129 NICUs, with 115 CCS-approved NICUs as members.

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. PQIP revised its charter and re-designed its structure developing 4 sub-committees.

> 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. CMQCC convenes the California Pregnancy-Associated Mortality Review Committee and provides technical assistance 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".

Family Voices of California (FVCA)

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

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

>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 Syndrome 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, Department of Social Services (DSS), Department of Mental Health (DMH), California Department of Education (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.

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 California (PHCC)

One of the key ways that MCAH partners with other entities is through PHCC which was established in 2006 by MCAH and the 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.

>Transition Workgroup

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

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

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

Business Partners

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

> Advanced Practice Nurse Program (APN)

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

>Branagh Information Group

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

>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. Through Internet Sexuality Information Service, CAHC reaches adolescents using digital media.

>California State University, Sacramento (CSUS)

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

>Childhood Injury Prevention Program (CIPP)

To reduce injury-related mortality and morbidity among children and adolescents, MCAH contracts with the Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University. CIPPP provides technical support for local MCAH programs and their partner agencies via face to face meetings, teleconferences, e-mail, a list serve, and literature reviews of the latest injury prevention research.

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

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

>Health Information Solutions

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

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

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

>Public Health Insitute (PHI)

Under contract with MCAH, PHI is responsible for medical record abstraction and assists in the analysis for the California Pregnancy-Associated Mortality Review (CA-PAMR).

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

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

Select Statewide Programs Serving the MCAH Population

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

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

Specific to infants, Medi-Cal, HF and 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. As of February 2011, 865,480 children were enrolled in HF. Of these, 2.6% (22,130) are served by CCS.

>Rehabilitation services

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

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

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

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

In 2009 the Children's Regional Integrated Service System (CRISS) annual family-centered care 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), Family Voices of California, and CMS. In 2010 the CRISS FCC conference was "Working Together in Challenging Times: CCS, Families and the Community".

The CRISS NICHQ project to promote medical homes for children with epilepsy in a Sonoma County Federally Qualified Health Center 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 the Federally Qualified Health Center (FQHC) is continuing activities to support medical homes for children with epilepsy.

Additionally, CRISS makes the parent health notebook and other medical home materials available on its website www.criss-ca.org.

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. LAPSNC is planning a conference in 2011 focusing on the impact of the 1115 waiver on CSHCN.

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

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

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

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

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

Other FVCA 2009 activities have included: Council's monthly meetings to address parent and community involvement; hosting 9 statewide webinars for families and professionals on topics such as the Family Opportunity Act, health care transition, nutrition for CSHCN, and impacting legislators; and participation in the Prematurity Coalition's Summit, providing and organizing a panel on Home Based Community Care to address parent and community involvement during and after hospital stays for families with babies born prematurely.

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

Approaches to Culturally Competent Service Delivery

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

- *BIH delivers culturally competent services to address the problem of disproportionate African American maternal and infant mortality.*
- *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*

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D. Data Tables

The reporting year for the Federal Fiscal Year 2011-2012 Title V Block Grant Application/Annual Report is 2010. The 2010 data shown in italics below are provisional data based on 2009 final data. Proposed annual objectives in this report are for the 2011-2015 time period.

National Performance Measures

California Title V National Performance Measures					
National Performance Measure		**Year**	**Measure**	**Year**	**Objective**
1.	*Percent of infants who are screened for conditions mandated by their State-sponsored newborn screening programs (e.g., phenylketonuria and hemoglobinopathies) and receive appropriate follow-up and referral as defined by their State.*	2006 2007 2008 2009 2010 2011 2012 2013 2014 2015	100.0 100.0 100.0 100.0 100.0	2006 2007 2008 2009 2010 2011 2012 2013 2014 2015	100 99.5 100.0 100.0 100.0 100.0 100.0 100.0 100.0 100.0
2.	*The percent of children with special health care needs age 0 to 18 whose family's partner in decision-making at all levels and are satisfied with the services they receive.* [a]National Survey of Children with Special Health Care Needs (CSHCN) 2001 [b]National Survey of CSHCN 2005-06	2006 2007 2008 2009 2010	47.6[a] 46.6[b] 46.6[b] 46.6[b] 46.6[b]	2006 2007 2008 2009 2010 2011 2012 2013 2014 2015	51.5 52.5 52.5 47.0 47.5 48.0 48.0 48.0 48.0 48.0
3.	*The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.* [a]CSHCN Survey 2001 [b]CSHCN Survey 2005-06	2006 2007 2008 2009 2010	44.7[a] 42.2[b] 42.2[b] 42.2[b] 42.2[b]	2006 2007 2008 2009 2010 2011 2012 2013 2014 2015	50.0 51.0 51.0 42.5 43.0 44.0 44.0 44.0 44.0 44.0

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California Title V National Performance Measures (continued)

National Performance Measure		*Year*	*Measure*	*Year*	*Objective*
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.* [a]*CSHCN Survey 2001* [b]*CSHCN Survey 2005-06*	*2006* *2007* *2008* *2009* *2010*	*59.3*[a] *59.6*[b] *59.6*[b] *59.6*[b] *59.6*[b]	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*66.5* *68.5* *65.5* *60.0* *60.3* *61.0* *61.0* *61.0* *61.0* *61.0*
5.	*The percent of children with special health care needs age 0 to 18 whose families report the community-based service system are organized so they can use them easily.* [a]*CSHCN Survey 2001* [b]*CSHCN Survey 2005-06*	*2006* *2007* *2008* *2009* *2010*	*65.9*[a] *85.3*[b] *85.3*[b] *85.3*[b] *85.3*[b]	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*70.0* *71.0* *85.5* *86.0* *86.5* *87.0* *87.0* *87.0* *87.0* *87.0*
6.	*The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life.* [a]*CSHCN Survey 2001; sample size too small for CA, therefore no state objective at this time* [b]*CSHCN Survey 2005-06*	*2006* *2007* *2008* *2009* *2010*	*5.8*[a] *37.1*[b] *37.1*[b] *37.1*[b] *37.1*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*5.8* *5.8* *37.5* *37.5* *38.0* *39.0* *39.0* *39.0* *39.0* *39.0*
7.	*Percent of children age 19 to 35 months who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.* [a)] *Based on 4:3:1:3:3 series.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*80.3*[a] *79.4*[a] *80.6*[a] *75.8*[a] *75.8*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*82.0* *78.4* *78.9* *79.4* *79.9* *82.1* *82.1* *82.1* *82.1* *82.1*

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California Title V National Performance Measures (continued)

National Performance Measure		*Year*	*Measure*	*Year*	*Objective*
8	*The birth rate (per 1,000 females) for teenagers aged 15 through 17 years.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*20.0* *19.9* *19.1* *17.5* *17.5*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*20.1* *20.0* *19.7* *19.4* *19.1* *16.5* *16.5* *16.5* *16.5* *16.5*
9.	*Percent of third grade children who have received protective sealants on at least one permanent molar tooth.* [a] *Oral Health Needs Assessment Survey.*	*2006* *2007* *2008* *2009* *2010* *2010* *2011* *2012* *2013* *2014* *2015*	*27.6*[a] *27.6*[a] *27.6*[a] *27.6*[a] *27.6*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*27.6* *27.6* *28.1* *28.6* *29.1* *29.6* *29.0* *29.0* *29.0* *29.0*

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California Title V National Performance Measures (continued)

National Performance Measure		*Year*	*Measure*	*Year*	*Objective*
10	*The rate of deaths to children aged 14 and younger caused by motor vehicle crashes per 100,000 children.* *Note: New methodology used in 2007 to exclude non-traffic motor vehicle incidents. 2000-2006 measure data were re-calculated to reflect change; objectives not re-calculated. 2000-2006 data had been previously re-calculated using new Dept. of Finance population projection estimates.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*2.4* *2.3* *1.7* *1.8* *1.8*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*3.0* *3.1* *3.0* *2.9* *2.9* *1.6* *1.6* *1.6* *1.6* *1.6*
11	*Percentage of mothers who breastfeed their infants at 6 months of age. (New National Performance Measure)* *[(a)] Percent of mothers breastfeeding at 2 months of age reported from the California Maternal and Infant Health Assessment (MIHA) Survey.* *[(b)] Percent of mothers breastfeeding at 3 months of age, based on revised California Maternal and Infant Health Assessment (MIHA) Survey.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*69.4[a]* *61.6[b]* *59.9[b]* *62.3[b]* *62.3 [b]*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*69.6* *71.0* *71.5* *72.0* *65* *64.2* *64.2* *64.2* *64.2* *64.2*
12	*Percentage of newborns that have been screened for hearing impairment before hospital discharge.*	*2006* *2007* *2008* *2009*	*75.7* *73.3* *93.2* *98.0*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*75.0* *75.0* *85.0* *95.0* *95.0* *98.0* *98.0* *98.0* *98.0* *98.0*

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California Title V National Performance Measures (continued)

National Performance Measure		*Year*	*Measure*	*Year*	*Objective*
13.	*Percent of children without health insurance.*	*2006*	*13.9*	*2006*	*13.0*
		2007	*11.2*	*2007*	*13.5*
		2008	*11.0*	*2008*	*13.3*
		2009	*11.2*	*2009*	*13.1*
		2010	*11.2*	*2010*	*12.9*
		2011		*2011*	*10.0*
		2012		*2012*	*10.0*
		2013		*2013*	*10.0*
		2014		*2014*	*10.0*
		2015		*2015*	*10.0*
14.	*Percent of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*	*2006*	*33.2*	*2006*	*33.7*
		2007	*33.6*	*2007*	*33.6*
		2008	*33.3*	*2008*	*33.6*
		2009	*32.9*	*2009*	*33.5*
		2010	*32.9*	*2010*	*33.5*
		2011		*2011*	*31.4*
		2012		*2012*	*31.4*
		2013		*2013*	*31.4*
		2014		*2014*	*31.4*
		2015		*2015*	*31.4*
15.	*Percent of women who smoke in the last three months of pregnancy.*	*2006*	*3.0*	*2006*	*3.4*
		2007	*2.6*	*2007*	*3.7*
		2008	*3.3*	*2008*	*3.6*
		2009	*2.8*	*2009*	*3.5*
		2010	*2.8*	*2010*	*3.4*
		2011		*2011*	*2.5*
		2012		*2012*	*2.5*
		2013		*2013*	*2.5*
		2014		*2014*	*2.5*
		2015		*2015*	*2.5*

** In development at the time of report*

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California Title V National Performance Measures (continued)

	National Performance Measure	Year	Measure	Year	Objective
16.	The rate (per 100,000) of suicide deaths among youths 15-19.	2006	5.2	2006	5.6
		2007	4.1	2007	4.7
		2008	4.4	2008	4.7
		2009	4.7	2009	4.6
		2010	4.7	2010	4.6
		2011		2011	3.9
		2012		2012	3.9
		2013		2013	3.9
		2014		2014	3.9
		2015		2015	3.9
17.	Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.	2006	66.9	2006	68.2
		2007	67.3	2007	67.2
		2008	73.8	2008	67.5
		2009	75.9	2009	67.8
		2010	75.9	2010	68.1
		2011		2011	78.6
		2012		2012	78.6
		2013		2013	78.6
		2014		2014	78.6
		2015		2015	78.6
18.	Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.	2006	85.9	2006	87.1
		2007	82.9	2007	86.7
		2008	82.4	2008	86.9
		2009	82.9	2009	87.1
		2010	82.9	2010	87.3
		2011		2011	86.8
		2012		2012	86.8
		2013		2013	86.8
		2014		2014	86.8
		2015		2015	86.8

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State Performance Measures

California Title V State Performance Measures

State Performance Measures		Year	Measure	Year	Objective
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.	2010	-	2010 2011 2012 2013 2014 2015	- - 30 40 40 40
2.	The percent of primary care physicians, approved to participate in the CCS program, who are receiving authorizations for care.	2010	23.7	2010 2011 2012 2013 2014 2015	- 25 25 27 27 27
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.	2010 2011 2012 2013 2014 2015		2010 2011 2012 2013 2014 2015	
4.	The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.	2009 2010 2011 2012 2013 2014 2015		2009 2010 2011 2012 2013 2014 2015	- - 12.7 12.7 12.7 12.7 12.7
5.	The percent of cesarean births among low-risk women giving birth for the first time.	2009 2010 2011 2012 2013 2014 2015	26.6 26.6	2009 2010 2011 2012 2013 2014 2015	- - 25.1 25.1 25.1 25.1 25.1
6.	The percent of women of reproductive age who are obese.	2009 2010 2011 2012 2013 2014 2015	21.8 21.8	2009 2010 2011 2012 2013 2014 2015	- - 20.6 20.6 20.6 20.6 20.6

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California Title V State Performance Measures					
State Performance Measures		**Year**	**Measure**	**Year**	**Objective**
7.	The percent of women whose live birth occurred less than 24 months after a prior birth.	2009 2010	-	2009 2010 2011 2012 2013 2014 2015	- - 11.7 11.7 11.7 11.7 11.7
8.	The percent of public school students in 9th grade reporting a high level of school connectedness.	2009 2010 2011 2012 2013 2014 2015		2009 2010 2011 2012 2013 2014 2015	- -
9.	The rate of fetal and infant deaths with weight less than 1500 grams per 1,000 live births and fetal deaths.	2009 2010 2011 2012 2013 2014 2015		2009 2010 2011 2012 2013 2014 2015	- -

State Outcome Measure

California Title V State Outcome Measures					
State Outcome Measure		**Year**	**Measure**	**Year**	**Objective**
1	The pregnancy related mortality rate per 100,000 live births.	2009 2010 2011 2012 2013 2014 2015	18.0 18.0	2009 2010 2011 2012 2013 2014 2015	- - 15.4 15.4 15.4 15.4 15.4

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National Outcome Measures

California Title V National Outcome Measures					
National Outcome Measures		***Year***	***Measure***	***Year***	***Objective***
1	*The infant mortality rate per 1,000 live births.*	*2006*	*5.0*	*2006*	*5.1*
		2007	*5.2*	*2007*	*5.1*
		2008	*5.1*	*2008*	*5.1*
		2009	*4.9*	*2009*	*5.0*
		2010	*4.9*	*2010*	*5.2*
		2011		*2011*	*4.8*
		2012		*2012*	*4.8*
		2013		*2013*	*4.8*
		2014		*2014*	*4.8*
		2015		*2015*	*4.8*
2	*The ratio of the black infant mortality rate to the white infant mortality rate.*	*2006*	*2.6*	*2006*	*2.5*
		2007	*2.5*	*2007*	*2.5*
		2008	*3.0*	*2008*	*2.5*
		2009	*2.6*	*2009*	*2.4*
		2010	*2.6*	*2010*	*2.4*
		2010		*2011*	*2.4*
		2011		*2012*	*2.4*
		2012		*2013*	*2.4*
		2013		*2014*	*2.4*
		2014		*2015*	*2.4*
		2015			
3	*The neonatal mortality rate per 1,000 live births.*	*2006*	*3.5*	*2006*	*3.5*
		2007	*3.5*	*2007*	*3.5*
		2008	*3.4*	*2008*	*3.4*
		2009	*3.3*	*2009*	*3.4*
		2010	*3.3*	*2010*	*3.4*
		2011		*2011*	*3.2*
		2012		*2012*	*3.2*
		2013		*2013*	*3.2*
		2014		*2014*	*3.2*
		2015		*2015*	*3.2*

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California Title V National Outcome Measures (continued)					
National Outcome Measures		**Year**	**Measure**	**Year**	**Objective**
4	The post neonatal mortality rate per 1,000 live births.	2006	1.6	2006	1.6
		2007	1.6	2007	1.6
		2008	1.6	2008	1.6
		2009	1.6	2009	1.6
		2010	1.6	2010	1.6
		2011		2011	1.5
		2012		2012	1.5
		2013		2013	1.5
		2014		2014	1.5
		2015		2015	1.5
5	The Perinatal mortality rate ((deaths: fetal and infant/fetal deaths and live births) *1,000)).	2006	5.4	2006	5.4
		2007	5.4	2007	5.4
		2008	5.3	2008	5.4
		2009	5.3	2009	5.3
		2010		2010	5.3
		2011		2011	
		2012		2012	
		2013		2013	
		2014		2014	
		2015		2015	
6	The child death rate per 100,000 children aged 1 through 14.	2006	15.9	2006	17.2
		2007	15.1	2007	17.1
		2008	14.1	2008	17.0
		2009	14.4	2009	17.0
		2010	14.4	2010	16.8
		2011		2011	13.5
		2012		2012	13.5
		2013		2013	13.5
		2014		2014	13.5
		2015		2015	13.5

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Health System Capacity Indicators

Health System Capacity Indicators		***Year***	***Indicator***
1	*The rate per 10,000 for asthma hospitalizations among children less than five years old.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*24.3* *22.8* *22.0* *22.9* *22.9*
2	*The percent of Medicaid enrollees whose age is less than one year during the reporting year that received at least one initial periodic screen.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*71.3* *82.5* *83.4* *90.1* *90.1*
3	*The percent of Children's Health Insurance Program (CHIP) enrollees whose age is less than one year during the reporting year that received at least one periodic screen.*		*NA*
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 percent on the Kotelchuck Index.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*78.7* *78.6* *79.0* *79.7* *79.0*

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California Title V Health System Capacity Indicators (continued)					
Health System Capacity Indicator 5: Medicaid and Non-Medicaid Comparisons		**Year**	**Indicator**		
			MediCal	**Non-MediCal**	**All**
5A.	*Percent of low birth weight (<2,500 grams): Payment source from birth certificate.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*6.8* *6.8* *6.7* *6.7*	*6.9* *6.9* *6.9* *6.8*	*6..9* *6.9* *6.8* *6.8*
5B.	*Infant deaths per 1,000 live births: matching data files.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*5.7* *5.6* *5.7*	*4.5* *4.7* *4.5*	*5.2* *5.3* *5.3*
5C	*Percent of pregnant women entering care in the first trimester: Payment source from birth certificate*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*80.6* *76.6* *76.0* *76.7*	*90.5* *88.3* *88.0* *88.4*	*85.9* *82.9* *82.4* *82.9*
5D	*Percent of women with adequate (observed to expected prenatal visits is greater or equal to 80% (Kotelchuck Index) prenatal care.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*75.4* *74.7* *75.0* *76.4*	*81.5* *81.9* *82.4* *82.6*	*78.7* *78.6* *79.0* *79.7*

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California Title V Health System Capacity Indicators (continued)					
Health System Capacity Indicator 6: Medicaid and CHIP Eligibility Levels			**Year**	**Indicator**	
6A	*The percent of poverty for eligibility in the State's Medicaid and CHIP programs for infants.*	*(Age 0-1)*	*2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*Medi* *200* *200*	*CHIP* *250* *250*
6B	*The percent of poverty for eligibility in the State's Medicaid and CHIP programs for children.*	*(Ages 1-5)*	*2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*133* *133*	*250* *250*
		(Ages 6-18)	*2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*100* *100*	*250* *250*
6C	*The percent of poverty for eligibility in the State's Medicaid and CHIP programs for pregnant women*		*2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*200* *200*	*300* *300*

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California Title V Health System Capacity Indicators (continued)			
7A	*Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program. (Previously National Performance Measure 14)*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*92.4* *98.7* *94.8*
7B	*The percent of EPSDT eligible children aged 6 through 9 years who have received any dental service during the year.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*41.1* *43.0*[a] *49.4* *49.9*

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California Title V Health System Capacity Indicators (continued)			
8	*The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.* [a]*New methodology.* [b]*Figures are not comparable because of another change in methodology.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*32.5* *31.1* *28.2* *30.1* *31.4*

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Health Status Indicators

Health Status Indicators		***Year***	***Indicator***
1A	*The percent of live births weighing less than 2,500 grams*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*6.8* *6.9* *6.8* *6.8* *6.8*
1B	*The percent of live singleton births weighing less than 2,500 grams*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*5.2* *5.3* *5.2* *5.2* *5.2*
2A	*The percent of very low birth weight births.*	*2006* *2007* *2008* *2009* *2010*	*1.2* *1.2* *1.1* *1.2* *1.2*
2B	*The percent of very low birth weight singleton births.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*0.9* *0.9* *0.9* *0.9* *0.9*

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Health Status Indicators (continued)		***Year***	***Indicator***
3A	*The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*5.5* *5.3* *4.2* *4.4* *4.4*
3B	*The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger* *Note: New methodology used in 2007 to exclude non-traffic motor vehicle incidents. 2000-2006 measure data were re-calculated to reflect change.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*2.4* *2.3* *1.7* *1.8* *1.8*
3C	*The death rate per 100,000 due to motor vehicle crashes among youth aged 15 through 24 years.* *Note: New methodology used in 2007 to exclude non-traffic motor vehicle incidents. 2000-2006 measure data were re-calculated to reflect change.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*19.8* *18.2* *14.0* *11.5* *11.5*
4A	*The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*210.9* *198.0* *194.0* *193.9* *193.9*

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Health Status Indicators (continued)		***Year***	***Indicator***
4B	*The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*26.5* *23.0* *19.6* *18.6* *18.6*
4C	*The rate per 100,000 of nonfatal injuries due to vehicle crashes among youth aged 15 through 24 years.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*146.7* *135.4* *110.8* *99.0* *99.0*
5A	*The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*22.8* *23.1* *23.5* *22.2* *22.2*
5B	*The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*	*2006* *2007* *2008* *2009* *2010* *2011* *2012* *2013* *2014* *2015*	*9.7* *10.1* *10.2* *10.0* *10.0*

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E. References:

1. *California Department of Finance, Economic Research Unit. California Statistical Abstract. Sacramento, CA: CA Department of Finance; 2009.*
2. *Beery WL, Greenwald HP, Marzotto A. The Designation of Rural Areas in California. Los Angeles, CA: The California Endowment; 2006.*
3. *California Department of Finance. Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, CA: CA Department of Finance; July, 2007.*
4. *California First 5 California Children and Families Commission. Research Identifying Hard to Reach Communities. Sacramento, CA: California First 5 California Children and Families Commission.*
5. *California Department of Finance. Population Projections for California and Its Counties 2000-2050. Sacramento, CA: California Department of Finance; July, 2007.*
6. *Ventura SJ, Matthews TJ, Hamilton BE. Births to teenagers in the United States, 1940-2000. National Vital Statistics Reports. Hyattsville, MD: Centers for Disease Control and Prevention; 2001:10.*
7. *Hoffman SD. Kids having kids: economic costs and social consequences of teen pregnancy: The Urban Institute Press; 2008.*
8. *U.S. Census Bureau, American Community Survey. Selected Social Characteristics in the United States, 2006-2008 American Community Survey 3-Year Estimates. Washington, DC: U.S. Census; 2008.*
9. *California Department of Public Health. Birth Statistical Master File (BSMF). Sacramento, CA: California Department of Public Health; 2008.*
10. *Fortuny K, Capps R, Passel R. Unauthorized immigrants in California, Los Angeles County, and the United States. San Francisco, CA: Urban Institute; March 2007.*
11. *Passel JS, Cohn D. A Portrait of unauthorized immigrants in the United States. Washington, D.C.: Pew Hispanic Center; April 14, 2009.*
12. *California Department of Education, Educational Demographics Unit. Number of English Learners by Language. Sacramento, CA: California Department of Education; 2008-2009.*
13. *California Department of Education, Educational Demographics Office, CBEDS data collection. Enrollment, Graduates and Dropouts in California Public Schools, 1974-75 Through 2007-2008; 2010.*
14. *California Department of Education, Eucational Demographics Office. Dropouts by Ethnic Designation by Grade, State of California for the Year 2007-08. Sacramento, CA: California Department of Education; 2007-08.*
15. *Rumberger R, Rotermund S. Ethnic and Gender Differences in California High School Graduation Rates. Santa Barbara, CA: Gervitz Graduate School of Education, University of California, Santa Barbara; 2010.*
16. *California Department of Education, Educational Demographics Office. Dropouts by Ethnic Designation by Grade, State of California for the Year 2008-09. Sacramento, CA: California Department of Education; 2008-09.*
17. *California Department of Education, Educational Demographics Office, CBEDS data collection. Enrollment, Graduates and Dropouts in California Public Schools, 1974-75 Through 2009-2010; 2010.*
18. *U.S. Census Bureau, American Community Survey. S1701. Poverty Status in the Past 12 Months, 2006-2008 American Community Survey 3-year Estimates. Washington, DC: U.S. Census; 2008.*
19. *California Department of Public Health. County Health Status Profiles 2010. Sacramento, California: California Department of Public Health; 2010.*
20. *Kidsdata.org. The California Index of Child and Youth Well-Being, Projections of the Current Economic Recession. http://www.kidsdata.org/index/poverty.html. Accessed May 15, 2010.*

DRAFT

21. *U.S. Census Bureau, American Community Survey. B17017. Poverty status in the past 12 months by household type by age of householder, 2006-2008 American Community Survey 3-year Estimates. Washington, D.C.: U.S. Census; 2008.*

22. *Pearce DM. Overlooked and Undercounted 2009: Struggling to Make Ends Meet in California: School of Social Work, Center for Women's Welfare, University of Washington; December, 2009.*

23. *Braveman P, Marchi K, Egerter S, et al. Poverty, near-poverty, and hardship around the time of pregnancy. Matern Child Health J. Jan;14(1):20-35.*

24. *Kidsdata.org. California Department of Education, Free/Reduced Price Meals Progarm & CalWORKS Data Files. http://www.cde.ca.gov/ds/sh/cw/filesafdc.asp.*

25. *U.S. Department of Labor, Statistics BoL. Regional and State Unemployment - 2010 Annual Averages.: U.S. Department of Labor,Bureau of Labor Statistics; February 25, 2011.*

26. *Kolko J. Just The Facts: The California Economy: Employment in 2010. . http://www.ppic.org/main/publication_show.asp?i=794.*

27. *Beyers M, Brown J, Cho S, et al. Life and death from unnatural causes: Health and social inequity in Alameda County. Oakland, CA: Alameda County Public Health Department; April 2008.*

28. *Kidsdata.org. Housing Affordability: Selected Facts. http://www.kidsdata.org/Data/Topic/Dashboard.aspx?gsa=1&cat=41. Accessed May 15, 2010.*

29. *National Low Income Housing Coalition. Out of Reach 2007-2008. http://www.nlihc.org/oor/oor2008/data.cfm?getstate=on&state=CA. Accessed May 15, 2010.*

30. *Rand Corporation, Business and Economic Statistics. Housing Foreclosure Statistics. http://ca.rand.org/stats/economics/foreclose.html. Accessed May 15, 2010.*

31. *The National Center on Family Homelessness. A State Report Card on Child Homelessness: America's Youngest Outcasts Newton, MA: The National Center on Family Homelessness; 2009.*

32. *Rand Corporation, Business and Economic Statistics. Housing Foreclosure Statistics. http://ca.rand.org/stats/economics/foreclose.html. Accessed March 16, 2011.*

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