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- *Abridged Document* -

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

FFY 2010-2011
(October 1, 2010 – September 30, 2011)

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

**Children's Medical Services Branch
Department of Health Care Services**

State of California

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A. STATE OVERVIEW

Geography

California is the most populous state and, in terms of total land area, the third largest state in the nation. Covering over 156,000 square miles, California is home to numerous mountain ranges, valleys and deserts. 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.

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, and Amador Counties.

Population

In 2010, an estimated 39.1 million people resided in California, an increase from 34.1 million in 2000. California's population growth is expected to continue over the next 10 years to reach 44.1 million by 2020. Currently, in 2010, an estimated 42% of the population is White, 37% Hispanic, 12% Asian, 6% Black, 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, Orange, and San Bernardino counties, counties with the largest percentage of Asian residents are in the San Francisco Bay Area.

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. At 77%, Imperial County has by far the largest proportion of Hispanic population in

California. Other counties in which greater than 50% of the population is Hispanic are in the agricultural region of Central California, while Southern California counties have the largest numbers of Hispanic residents.

Age Distribution

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 will continue to decline. Other racial/ethnic groups will 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 will 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 will decline. Other groups will 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 will continue to increase through 2020, while the proportion that is white will continue to decline. Other racial/ethnic groups are projected to remain fairly stable through 2020.

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 will continue to increase among this age group through 2020 to 47%, and the percentage of White women will decline to 32%. Other groups will 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. In 2010, there were an estimated 1.5 million women ages 15-19

and 875,000 women ages 15-17 in California. Hispanic women 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 women ages 15-17.

Immigration

California is home to 9.9 million immigrants, the largest number and percentage of foreign born residents in the United States. 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., 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).

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% had 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.

California has the largest number and proportion of undocumented immigrants of any state. Many undocumented immigrants in California experience difficulty in meeting basic needs and accessing services, while facing additional health risks related to low wage jobs that lack protections and benefits. In 2008, approximately 2.7 million undocumented immigrants lived in California, an increase from 1.5 million in 1990. In 2004, approximately 41% of California's undocumented immigrants resided in Los Angeles County.

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.

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.

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 slightly from 69.6% in 2000 to 68.5% in 2008, drop out rates have risen sharply from 10.8% in 2000 to 18.9% in 2008.

Educational attainment varies greatly by race/ethnicity and gender. The 2007-08 drop out 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%).

California's 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.

Income

According to the most recent census data, over 4.6 million Californians, 13% of the population, have incomes below the federal poverty level (100% FPL). African Americans, Hispanics, and American Indians have the highest rates of poverty in California. Among children under age 18 the rate is higher: 16% of the population is in poverty, or approximately 1.6 million children. 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 Los Angeles County, home to 25% of California's children, one in three children is projected to be in poverty in 2010.

California child poverty varies tremendously by region. Counties with the highest child poverty rates are in the Central Valley, Northern Mountain, or border regions of California: Tulare (31%), Lake (28%), Fresno (28%), Del Norte (28%), and Imperial (27%). Counties with the lowest rates of child poverty (below 10%) are in the San Francisco Bay Area, Wine Country, and the Lake Tahoe/mountain recreational area.

The high cost of living in California obscures the struggles faced by many families when looking only at those below the federal poverty level. 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.

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 stresses 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.

Housing

California's high housing costs create a burden for families, resulting in less income available for other resources needed to maintain health. Lack of affordable housing also forces families to live in conditions that negatively impact MCAH outcomes: overcrowded or substandard housing increases exposure to toxins such as mold and lead, as well as increased stress and respiratory infections

In 2010, the fair market rent in California ranged from \$672 in Tulare County to \$1,760 in San Francisco Bay Area counties. 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

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. 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 families. More than 292,624 children are homeless each year in California, which is ranked 48th in the percent of child homelessness in the United States. Homelessness in children has been linked to behavioral health problems, and negatively impacts educational progress.

Public Health System

The California Department of Public Health is the lead 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. The Center for Family Health also oversees provision of supplemental food to women, infants and children 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 local health jurisdictions (LHJs), including 58 counties and three incorporated cities. These cities are Berkeley, Long Beach, and Pasadena. In addition to providing the basic framework to protect the health of the community, 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 reallocates 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 people eligible for Medi-Cal. Other LHJ activities include assessment of health status indicators for the MCAH population, and community health education and promotion programs. Specific MCAH categorical programs administered by LHJs include the Adolescent Family Life Program, the Black Infant Health program, the Comprehensive Perinatal Services Program, Sudden Infant Death Syndrome and Fetal and Infant Mortality Review.

The California Children's Services (CCS) addresses the health service needs of children with special health care needs (CSHCN) in the state. CCS authorizes and pays for specific medical services and equipment provided by CCS – approved specialist for children with special needs. Larger counties operate their own CCS programs and smaller counties share the operation of their programs with the state CCS regional offices in Sacramento, San Francisco and Los Angeles.

Major State Initiatives

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

As authorized by legislation (ABx4 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 (SAC), 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 SAC are technical workgroups (TWG) constructed to discuss each of the populations and make recommendations to DHCS on what could be included in the 1115 Waiver that would improve the delivery of care for CSHCN. The workgroups are to assist in specifically identifying and designing several delivery models to pilot test in order to determine if any one of them can be used to more effectively provide care for CCS clients.

Members of the CCS TWG represent families, provider organizations (American Academy of Pediatrics, Children's Specialty Care Coalition, California Association of Medical Product Suppliers, 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>.

>Child Health Insurance Coverage
State legislation Assembly Bill 1422, along with funding from the First Five Commission and program savings enacted by the Managed Risk Medical Insurance Board will allow the Healthy Families Program, California's low cost insurance for children and teens who do not qualify for Medi-Cal, to continue providing health care coverage to current enrollees.

From July 2003 through December 2009, over 4 million children receiving assessments were pre-enrolled for up to two months of no cost, full-scope Medi-Cal benefits. The number of families utilizing the Child Health and Disability Prevention (CHDP) Program via this process appears to be gradually increasing due to the number of families losing private health insurance due to the economy.

>Breastfeeding

Due to state budget cuts in August 2009, funds for the Birth and Beyond California (BBC) a hospital-based breastfeeding continuous quality improvement (QI) project were reduced. Funding continues for the regional Perinatal Program of California (RPPC) in Los Angeles to develop a report on BBC findings and provide technical assistance for all other RPPC regions for 2 years. To date, 20 hospitals fully participated, though 2 of the funded RPPC regions have obtained other funds to continue the BBC work. BBC curriculums and tools will be posted on the MCAH breastfeeding web-site.

MCAH is in the process of releasing 2008 hospital breastfeeding initiation 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 percents. New breastfeeding guidelines are being finalized for other state MCAH programs.

In December 2009, CDPH, the California Breastfeeding Coalition, and the California WIC Association began the California Breastfeeding Roundtable. The Roundtable meets for the second time in June 2010 and has drafted a strategic plan that will be used by the obesity grant funded by 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. Additionally, MCAH has been advocating for a new CDPH lactation policy and piloting a bring-your-infant to work lactation supportive policy.

CCS is partnering with the California Perinatal Quality Care Collaborative (CPQCC) in a breast milk nutrition quality improvement collaborative for 2010 involving 11 community and regional 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.

>Comprehensive Black Infant Health (BIH) Program Assessment

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

In 2006, CDPH/MCAH contracted with the University of California, San Francisco (UCSF) Center for 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, including by addressing: (1) health & 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 lacked of standardization across sites and was out-dated. The data collection requirements were not standardized which meant data collected could not show the program's effectiveness.

The report recommended the development and implementation of a single core model for all local BIH program sites to enhance its impact on Black maternal and infant health. CDPH/MCAH convened groups of key stakeholders including local BIH and MCAH staff, state MCAH staff, and UCSF Center for 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 will be strength-based and empower the women to make better health choices for themselves and their family, as well as encouraging 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 prenatal care as well as empowering women to improve her ability to manage stress from the social, cultural, and economic issues that are known to influence health. The program starts with an intake that will assess clients' needs and identify strengths. There is an individual intervention that is primarily case management based on each clients 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 system has been fully revised to assess the programs effectiveness. In addition, CDPH/MCAH is conducting quality assurance measure to ensure the revised model's fidelity.

The group intervention will start piloting at 4 sites (Fresno, Sacramento, San Diego and Solano) in April 2010. BIH staff and clients at those sites will be giving feedback in "real time" via a website for changes to be made to the group intervention.

Program implementation including intake, case management, group intervention, evaluation and quality assurance will be staggered with eight of the 15 sites implementing the revised intervention starting on July 1, 2010. These sites will provide feedback to CDPH/MCAH about the model and revisions will be made.

The other seven sites will be implementing the current program. This staggered approach will allow for comparisons within and between sites about the new intervention. It is anticipated that all 15 sites will fully implement the new intervention on July 1, 2011.

>Preconception Health and Health Care Initiative (PHHI)

While the main goal of preconception care is to provide health promotion, screening and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies, the Maternal Child and Adolescent Health Division of the California Department of Public Health takes a broader approach. Implicit in its Preconception Health and Health Care Initiative (PHHI) is a life course perspective that promotes care 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>.

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 PSAs; outreach to the community through health promoter training; and vitamin distribution and education through WIC agencies. It resulted in 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 HRSA/MCHB to implement a preconception health social marketing campaign. 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 continue 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 (ICAC), an ACOG 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 plans for future children.

Local MCAH health jurisdictions have also undertaken activities related to preconception health. The Los Angeles 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 PHFE-WIC's WOW project (WIC Offers Wellness) which extended its integration of interconception health into WIC from one center to 61 centers throughout Los Angeles and Orange County.

>High Risk Infant Follow-up (HRIF) Program

The HRIF Program follows infants who might develop CCS-eligible conditions after discharge from a neonatal intensive care unit (NICU) and assures 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.

>Improving Quality of Vital Statistics Data

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 award hospitals for improvement and high achievement.

>Neonatal Quality Improvement (QI) Initiative

Children's Medical Services (CMS) Branch and the California Children's Hospital Association (CCHA) sponsored a statewide QI Collaborative, partnering with CPQCC, to decrease central line associated blood stream infections (CLABSIs) in NICUs using the Institute for Healthcare Improvement (IHI) model for QI. Thirteen regional NICUs participated in 2006-07, reducing CLABSIs by 25 percent for all weight groups. In the second year, all 22 Regional NICUs participated, aided by a Blue Shield Foundation grant. The CLABSI rate in 2008 was 2.33 per 1000 line days and 3.22 in 2007, but some of this reduction was due to a CDC definitional change for CLABSIs beginning Jan. 1, 2008. After the grant extension ended June 30, 2009, 14 regional NICUs continued the CLABSI prevention collaborative and for 2010 the NICUs 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.

>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.

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.

>Pediatric Palliative Care

CMS submitted a 1915(c) waiver to the Centers for Medicare and Medicaid Services which was approved in 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 with specified CCS eligible medical conditions 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.

>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. 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 (CHIS). MCAH conducts The California Pregnancy Associated Mortality Review (CA-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 Maternal Quality Indicator Work Group (MQI) trends maternal morbidity data and tests methods for monitoring national obstetric quality measures in California.

Secondly, MCAH promotes a regionalized approach to create collaborative networks of care and ensure that patients access care appropriate to their level of risk. The Regionalized Perinatal Programs of California (RPPC) is a statewide regional network that provides consultation to all delivery hospitals. RPPC uses current statewide and hospital-specific outcomes data to implement strategies to improve risk-appropriate care for mothers and their babies and collaborates with perinatologists for high-risk mothers and their infants. 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. Maternity care improvement projects (Local Assistance for Maternal Health) have started. Currently, San Bernardino County is providing leadership to reduce non-medically indicated labor induction with anticipated health benefits to mother and infant. Los Angeles County is leading a collaborative effort to improve hospital response to obstetrical hemorrhage, a leading cause of maternal morbidity and mortality.

Thirdly, MCAH has developed a Maternal Health Framework (MHF) to guide program development. The MHF considers contributing factors to maternal health in 3 phases of a life course perspective: factors that contribute to health prior to pregnancy, factors that contribute to maximize the health of the mother during pregnancy and factors that help restore a mother to health should a health complication arise during pregnancy. 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, Phase II. The Black Infant Health (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. Comprehensive Perinatal Services Program (CPSP) provides enhanced prenatal services to meet nutrition, psychosocial and health education needs of clients. Adolescent Family Life Program (AFLP) provides case management and education to pregnant and parenting adolescents to promote healthy pregnancy outcomes, effective parenting and socioeconomic independence. 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. Women, Infants and Children (WIC) links families to community services and addresses lactation support, supplemental food and nutrition education for low-income pregnant women, new mothers and children in order to optimize nutrition and health weight. Obesity is a risk factor for poorer maternal health outcomes. Finally, in Phase III, MCAH provides programs and services to address common complications of pregnancy. The California Diabetes and Pregnancy Program (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. The California Maternal Quality Care Collaborative (CMQCC) has developed two 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. Toolkits contain decision-tree wall posters, management guidelines, equipment lists and quality improvement measures.

B. AGENCY CAPACITY

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

MCAH and CMS Programs

Programs affiliated with the MCAH and CMS Branches 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 and adolescents or 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 uses a case management model to address the social, medical, educational, and economic consequences of adolescent pregnancy and parenting on the adolescent, her child, family, and society. This program is providing services to approximately 6000 adolescents in 38 programs throughout the State.

>Black Infant Health (BIH)

BIH whose goal is 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.

>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 program 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. SSI beneficiaries with a CCS medically-eligible diagnosis are served by the CCS program

CCS has structured a system of regional affiliation 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.

The estimated CCS caseload for FFY 2008-09 is 177,950 (9.2% increase from prior year). This includes 135,046 (75.9%) enrolled in Medi-Cal; 25,602 (14.3%) in HF, and 17,302 (9.7%) enrolled in state-only CCS.

>California Diabetes and Pregnancy Program (CDAPP)

CDAPP promotes optimal management of diabetes in at-risk women, before, during and after pregnancy. Progress continues on revisions and edits to the Sweet Success Guidelines for Care, the resource book developed and last updated in 2002 by CDAPP. Once the Guidelines for Care are completed and approved they will be available on the website. In 2009, a standardized annual report form for the statewide CDAPP Regions to summarize their activity was developed. It will be modified in 2010. The affiliate data form used by Sweet Success providers to document the types of clients seen, services provided and pregnancy outcomes has been streamlined for 2010. The CDAPP website continues to be enhanced and modified. Based upon the need for patient guidance between the time they are advised they have gestational diabetes and their initial visit with a CDAPP affiliate provider, in 2009 we added a section including, Patient Information, Dietary Recommendation, Eating Out Wisely, Exercise in Pregnancy, Foods and Exercise Record and Sample Snacks.

The “Diabetes and Pregnancy Pocket Guide for Professionals” was published in 2008; updated “Guidelines for Care” was published in 2009. Standardized training for all affiliates, including webinars and videos are being considered.

>California Early Childhood Comprehensive Systems (CA ECCS)

CA ECCS provides the Child Health and Disability Prevention (CHDP) Program with guidance on validated and standardized development/social-emotional health screening tools for earlier identification of children with developmental delays. CHDP released the revised developmental screening chapter for the Health Assessment Guidelines to its providers in late 2009, encouraging them to use standardized developmental screening tools per the 2006 American Academy of Pediatrics Policy statement. The revised chapter was an important collaboration between CHDP and the MCAH led team of the national Assuring Better Child Health and Development (ABCD) Screening Academy Project. Although the project ended in 2008, 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.

CA ECCS provides CHDP with guidance on validated and standardized development/social-emotional health screening tools for earlier identification of children at risk or with developmental delays.

>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 Child Health and Disability Prevention (CHDP) Program in California. 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.

In FY 2007-08, 552,206 infants under one year of age received health services through CHDP. Nearly all (99%) had Medi-Cal. In FY 2008-09, 1,918,424 children received screening and health assessments through CHDP; compared to 1,947,575 in FY 2007-08. The funding for the CHDP program remains the same as the previous year with 98% funded by Medi-Cal and 2% by state general funds

The CHDP Gateway program pre-enrolled 3.9 million children from July 2003 to December 2008; 76 percent of whom requested a joint Medi-Cal/HF application. From January 2008 to December 2008, 70,786 infants were "deemed" eligible for full-scope, no cost Medi-Cal as a result of the modified CHDP Gateway pre-enrollment process.

>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. MCAH develops standards and policies; provides technical assistance and consultation to the local health perinatal services coordinators; and, maintains an ongoing program of training for all CPSP practitioners throughout the state. Local MCAH staff 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 1750 clients for 2008-2009.

> 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, institute referrals, and monitor outcomes

In 2006, CCS redesigned the HRIF Program which integrated the Medically Vulnerable Infant Program and started the Quality of Care Initiative (QCI) with CPQCC. 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. As of March 1, 2010, 60 of the 74 CCS-approved HRIF Programs are reporting on-line, with over 2,000 referrals and 1500 HRIF Program visits.

>Human Stem Cell Research Program

Mandated by State law to develop a comprehensive set of guidelines to fully address the ethical, legal, and social aspects of stem cell research as well as ensure the systematic monitoring and reporting of human stem cell research activity in California 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 Human Stem Cell Research (HSCR) Advisory Committee to advise the Department on statewide guidelines for human stem cell research.

>Local Health Department Maternal Child and Adolescent Health Program (LHDMP)

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

>Maternal and Infant Health Assessment (MIHA)

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. The survey is conducted by MCAH with technical assistance provided by the Center on Social Disparities in Health, University of California in San Francisco

> 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.

>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 2010).

>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. Over 429,000 newborns were screened in CY 2007, with 717 identified to have hearing loss (1.7 per 1000).

>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 quality improvement activities. RPPC facilitate local perinatal advisory councils to provide regional planning, coordination, and recommendations to assure appropriate levels of care., perform hospital surveys and perinatal assessments of regional and statewide significance, including

collecting and assessing data., develop communication networks among agencies, providers, and individuals to exchange information, disseminate educational materials and produce a statewide newsletter: Perinatal Care Matters, provide resource directories, referral services, and hospital linkages to the Northern and Southern California Perinatal Transport systems (CPeTS), which 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 and assist hospitals with quality improvement activities, data collection protocols, and quality assurance policies and procedures.

CPeTS maintains a web-based bed availability list. Maternity hospitals can obtain information 24 hours a day, 7 days a week to facilitate transfers. For 2008, there were 7114 neonatal transports. As of 2/4/2010 there were 6185 neonatal transports for 2009, however this is not the final figure as the sites still have time to complete their data submission before the 2009 data is closed and finalized which usually occurs by around June.

>Sudden Infant Death Syndrome (SIDS) Program

SIDS is funded in all 61 LHJs to enable them to provide support to families that experience a SIDS death, conduct prevention activities, and enable staff to attend annual training. SIDS Program focuses on providing education about SIDS, grief counseling, and what can be done to reduce the risk of SIDS, like placing babies on their back to sleep.

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

The Breastfeeding Program promotes and supports public health and health care efforts to make breastfeeding the normal method of infant feeding in California for at least the first year of life in order to provide proven benefits to the mother, infant, and society.

>Oral Health Technical Assistance Program

Oral Health Program helps 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. Their activities include dental screening, education and fluoride varnish programs, and creating networks of dental providers for referral. Another 25 other local MCAH programs collaborate on various community tasks forces involving oral health issues. Further direction has been provided by updating oral health educational components in the CPSP "Steps to

Take” Guidelines, BIH perinatal and postpartum curriculums, AFLP “Infant Feeding” Guidelines and CDAPP’s Sweet Success Guidelines.

>Perinatal Substance Use Prevention

MCAH’s efforts related to perinatal substance use prevention are conducted through partnerships and collaboration. MCAH representatives participate in the California 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. Led by the Arc of California, the goal of the task force is to advance the effective prevention and treatment of FASD. MCAH also participates in the State Interagency Team Workgroup on Alcohol and Other Drugs, composed of members from the Departments of Public Health (MCAH), Social Services, Mental Health, Education, Developmental Services and Alcohol and Drug Programs (lead). The goal of the workgroup is to identify interagency and systems issues that, if addressed, could improve identification and treatment of families and children impacted by alcohol and other drugs.

Local MCAH jurisdictions 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 and Healthcare

MCAH is partnering with organizations and stakeholders across the state to provide direction for the integration of preconception care into public health practice, develop policy strategies to support preconception care, and promote preconception health messages to women of reproductive age

One of the key ways that MCAH partners with other entities is through Preconception Health Council of California (PHCC) which was established in 2006 by MCAH and the March of Dimes 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.

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 MCH 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 public health and education professionals 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.

> California Maternal Quality Care Collaborative (CMQCC)

CMQCC is a joint effort with the CPQCC and UCLA's Maternal Quality Indicators group to improve quality of maternity care in hospitals. CMQCC has two major divisions: 1) data collection and analysis and 2) quality improvement (QI) initiatives. The QI division identified and validated "hemorrhage" as a clinical indicator, and QI activities are ongoing. 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 at the state and national level.

The CMQCC Data and Program committees are active. The CMQCC Hemorrhage Task Force provides a toolkit on early recognition and intervention in obstetrical hemorrhage through hospital learning collaboratives and through the CMQCC website.

> 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. CPQCC membership has grown to over 100 hospitals. For 2010, CPQCC membership is at 128 NICUs, with all of the 114 CCS-approved NICUs as members.

The Perinatal Quality Improvement Panel (PQIP), a standing subcommittee of CPQCC, is comprised of neonatologists, perinatal/neonatal nurses, QI experts, and other disciplines, as well as designees from CCS and MCAH. PQIP 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.

CCS and CPQCC are partnering on a Breast milk Nutrition Quality Improvement Collaborative (2009-2010) to improve the percentage of <1500gm infants discharged on any breast milk in 11 community and regional NICUs.

>Children's Regional Integrated Service Systems (CRISS)

CRISS is a collaboration of family support organizations, pediatric providers, statewide organizations, 14 county CCS programs, and Family Voices of California, and has a Family Centered Care (FCC) Work Group that meets bimonthly. The group develops and sponsors annual conferences, assists with workshops, resource fairs, and with addressing issues regarding FCC. In 2009 the CRISS annual FCC Conference focused on mental health services for CSHCN and over 20% of attendees were families and youth. The parent health notebook continues to be available, along with the other medical home materials, on the CRISS website (www.criss-ca.org).

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.

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 April 30, 2009, as a CCS Information Notice.

CMS currently collaborates with the California Health Incentives Improvement Project (CHIIP) which is funded by the Medicaid Infrastructure Grant from the Centers for Medicare and Medicaid Services. The funding allowed the development of a transition toolkit entitled "*Things are About to Change*" *A Young Person's Guide to Transitioning to Adulthood*". The toolkit, with training, will be

available Fall 2010. The toolkit will include transition of health care. As staffing allows, CMS will participate on the CHIP 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:

>Branagh Information Group

MCAH contracted with the Branagh Information Group develop and maintain LodeStar, a comprehensive software package for AFLP agencies conducting case management for pregnant and parenting teens and their siblings. It also was contracted to develop and maintain BIH MIS, a software package for BIH agencies conducting case management.

>California State University, Sacramento (CSUS)

CSUS provides CPSP Provider Training, 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 via conferences, 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.

>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.

Rehabilitation services such as physical therapy for supplemental security income (SSI) beneficiaries under the age of 16 with a CCS medically-eligible diagnosis are served by the Medical Therapy program. Children with mental or developmental conditions receiving SSI are served by the Department of Mental Health, Department of Developmental Services and the California Department of Education. 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.

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 their 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 which include:

- BIH delivers culturally competent services to address the problem of disproportionate mortality in Black infants.
- The Local MCAH Scope of Work requires local programs to report whether their staff has received training in cultural competency.
- 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

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

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

Specific to infants, Medi-Cal, HF and Access for Infants and Mothers (AIM) provide health insurance for infants. Medi-Cal reaches infants in households below 200% of FPL. HF reaches infants in households up to 250% of FPL;

monthly premiums and co-payments are required. AIM provides state-subsidized third party insurance for infants in households at 200-300% of FPL.

State law requires MRMIB to enroll infants of AIM mothers into HF. AIM infants above 250% will be able to continue in HF up to 2 years of age before having to meet current eligibility. As of January 2010, CCS serves 418 AIM children.

DRAFT

C. BUDGET

Budget Impact

California, like the rest of the nation, is in a severe economic downturn. The combined effect of the state's continuing structural budget deficit and the loss of revenues resulting from the economic downturn resulted in a budget gap of \$26.3 billion for State Fiscal Year (FY) 2009-10. In order to address the budget shortfall, all California State General Funds (SGF) for the Maternal, Child and Adolescent Health (MCAH) Program were eliminated effective July 1, 2009, reducing the state and local MCAH Program budget by \$20.3 million in SGF and \$12 million in related matching Federal Title XIX funds.

Legislatively, MCAH administers the State's Public Health Domestic Violence Program. The FY 2009-10 budget eliminated \$20.4 SGF from the MCAH Domestic Violence Program. Subsequently, 80% of the eliminated funds (\$16.3 million) was reinstated for one year using a special fund to Domestic Violence Programs as a result of an emergency Senate bill (SBX 13). These reinstated funds are no longer administered by MCAH; the funds are administered by CalEMA (California Emergency Medical Agency).

The loss of SGF to local and state MCAH Programs, Black Infant Health (BIH) Programs, Adolescent Family Life Programs (AFLP), the Comprehensive Perinatal Services Program (CPSP), Domestic Violence Programs, and the California Birth Defects Monitoring Program (CBDMP) has resulted in deep reductions to local staffing, the numbers of clients served, and public health activities.

In addition, local MCAH programs are being impacted by a reduction in state realignment revenues and associated Title XIX matching funds. Public Health Realignment funds come from a one-half cent sales tax and a portion of vehicle license fees, both of which have been reduced as the result of the shrinking economy. Between FY 2006-2007 and FY 2009-2010, the total Public Health Realignment funds transferred to counties has declined by \$228.7 million. Public Health Realignment funding distributions to local public health agencies for FY 2009-2010 are projected to be approximately \$62 million lower than FY 2008-09.

Statewide, Local Health Jurisdictions (LHJs) allocate approximately 3.25% of Public Health Realignment funds to local MCAH, BIH, and AFLP programs. Realignment funds are the source of nearly all local agency funding for MCAH programs, including BIH and AFLP. The Federal Title XIX match to these funds is approximately 35% (enhanced and non-enhanced). The projected \$62 million reduction in total Public Health Realignment funds has resulted in reduced local/county funding contributions to MCAH and AFLP budgets, while counties increased local funding for BIH programs through the use of various other funding sources, such as First 5.

Local MCAH Programs

The California MCAH Program funds all 61 LHJs (58 counties and 3 city health departments) for provision of MCAH services and programs to improve the health of mothers, infants, children, adolescents, and their families in their communities. LHJs also facilitate increased utilization of medical assistance programs, such as Medi-Cal, Healthy Families, Healthy Kids, and California Children's Services through outreach and referral. Allocations to LHJs are determined by the percentage of women and children living in poverty each jurisdiction, with special allocations to LHJs serving California's smallest populations to ensure minimum program support. Some LHJs also receive separate funding to operate BIH and AFLP programs.

The MCAH Program requirements for a minimum basic Local MCAH program include:

- an MCAH Director;
- operation of a toll-free information and referral line for MCAH issues;
- provision of outreach and application assistance for pregnant women, infants, and children eligible for Medi-Cal;
- development of infrastructure and partnerships to implement services for the MCAH population;
- identification of emerging health issues;
- public health prevention activities; and
- SIDS risk reduction mandated activities.

The elimination of \$2.1 million in SGF from local MCAH programs resulted in a loss of \$2.1 million in Title XIX federal matching funds. Total local MCAH funds lost as a direct result of the elimination of SGF and the related Title XIX federal match was \$4.2 million statewide in FY 2009-10.

Due to reduced realignment revenue statewide, local MCAH programs have budgeted \$1,900,000 less in county agency funds and \$600,000 less in matching Title XIX funds for FY 2009-10.

Based on personnel lists submitted with the FY 2009-10 MCAH budgets, 69 full time equivalent (FTE) local MCAH positions were eliminated statewide as a result of budget cuts.

Local MCAH programs have decreased infrastructure and capacity due to loss of staff from decreased funding. In turn, this has meant the elimination of certain programs such as Youth Substance Abuse Prevention Programs, a decrease in client outreach activities along with reduced or eliminated perinatal care guidance programs and drastically reduced referrals for prenatal care in most counties. Along with the availability of fewer Public Health Nurses (PHNs), this results in only the very highest risk clients receiving service whereas others are turned away for care. MCAH Action estimates elimination or reduction in services to over 1 million individuals as a result of state and local budget reductions.

Sacramento County MCAH

Sacramento County MCAH serves as a common example of the effects budget reductions at the state and local level have had on local MCAH programs. Like most California counties, Sacramento County is experiencing budget deficits and has been unable to replace the loss of SGF. In fact, Sacramento County reduced its own MCAH agency budget by \$61,350.

The loss of \$47,445 SGF and \$61,350 local agency funds has resulted in an additional loss of \$143,844 in Title XIX match, due to matching requirements related to indirect costs and personnel matching. Title XIX matching is primarily driven by the level of matching to personnel costs. Sacramento County lost the Title XIX match for personnel costs because they were required to use local agency funds to pay for indirect/overhead costs, which are not matchable.

The loss of SGF to Sacramento County MCAH, compounded by the County's reduction of local agency funds, has resulted in a net budget reduction of \$252,058 in FY 2009-10 from FY 2008-09 (a 47% reduction in funding).

Sacramento County MCAH Budget Comparison

<u>FY 2008-09</u>		<u>FY 2009-10</u>	
Title V	\$186,040	Title V*	\$161,059
SGF	\$47,445	SGF	
Agency Funds	\$165,096	Agency Funds	\$103,746
Title XIX	\$143,263	Title XIX	
Total Budget	\$541,844	Total Budget	\$264,805

*BIH FIMR (\$24,981) was shifted from MCAH to BIH

Sacramento County MCAH currently operates with one Public Health Nurse who is budgeted at 100% FTE in MCAH and an MCAH Director who is budgeted at 42% FTE in MCAH. They are maintaining the minimum level of staffing and services needed to comply with Scope of Work (SOW) requirements in order to remain operational.

Black Infant Health Program (BIH)

The BIH Program addresses the disproportionate burden of infant mortality among African American women in California. Until 2009, BIH operated in the 17 local health jurisdictions where over 90% of all African American infant births and deaths occur.

The 2009-2010 California budget eliminated \$3.9 million SGF and \$3.7 million related Title XIX to BIH programs statewide. A number of local programs were able to identify short-term external funding to address budget shortfalls, primarily

from First 5 County Commissions, but this varied based on local resources. BIH is the only program that was able to increase local agency funding statewide in FY 2009-10. Local agency funding in FY 2008-09 was \$2.7 million, which was matched to \$1 million Title XIX federal funding. Local agency funding increased to \$4.2 million in FY 2009-10, with Title XIX match of \$1.6 million statewide. However, the additional \$2.1 million is inadequate to backfill the combined loss of \$7.6 million in SGF and Title XIX funds. In October 2009, BIH programs enrolled 58% fewer new clients than were newly enrolled during October 2008. The total number of BIH clients served was 1,797 lower in calendar year 2009 than in calendar year 2008, a 14% decrease in clients served. The number of total clients served will continue to decline as a result of ongoing restrictions in enrollment and length of program participation.

Budget reductions have caused two sites, Riverside and San Bernardino Counties, to close. As a result, BIH currently operates in LHJs where 75% of all African American births occur, down from 90% in 2009. Statewide, local agency BIH staffing was reduced by 12 FTE, with an additional 18 FTE reduction as a result of the Riverside and San Bernardino County closures.

Other counties have implemented program changes in response to budget cuts, such as drastically reduced enrollment capacity, eliminated PHN case management services, limited the length of enrollment to one year after the birth of the child instead of two years, and referred many other clients to other programs that may not be able to meet their needs. Potential consequences of these reductions among populations targeted by BIH are:

- late or no prenatal care;
- increased low birth weight and prematurity;
- increased maternal, fetal, and infant mortality;
- increased domestic violence;
- fewer referrals to social services;
- higher costs for delivery, postpartum, and infant care; and
- increased need and costs for special care units and neonatal intensive care units.

Kern County

A comparison of Kern County's BIH FY 2008-09 and FY 2009-10 budgets shows the financial impact of recent budget reductions to local BIH programs:

Kern County BIH Budget Comparison

<u>FY 2008-09</u>		<u>FY 2009-10</u>	
Title V	\$215,786	Title V	\$215,786
SGF	\$187,812	SGF	
Agency Funds	\$21,727	Agency Funds	\$114,839
Title XIX	<u>\$237,320</u>	Title XIX	<u>\$136,510</u>
Total Budget	\$662,645	Total Budget	\$467,135

Although Kern County was able to increase agency funding by \$93,112, the net loss of funding due to the elimination of SGF and reduction of Title XIX reduced Kern County’s BIH budget by \$195,510 – 30% of their budget. Since local agency funds have been enhanced by First 5, which is a short-term measure, it is unknown how long local agencies like Kern County will be able to maintain increased levels of local agency funds.

Adolescent Family Life Program (AFLP)

In 2009-2010, \$10.7 million SGF and \$5.1 million related Title XIX were eliminated for AFLP, the case management program that serves approximately 17,000 pregnant and parenting teens in 37 counties. In FY 2008-09, AFLP served 20% of all women under age 19 giving birth in California.

Statewide, local agency funding for AFLP was \$4.3 million in FY 2008-09. In FY 2009-10, local agency funding for AFLP was \$3.8 million. Community Based Organizations (CBOs) that participate in AFLP may match local agency funds for Title XIX, but may not match at the higher, enhanced level. Counties may match local agency funds at both the enhanced and non-enhanced matching levels. Given that local agency funding for AFLP was reduced statewide in FY 2009-10, there was no backfill for the lost SGF or Title XIX funds.

AFLP reductions resulted in 4,522 fewer clients served in October 2009 compared to October 2008 – a 44% reduction in clients served. New client enrollments were 34% lower in October 2009 than in October 2008. AFLP agencies experienced staff reductions of 170 FTE statewide.

As a result of reduced staffing and program activity funds, program services to clients have also been reduced, resulting in:

- limited outreach;
- case finding and intake reductions;
- reduced assessment;
- minimal intervention; and
- elimination of advocacy for clients.

The impacts of these reductions will likely result in increased teen birth rates, increased dependency on welfare by teen mothers and their children, and poor birth outcomes due to inadequate prenatal education and care.

At an administrative level, cuts have been made to program planning, monitoring, and evaluation.

Three AFLP programs – Riverside, San Bernardino, and Siskiyou Counties – have been discontinued in FY 2009-10 as a result of their inability to perform program activities at the current funding levels. These program closures will result in an additional 39 staff reductions and elimination of client services for approximately 1,400 clients. Additional program closures and staff reductions are anticipated as short-term budget solutions are exhausted by local AFLP agencies.

AltaMed Health Services Corporation (AltaMed)

AltaMed provides AFLP services to Los Angeles County. A comparison of their FY 2008-09 and FY 2009-10 budgets is indicative of the financial impact state and local budget reductions have on local AFLP agencies.

Alta Med AFLP Budget Comparison

<u>FY 2008-09</u>		<u>FY 2009-10</u>	
Title V	\$377,430	Title V	\$377,430
SGF	\$479,555	SGF	
Agency Funds	\$53,372	Agency Funds	\$40,558
Title XIX	\$243,950	Title XIX	
Total Budget	\$1,154,307	Total Budget	\$417,988

The elimination of SGF and the Title XIX match reduced AltaMed’s budget by \$723,505 – 63% of their FY 2008-09 budget. Local agency funds further reduced their budget by \$12,814. These budget reductions resulted in a loss of 10 FTE – 66% of their AFLP staff.

State Operations

State MCAH Support

State support staffing and activities have been significantly adversely impacted by the elimination of SGF for MCAH programs as follows:

- The State has lost the ability to leverage SGF to draw down Title XIX matching funds. The loss of \$3.5 million resulted in an additional loss of approximately \$1 million in federal Title XIX matching funds.
- State staffing levels were reduced – vacant positions have not been filled, creating added work burden for remaining State staff.

- Reduced capacity at the local level to collect data has impacted the State's ability to document positive program outcomes and identify and address needed changes.
- Reduced resources to coordinate services across LHJs and advocate for vulnerable at-risk MCAH populations.
- Overall reduction in statewide collaboration to assure statewide program equality, information sharing, training, and problem solving.
- Travel reduction for state staff to audit and monitor budgets and operations and provide crucial technical assistance.

California Birth Defects Monitoring Program (CBDMP)

Birth defects are the leading cause of infant mortality in the U.S. The California Birth Defects Monitoring Program (CBDMP) has been an active ascertainment population based registry since 1982, when the California State legislature mandated the collection of data on birth defects, stillbirths, and miscarriages. CBDMP monitors birth defects counts and trends in California for the safety of the public, performs public outreach and education, responds to public concerns, helps plan intervention and prevention strategies in California, and provides information to other CDPH programs, the Local Health Jurisdictions, national reporting systems, and researchers worldwide.

- Of the \$3.5 million SGF eliminated from the State Operations budget, \$1.6 million was for CBDMP.
- Registry activities have been reduced from 40% of California births to 26% with the loss of data collection in the Inland Empire.
- Registry activities have been reduced to 10 counties.
- Reduced funding has led to program restructuring and loss of staff.
- The core business of data collection, processing, analysis, and reporting has been cut back.
- Public health surveillance activities have been reduced.

Comprehensive Perinatal Services Program (CPSP)

CPSP enhances the range of perinatal services reimbursed by Medi-Cal, from conception through 60 days postpartum. In addition to standard obstetric services, women receive nutrition, psychosocial, health education services, and related case coordination services from a multi-disciplinary team. This program is closely linked with the LHJ MCAH programs. The CPSP Perinatal Services Coordinator for each LHJ works within the MCAH program and is responsible for provider recruitment, training, and quality assurance.

As a result of the loss of SGF to other programs, there has been a reduction in resources to address the needs of pregnant and post-partum women. At the same time, expansion of CPSP services, such as case coordination, that could fill some of these gaps is limited.

The loss of SGF to MCAH has reduced the LHJs' capacity to:

- promote access to early prenatal care;
- recruit new CPSP providers;
- provide training to new CPSP providers;
- provide technical assistance to existing and new CPSP providers; and
- monitor and evaluate CPSP providers.

Domestic Violence (DV)

Through June 2009, MCAH DV funded 94 domestic violence shelter agencies to provide emergency and non-emergency services to victims of domestic violence. Over 105,000 victims and their children received emergency shelter, legal assistance with restraining orders, transitional housing, and other support services. Additionally, CDPH DV administered a major Training and Technical Assistance Project to build shelter agencies' capacity to serve certain unserved and underserved populations; namely, the disabled and developmentally disabled, persons with mental health and substance abuse issues, and lesbian, gay, bisexual, transgender, questioning individuals.

The replacement of 80% of DV funding for FY 2009-10 was a one-time special fund loan and is administered by CalEMA. It is unknown to what extent the funding was directed to specific CDPH grantees, or to what extent non-emergency preventative services were continued.

Budget Outlook and its Potential Impact on Populations served by Title V Programs

All signs point to another tough budget year for California for 2010-2011. The Governor had included \$6.9 billion in federal dollars in his January budget plan, but so far the state has received just under \$3 billion. The state was hoping for unexpected gains in state revenues to significantly cut the budget deficit yet, revenues from personal and corporate taxes fell \$3.6 billion short of what was projected for April 2010 the month when the bulk of revenues are collected. That means the state's budget deficit, which at the start of 2010 was projected at \$20 billion and dipped to about \$18.6 billion after some midyear actions by the Legislature, could exceed the original estimate. State legislators have stated that they do not intend to seek higher taxes this year to bridge the gap. This leaves lawmakers and the governor to face decisions such as the wholesale elimination of certain programs. More than ever, California faces the specter of this being the most damaging year for the health of children, the poor and the disabled .

As a result of the new federal health reform law, the May Revision budget proposal for Fiscal year 2010-11 does not include a number of earlier health care proposals that were aimed at reducing eligibility and enrollment in both the Medi-

Cal Program and the Healthy Families Program(HF). The Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 require states to maintain eligibility standards for their Medicaid Program and Children's Health Insurance Program (CHIP) or lose all federal funds for both programs. The May Revision also drops proposals to eliminate the HF and reduce Medi-Cal eligibility to the minimum required by federal law. The new federal requirement to maintain existing eligibility standards mirrors provisions included in the ARRA, which limited states' ability to impose eligibility policies more restrictive than those in effect as of July 1, 2008. This limitation also restricts states' ability to increase premiums for enrollees

The most recent budget proposal which is the May Revision have targeted cutting MediCal services and safety-net programs that low-income women rely on to access health services, support their families, find and retain jobs, and for those with disabilities , remain safely in their own homes.

The May Revision would eliminate Medi-Cal coverage for Adult Day Health Care services, reduce Medi-Cal payments for family planning services, and reduce services provided to certain immigrants and significantly cut spending in the Medi-Cal Program by limiting services (e.g., limit medical visits to 10 per year) and increasing what Medi-Cal recipients must pay for medical services. Seniors and those with disabilities will be required to enroll in managed care. The Medi-Cal Program is the state's version of Medicaid, a federal-state health coverage program for approximately 7.2 million low-income Californians who cannot afford or who do not have access to private coverage. Medi-Cal provides comprehensive health coverage, including reproductive and prenatal care, and is a key component of California's safety net for low-income families. Women comprise nearly two-thirds of adult enrollees in the program. In addition, more than half (56.5 percent) of women enrolled in the program are in their peak reproductive years, a period where women seek more health services than men. Medi-Cal is also an important source of affordable coverage for unmarried women and their children. Nine out of 10 single parents enrolled in Medi-Cal are women. Because women make up a large share of adult Medi-Cal enrollees, women and their children are disproportionately affected by reductions to the program.

Healthy Families is the state's version of SCHIP, a low cost health, dental and vision insurance for children and teens who do not have insurance and do not qualify for free Medi-Cal. The May Revision proposes to eliminate vision services, increase copayments and increase health premium for some children in households whose income fall between 200 and 250 percent of the federal poverty level.

California Work Opportunity and Responsibility to Kids Program (CalWORKs) is the state's version of TANF, a program that provides cash assistance for low-income families with children, while helping parents find jobs and overcome barriers to employment. The May Revision proposes to eliminate the program or, if not eliminated, reduce CalWORKs grants by 15.7 percent, eliminate

CalWORKs eligibility for recent legal immigrants, and cut reimbursement rates for CalWORKs child care providers. CalWORKs is primarily a children's program: Kids make up more than three out of four recipients (77.9 percent), equivalent to 1.1 million of the more than 1.4 million Californians who are projected to receive CalWORKs cash assistance in 2010-11. Women comprise more than three-quarters (77.7 percent) of all adult recipients, and women make up an even larger share (92.5 percent) of single parents who receive cash assistance.

The SSI/SSP Program provides cash assistance to help low-income seniors and people with disabilities meet basic living expenses. The May Revision proposes to reduce the month SSI/SSP grant to individual recipients and eliminate the Cash Assistance Program for Immigrants (CAPI). CAPI provides state-funded cash assistance to elderly and disabled legal immigrants who are not eligible for SSI/SSP grants solely due to their immigration status. More than half (57.3 percent) of SSI/SSP recipients are women, equivalent to approximately 666,500 of the 1.2 million adults who are projected to receive SSI/SSP grants in 2010-11.

The IHSS Program helps low-income seniors and people with disabilities live safely in their own homes, thereby preventing more costly out-of-home care. The May Revision proposed to develop specific IHSS cost-containment measures to achieve state savings of \$637.1 million. More than three out of five IHSS recipients (63.1 percent) are women and girls, equivalent to approximately 300,500 out of the more than 476,200 Californians who are projected to enroll in IHSS in 2010-11. IHSS provides a range of services, including assistance with dressing, bathing, and medications in addition to domestic tasks such as cleaning, shopping, and meal preparation. Women comprise more than three out of five adults enrolled in the major safety-net programs that provide these benefits and services :

The May Revision proposes to eliminate all state funding for child care assistance and would end child care assistance for approximately 142,000 children, but would not affect the State Preschool Program or state-funded after-school programs.

State lawmakers made significant cuts to MediCal, CalWORKs, SSI/SSP, IHSS and child care assistance programs in 2009. The May 2010 include even deeper reductions to these programs to help close the budget gap. Local health jurisdictions are the safety net of last resort under California's law. Needed services that will be cut or eliminated through these state programs will make individual adults – not families with children, eligible for general assistance which is solely funded by counties.

These health and safety net programs are not administered by Title V although Title V funding is used to support the maternal and child health needs of populations that utilize these programs. The reduction and even wholesale elimination of certain programs for children, the poor and the disabled will further exacerbate and create additional challenges for existing Title V administered programs to address the unmet needs of the vulnerable population it serves.

D. TABLES

NOTE: The reporting year for the Federal Fiscal Year 2010-2011 Title V Block Grant Application/Annual Report is 2009. The 2009 data shown in italics below are provisional data based on 2008 final data. Proposed annual objectives in this report are for the 2010-2014 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.	2001	98.4	2001	-	
	2002	98.7	2002	-	
	2003	99.5	2003	-	
	2004	100.0	2004	-	
	2005	99.2	2005	-	
	2006	100.0	2006	-	
	2007	100.0	2007	99.5	
	2008	100.0	2008	100.0	
	2009		2009-2014	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	2002	47.6 ^a	-	-	
	2003	47.6 ^a	2003	48.5	
	2004	47.6 ^a	2004	49.5	
	2005	47.6 ^a	2005	50.5	
	2006	47.6 ^a	2006	51.5	
	2007	46.6 ^b	2007	52.5	
	2008	46.6 ^b	2008	52.5	
	2009	46.6 ^b	2009	47.0	
			2010	47.5	
			2011	48.0	
			2012	48.5	
			2013	49.0	
			2014	49.5	
	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	2002	44.7 ^a	2002	30.0
2003		44.7 ^a	2003	45.5	
2004		44.7 ^a	2004	46.5	
2005		44.7 ^a	2005	48.0	
2006		44.7 ^a	2006	50.0	
2007		42.2 ^b	2007	51.0	
2008		42.2 ^b	2008	51.0	
2009		42.2 ^b	2009	42.5	
			2010	43.0	
			2011	43.5	
			2012	44.0	
			2013	44.5	
			2014	45.0	

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	2002	59.3 ^a	2002	98.0	
	2003	59.3 ^a	2003	60.5	
	2004	59.3 ^a	2004	62.5	
	2005	59.3 ^a	2005	64.5	
	2006	59.3 ^a	2006	66.5	
	2007	59.6 ^b	2007	68.5	
	2008	59.6 ^b	2008	65.5	
	2009	59.6 ^b	2009	60.0	
				2010	60.3
				2011	60.6
				2012	61.0
				2013	61.3
				2014	61.6
	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	2002	65.9 ^a	-	-
2003		65.9 ^a	2003	67.0	
2004		65.9 ^a	2004	68.0	
2005		65.9 ^a	2005	69.0	
2006		65.9 ^a	2006	70.0	
2007		85.3 ^b	2007	71.0	
2008		85.3 ^b	2008	85.5	
2009		85.3 ^b	2009	86.0	
				2010	86.5
				2011-13	87.0
				2014	87.5
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	2002	5.8 ^a	-	-	
	2003	5.8 ^a	2003	-	
	2004	5.8 ^a	2004	-	
	2005	5.8 ^a	2005	-	
	2006	5.8 ^a	2006	5.8	
	2007	37.1 ^b	2007	5.8	
	2008	37.1 ^b	2008	37.5	
	2009	37.1 ^b	2009	37.5	
				2010-11	38.0
				2012-13	38.5
				2014	39.0

California Title V National Performance Measures (continued)						
	National Performance Measure	Year	Measure	Year	Objective	
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.	2000	75.3 ^a	2000	76.0	
		2001	74.9 ^a	2001	76.4	
		2002	75.8 ^a	2002	75.4	
		2003	77.4 ^a	2003	75.8	
		2004	81.3 ^a	2004	75.8	
		2005	77.9 ^a	2005	78.0	
		2006	80.3 ^a	2006	82.0	
		2007	81.4 ^a	2007	78.4	
		2008	80.6 ^a	2008	78.9	
		2009	80.6 ^a	2009	79.4	
					2010	79.9
					2011	80.4
					2012	80.9
					2013	80.9
			2014	*		
8	The birth rate (per 1,000 females) for teenagers aged 15 through 17 years.	2000	26.5	2000	28.7	
		2001	23.8	2001	25.0	
		2002	22.4	2002	23.5	
		2003	21.2	2003	22.3	
		2004	20.6	2004	21.9	
		2005	20.3	2005	20.0	
		2006	20.0	2006	20.1	
		2007	19.9	2007	20.0	
		2008	19.1	2008	19.7	
		2009	19.1	2009	19.4	
					2010	19.1
					2011	18.8
					2012	18.5
					2013	18.2
			2014	*		
9.	Percent of third grade children who have received protective sealants on at least one permanent molar tooth.	2000	18.7	2000	19.6	
		2001	19.5	2001	18.7	
		2002	19.7	2002	19.5	
		2003	31.0 ^a	2003	19.9	
		2004	27.6 ^a	2004	20.2	
		2005	27.6 ^a	2005	31.0	
		2006	27.6 ^a	2006	27.6	
		2007	27.6 ^a	2007	27.6	
		2008	27.6 ^a	2008	28.1	
		2009	27.6 ^a	2009	28.6	
					2010	29.1
					2011	29.6
					2012	30.1
					2013	30.6
			2014	*		

^{a)} Based on 4:3:1:3:3 series.

Note: 2000-2006 data had previously been re-calculated using new Dept. of Finance population projection estimates.

^{a)} New data source based on Oral Health Needs Assessment Survey. 2003 data based on preliminary survey results.

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. <i>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.</i>	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009	2.6 2.7 2.6 3.2 2.7 2.8 2.4 2.3 1.7 1.7	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014	2.7 2.6 2.8 2.6 2.6 2.9 3.0 3.1 3.0 2.9 2.9 2.8 2.7 2.6 *
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.	2004 2005 2006 2007 2008 2009	69.1 ^a 70.2 ^a 69.4 ^a 61.6 ^b 59.9 ^b 59.9 ^b	2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014	- - 69.6 71.0 71.5 72.0 72.5 73.0 73.5 73.5 *
12	Percentage of newborns that have been screened for hearing impairment before hospital discharge.	2002 2003 2004 2005 2006 2007 2008	52.2 56.2 68.6 75.0 75.7 73.3 93.2	2002 2003 2004 2005 2006 2007 2008 2009-13	40.0 60.0 70.0 70.0 75.0 75.0 85.0 95.0

* In development at the time of report

California Title V *National Performance Measures (continued)*

National Performance Measure		Year	Measure	Year	Objective	
13.	Percent of children without health insurance.	2000	15.7	2000	18.0	
		2001	15.3	2001	16.2	
		2002	14.3	2002	16.7	
		2003	13.1	2003	15.5	
		2004	13.1	2004	15.5	
		2005	13.6	2005	12.9	
		2006	13.9	2006	13.0	
		2007	11.2	2007	13.5	
		2008	11.0	2008	13.3	
		2009	11.0	2009	13.1	
					2010	12.9
					2011-2013	12.7
					2014	*
14.	Percent of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85 th percentile.	2004	33.8	2004		
		2005	33.7	2005		
		2006	33.2	2006	33.7	
		2007	33.6	2007	33.6	
		2008	33.3	2008	33.6	
		2009	33.3	2009	33.5	
				2010	33.5	
				2011	33.4	
				2012	33.4	
				2013	33.4	
				2014	*	
15.	Percent of women who smoke in the last three months of pregnancy.	2004	3.4	2004	-	
		2005	3.8	2005	-	
		2006	3.0	2006	3.4	
		2007	2.6	2007	3.7	
		2008	3.3	2008	3.6	
		2009	3.3	2009	3.5	
				2010	3.4	
				2011	3.3	
				2012	3.2	
				2013	3.1	
		2014	*			

* In development at the time of report

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. <i>Note: 2000-2006 data had previously been re-calculated using new Dept. of Finance population projection estimates.</i>	2000	5.2	2000	4.2	
		2001	4.9	2001	5.9	
		2002	4.7	2002	5.4	
		2003	5.0	2003	4.7	
		2004	5.7	2004	4.6	
		2005	4.9	2005	4.8	
		2006	5.2	2006	5.6	
		2007	4.1	2007	4.7	
		2008	4.4	2008	4.7	
		2009	4.4	2009	4.6	
					2010	4.6
					2011	4.5
					2012	4.4
					2013	4.3
			2014	*		
17.	Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.	2000	65.9	2000	66.4	
		2001	65.6	2001	66.5	
		2002	68.7	2002	66.6	
		2003	67.3	2003	68.7	
		2004	68.0	2004	69.6	
		2005	67.1	2005	68.5	
		2006	66.9	2006	68.2	
		2007	67.3	2007	67.2	
		2008	73.8	2008	67.5	
		2009	73.8	2009	67.8	
					2010	68.1
					2011-12	68.4
					2013	68.7
					2014	*
18.	Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.	2000	84.5	2000	84.5	
		2001	85.4	2001	85.0	
		2002	86.5	2002	85.9	
		2003	87.3	2003	87.4	
		2004	87.1	2004	88.4	
		2005	86.6	2005	89.4	
		2006	85.9	2006	87.1	
		2007	82.9	2007	86.7	
		2008	82.4	2008	86.9	
		2009	82.4	2009	87.1	
					2010	87.3
					2011-13	87.5
					2014	*

* In development at the time of report

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 California Children Services (CCS) program who have a designated medical home.	2005	57.9	2005	-	
		2006	76.4	2006	50.0	
		2007	84.2	2007	70.0	
		2008	88.9	2008	84.2	
		2009	83.6	2009	89.5	
					2010-13	89.5
2.	The ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists.	2005	1:491	2005	-	
		2006	1:445	2006	1:491	
		2007	1:409	2007	1:540	
		2008	1:366	2008	1:400	
		2009	1:325	2009	1:350	
					2010-2013	1:300
3.	The percent of women who reported 14 or more not good mental health days in the past 30 days (frequent mental distress).	2004	13.7	2004	-	
		2005	12.9	2005	-	
		2006	13.4	2006	13.6	
		2007	13.4	2007	12.8	
		2008	14.7	2008	12.7	
		2009	14.7	2009	12.6	
					2010	12.5
					2011	12.4
					2012	12.4
					2013	12.4
					2014	*
		4.	The percent of women who reported drinking any alcohol in the first or last trimester of pregnancy.	2004	16.5	2004
2005	17.3			2005	-	
2006	15.8			2006	16.4	
2007	15.0			2007	17.1	
2008	12.9			2008	16.9	
2009	12.9			2009	16.7	
					2010	16.5
					2011	16.3
					2012	16.0
					2013	15.7
					2014	*

* In development at the time of report

California Title V State Performance Measures (continued)

State Performance Measures		Year	Measure	Year	Objective	
5.	The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries. <i>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 also previously re-calculated using new Dept. of Finance population projection estimates.</i>	2000	12.6	2000	13.2	
		2001	17.0	2001	12.2	
		2002	20.0	2002	16.0	
		2003	19.4	2003	20.7	
		2004	18.1	2004	20.7	
		2005	16.6	2005	19.5	
		2006	16.5	2006	18.2	
		2007	13.5	2007	16.6	
		2008	10.1	2008	16.4	
		2009	10.1	2009	16.2	
					2010	16.0
					2011	15.8
					2012	15.8
					2013	15.6
			2014	*		
6.	The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System. (a) Preliminary data.	2000	7.3	2000	4.6	
		2001	5.4	2001	6.7	
		2002	7.7	2002	6.5	
		2003	7.7	2003	7.0	
		2004	5.2	2004	7.0	
		2005	6.7	2005	7.0	
		2006	6.8	2006	5.2	
		2007	6.0 ^a	2007	6.4	
		2008	5.7 ^a	2008	6.2	
		2009		2009	6.0	
				2010	5.8	
				2011	5.6	
				2012	5.6	
				2013	5.6	
		2014	*			
7.	The percent of newly referred clients to the CCS program whose cases are opened within 30 days of referral.	2005	75.7	2005	-	
		2006	70.4	2006	76.0	
		2007	76.2	2007	72.0	
		2008	81.1	2008	77.0	
		2009	78.4	2009	82.0	
				2010	83.0	
				2011	84.0	
				2012	85.0	
				2013	86.0	

* In development at the time of report

California Title V State Performance Measures (continued)

State Performance Measures		Year	Measure	Year	Objective
8.	The percent of births resulting from unintended pregnancy.	2005	41.3	2005	-
		2006	43.2	2006	42.1
		2007	44.6	2007	40.9
		2008	46.9	2008	40.5
		2009	46.9	2009	40.1
				2010	39.7
				2011	39.3
				2012	39.3
				2013	39.3
				2014	*
9.	The percent of 9 th grade students who are not within the Healthy Fitness Zone for Body Composition.	2005	33.1	2005	-
		2006	32.0	2006	32.8
		2007	31.3	2007	32.9
		2008	30.3	2008	32.7
		2009	30.3	2009	32.5
				2010	32.3
				2011	32.1
				2012	31.9
				2013	31.7
				2014	*
10.	The percent of women 18 years or older reporting intimate partner physical, sexual, or psychological abuse in the past 12 months.	2005	8.5	2005	-
		2006	7.6	2006	9.6
		2007	7.7	2007	8.4
		2008	6.3	2008	8.3
		2009	6.3	2009	8.2
				2010	8.1
				2011	8.0
				2012	7.9
				2013	7.9
				2014	*

* In development at the time of report

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.	2000	5.4	2000	5.3	
		2001	5.3	2001	5.2	
		2002	5.4	2002	5.2	
		2003	5.2	2003	5.4	
		2004	5.2	2004	5.4	
		2005	5.3	2005	5.2	
		2006	5.0	2006	5.1	
		2007	5.2	2007	5.1	
		2008	5.1	2008	5.1	
		2009	5.1	2009	5.0	
					2010	5.0
					2011	5.0
					2012	4.9
					2013	4.9
			2014	*		
2	The ratio of the black infant mortality rate to the white infant mortality rate.	2000	2.7	2000	2.6	
		2001	2.6	2001	2.7	
		2002	2.5	2002	2.6	
		2003	2.7	2003	2.4	
		2004	2.6	2004	2.4	
		2005	2.7	2005	2.6	
		2006	2.6	2006	2.5	
		2007	2.5	2007	2.5	
		2008	2.9	2008	2.5	
		2009	2.9	2009	2.4	
					2010	2.4
					2011	2.4
					2012	2.3
					2013	2.2
			2014	*		
3	The neonatal mortality rate per 1,000 live births.	2000	3.6	2000	3.5	
		2001	3.5	2001	3.5	
		2002	3.6	2002	3.5	
		2003	3.5	2003	3.5	
		2004	3.5	2004	3.5	
		2005	3.6	2005	3.5	
		2006	3.5	2006	3.5	
		2007	3.5	2007	3.5	
		2008	3.4	2008	3.4	
		2009	3.4	2009-11	3.4	
				2012-13	3.3	
		2014	*			

* In development at the time of report

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.	2000	1.7	2000	1.7	
		2001	1.8	2001	1.7	
		2002	1.8	2002	1.7	
		2003	1.7	2003	1.7	
		2004	1.7	2004	1.7	
		2005	1.7	2005	1.6	
		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
					2011	1.6
					2012-13	1.5
					2014	*
5	The Perinatal mortality rate ((deaths: fetal and infant/fetal deaths and live births) *1,000)).	2000	5.9	2000	8.0	
		2001	5.6	2001	7.9	
		2002	5.7	2002	5.5	
		2003	5.5	2003	5.6	
		2004	5.5	2004	5.6	
		2005	5.6	2005	5.5	
		2006	5.4	2006	5.4	
		2007	5.4	2007	5.4	
		2008	5.3	2008	5.4	
		2009	5.3	2009	5.3	
					2010-11	5.3
					2012	5.2
					2013	5.1
					2014	*
6	The child death rate per 100,000 children aged 1 through 14. <i>Note: 2000-2006 data had previously been re-calculated using new Dept. of Finance population projection estimates.</i>	2000	19.1	2000	16.4	
		2001	17.6	2001	16.9	
		2002	17.3	2002	16.2	
		2003	18.2	2003	16.2	
		2004	16.5	2004	16.0	
		2005	16.4	2005	18.4	
		2006	15.9	2006	17.2	
		2007	15.1	2007	17.1	
		2008	14.1	2008	17.0	
		2009	14.1	2009	17.0	
					2010	16.8
					2011	16.8
					2012	15.9
					2013	15.1
			2014	*		

• In development at the time of report

State Outcome Measure

California Title V <i>State Outcome Measures</i>					
State Outcome Measure		<i>Year</i>	<i>Measure</i>	<i>Year</i>	<i>Objective</i>
1	The pregnancy related mortality rate per 100,000 live births.	2005	19.1	2005	
		2006	19.0	2006	13.3
		2007	*	2007	13.0
		2008	*	2008	12.7
		2009	*	2009	12.4
				2010	12.1
				2011	12.1
				2012	12.1
				2013	12.1
				2014	*

* In development at the time of report

DRAFT

Health System Capacity and Health Status Indicators

Health System Capacity Indicators		<i>Year</i>	<i>Indicator</i>
1	<p>The rate per 10,000 for asthma hospitalizations among children less than five years old.</p> <p><i>Note: 2000-2006 data had previously been re-calculated using new Dept. of Finance population projection estimates.</i></p>	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009	35.1 32.8 33.6 31.6 29.6 23.9 24.3 22.8 22.0 22.0
2	<p>The percent of Medicaid enrollees whose age is less than one year during the reporting year that received at least one initial periodic screen.</p>	2000 2001 2002 2003 2004 2005 2006 2007 2008	66.0 70.8 66.2 67.3 66.3 73.7 71.3 82.5 83.4
3	<p>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.</p>		NA
4	<p>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.</p>	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009	76.3 76.6 77.8 78.7 78.5 78.4 78.7 78.6 79.0 79.0

Health System Capacity Indicator 5: Medicaid and Non-Medicaid Comparisons		<i>Year</i>	<i>Indicator</i>
5A.	Percent of low birth weight (<2,500 grams): Payment source from birth certificate.	2006	6.8(Medic)
		2006	6.9(N-Med)
		2006	6.9(All)
		2007	6.8(Medic)
		2007	6.9(N-Med)
		2007	6.9(All)
		2008	6.7(Medic)
		2008	6.9(N-Med)
		2008	6.8(All)
5B.	Infant deaths per 1,000 live births: matching data files.	2004	5.9 (Medic)
		2004	4.6 (N-Med)
		2004	5.3 (All)
		2005	6.0 (Medic)
		2005	4.6 (N-Med)
		2005	5.5 (All)
		2006	5.7 (Medic)
		2006	4.5 (N-Med)
		2006	5.2 (All)
		2007	5.6(Medic)
		2007	4.7(N-Med)
2007	5.3(All)		
5C	Percent of pregnant women entering care in the first trimester: Payment source from birth certificate	2006	80.6(Medic)
		2006	90.5(N-Med)
		2006	85.9(All)
		2007	76.6(Medic)
		2007	88.3(N-Med)
		2007	82.9(All)
		2008	76.0(Medic)
		2008	88.0(N-Med)
2008	82.4(All)		
5D	Percent of women with adequate (observed to expected prenatal visits is greater or equal to 80% (Kotelchuck Index) prenatal care.	2006	75.4(Medic)
		2006	81.5(N-Med)
		2006	78.7 (All)
		2007	74.7(Medic)
		2007	81.9(N-Med)
		2007	78.6 (All)
		2008	75.0(Medic)
		2008	82.4(N-Med)
2008	79.0(All)		

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	<u>Medi</u> 200	<u>CHIP</u> 250
6B	The percent of poverty for eligibility in the State's Medicaid and CHIP programs for children.	(Ages 1-5)	2008	133	250
		(Ages 6-18)	2008	100	250
6C	The percent of poverty for eligibility in the State's Medicaid and CHIP programs for pregnant women		2008	200	300
7A	Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program. (Previously National Performance Measure 14) a) New methodology.		2000	60.8	
			2001	60.9	
			2002	61.7	
			2003	70.9	
			2004	90.0 ^a	
			2005	87.9 ^a	
			2006	92.4 ^a	
			2007	98.7 ^a	
			2008	98.7 ^a	
7B	The percent of EPSDT eligible children aged 6 through 9 years who have received any dental service during the year. ^a New methodology.		1999	43.8 ^a	
			2000	44.6	
			2001	45.5	
			2002	48.1	
			2003	35.5 ^a	
			2004	37.8 ^a	
			2005	44.2 ^a	
			2006	41.1 ^a	
			2007	43.0 ^a	
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.		1999	28.5	
			2000	26.9	
			2001	27.0	
			2002	23.0 ^a	
			2003	22.6 ^a	
			2004	10.9 ^b	
			2005	8.7	
			2006	32.5	
			2007	31.1	
	2008	28.2			
	2009	30.1			

Health Status Indicators

Health Status Indicators		Year	Indicator
1A	The percent of live births weighing less than 2,500 grams	2000	6.2
		2001	6.3
		2002	6.4
		2003	6.6
		2004	6.7
		2005	6.9
		2006	6.8
		2007	6.9
		2008	6.8
		2009	6.8
1B	The percent of live singleton births weighing less than 2,500 grams	2000	4.9
		2001	4.9
		2002	5.0
		2003	5.1
		2004	5.2
		2005	5.2
		2006	5.2
		2007	5.3
		2008	5.2
		2009	5.2
2A	The percent of very low birth weight births.	2000	1.1
		2001	1.1
		2002	1.1
		2003	1.2
		2004	1.2
		2005	1.2
		2006	1.2
		2007	1.2
		2008	1.1
		2009	1.1
2B	The percent of very low birth weight singleton births.	2000	0.9
		2001	0.9
		2002	0.9
		2003	0.9
		2004	0.9
		2005	0.9
		2006	0.9
		2007	0.9
		2008	0.9
		2009	0.9

Health Status Indicators (continued)		<i>Year</i>	<i>Indicator</i>
3A	The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009	6.9 6.2 5.8 6.0 5.6 6.2 5.5 5.3 4.2 4.2
3B	The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger <i>Note: New methodology used in 2007 to exclude non-traffic motor vehicle incidents. 2000-2006 measure data were re-calculated to reflect change.</i>	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009	2.6 2.7 2.6 3.2 2.7 2.8 2.4 2.3 1.7 1.7
3C	The death rate per 100,000 due to motor vehicle crashes among youth aged 15 through 24 years. <i>Note: New methodology used in 2007 to exclude non-traffic motor vehicle incidents. 2000-2006 measure data were re-calculated to reflect change.</i>	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009	14.2 18.7 21.0 20.8 19.7 19.7 19.8 18.2 14.0 14.0
4A	The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009	284.9 273.4 266.2 257.3 250.7 229.2 210.9 198.0 194.0 194.0

Health Status Indicators (continued)		<i>Year</i>	<i>Indicator</i>
4B	The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.	2000	39.6
		2001	35.9
		2002	36.4
		2003	35.9
		2004	35.4
		2005	29.6
		2006	26.5
		2007	23.0
		2008	19.6
		2009	19.6
4C	The rate per 100,000 of nonfatal injuries due to vehicle crashes among youth aged 15 through 24 years.	2000	147.7
		2001	152.0
		2002	162.4
		2003	164.2
		2004	164.5
		2005	156.0
		2006	146.7
		2007	135.4
		2008	110.8
		2009	110.8
5A	The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia	2000	21.8
		2001	21.9
		2002	22.3
		2003	22.2
		2004	22.3
		2005	22.8
		2006	22.8
		2007	23.1
		2008	23.5
		2009	23.5
5B	The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.	2000	7.1
		2001	7.6
		2002	8.2
		2003	8.4
		2004	8.6
		2005	9.1
		2006	9.7
		2007	10.1
		2008	10.2
		2009	10.2

E. ATTACHMENT TO SECTION B, AGENCY CAPACITY

Title-V Programs	Agency Affiliation	Primary Target Population				Community-based services
		Infants	Pregnant Mothers	Children and Adolescents	CSCHN	
Adolescent Family Life Program (AFLP)	MCAH		x	x		x
Black Infant Health (BIH)	MCAH		x			x
Breastfeeding Program	MCAH/ CMS	x	x		x	x
California Birth Defects Monitoring Program (CBDMP)	MCAH	x	x			
California Children's Services (CCS) Program	CMS				x	x
California Diabetes and Pregnancy Program (CDAPP)	MCAH	x	x			x
California Early Childhood Comprehensive Systems	MCAH			x		
California Perinatal Transport System (CPeTS)	MCAH	x	x			x
Child Health and Disability Prevention Program (CHDP)	CMS			x		x
Comprehensive Perinatal Services Program (CPSP)	MCAH	x	x			x
Family-Centered Care	CMS				x	x
Fetal Infant Mortality Review Program (FIMR) and BIH FIMR	MCAH	x	x			x
Genetically Handicapped Persons Program (GHPP)	CMS				x	x
Hearing Conservation Program	CMS			x		x
Health Care Program for Children in Foster Care (HCPFC)	CMS	x		x		x
High Risk Infant Follow-up (HRIF)	CMS	x				x
Human Stem Cell Research Program	MCAH		x			
Local Health Department Maternal Child and Adolescent Health Program (LHDMP)	MCAH	x	x	x		x
MCAH Toll Free Hotline	MCAH	x	x	x		x
Medical Therapy Program (MTP)	CMS				x	x
Newborn Hearing Screening Program (NHSP)	CMS	x				x
Oral Health Program	MCAH	x	x	x		
Pediatric Palliative Care Waiver Program	CMS				x	x
Regional Perinatal Programs of California (RPPC)	MCAH	x	x			x
Sudden Infant Death Syndrome (SIDS) Program	MCAH	x	x			x

Major Title-V Collaboratives, Task Forces and Advisory/Work Groups	Agency Affiliation	Primary Target Population				Quality Improvement effort
		Infants	Pregnant Mothers	Adolescents and Children	CSCHN	
Adolescent Sexual Health Work Group (ASHWG)	MCAH		x	x		x
California Maternal Quality Care Collaborative (CMQCC)	MCAH	x	x			x
California Perinatal Quality Care Collaborative (CPQCC)	MCAH	x	x			x
Children's Regional Integrated Services Systems (CRISS)	CMS				x	
Neonatal Quality Improvement	CMS	x				x
Perinatal Substance Use Prevention	MCAH		x			
Preconception Health and Healthcare	MCAH		x			
Transition Workgroup	CMS				x	

Capacity Building Business Partners	Agency Affiliation	Primary Target to Provide Technical Assistance		
		State	Local	
Branagh Information Group	MCAH	x	x	
California Adolescent Health Collaborative	MCAH	x		
California State University, Sacramento	MCAH		x	
Childhood Injury Prevention Program	MCAH		x	
Family Health Outcomes Project at UCSF	MCAH/ CMS		x	
Health Information Solutions	MCAH		x	
Perinatal Profiles at UCB	MCAH		x	
Maternal and Infant Health Assessment Survey with UCSF	MCAH	x	x	