

Preliminary Draft

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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 2009-2010
(October 1, 2009 – September 30, 2010)

**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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Note: The Title V Report and Application is submitted annually in a format that reports activities for a five-year cycle. Updates after the first year are identified with the year in brackets. For this year's report cycle, program information not enclosed in brackets applies to information submitted for FY 2005-2006; information enclosed in /2007/ brackets applies to FY 2006-2007; information enclosed in /2008/ brackets applies to FY 2007-2008; and information enclosed in /2009/ brackets applies to FY 2008-2009. Information that applies to FY 2009-2010 is presented in italics and enclosed /2010/ brackets.

III. STATE OVERVIEW

A. OVERVIEW

Demographics

/2008/ California is the most populous of all US states, with 37.2 million residents in 2006, an increase of 444,000 over the previous year. One in every eight of the nation's residents lives in California. The state's population has increased annually since 1940, but the rate of increase has slowed each year since 2000, from 2.0 percent in 2000-01 to 1.2 percent in 2005-06. [1] California is the third largest state in terms of land area and is more than twice the size of 35 other states. [2] //2008//

/2009/ The population of young people age 0-20 in California increased by 71,000 between 2006 and 2007. Hispanic/Latino, Asian, Pacific Islander, and American Indian youth populations combined increased by 110,000, while White, Black, and Multirace youths decreased by 39,000. [3] Many (44%) new mothers in California were born outside the US. Of these, 66% are from Mexico, with the rest primarily from Central America and Asia. [4] A language other than English is spoken at home by 40 % of Californians over age 5, and by 41% of new mothers. [5,6] California has been hard hit by the recent real estate and mortgage crises. In 2007, the highest number --more than one in five --of all US foreclosure filings was in California (although the rate of foreclosure filings was higher in 3 other states).[7] In the US, of the 18 major metropolitan areas that posted the largest increases in mortgage delinquency rates, 12 were in California [8] //2009//

/2010/ California's population surpassed 38 million by July 2008, mostly due to new births. For the 4th straight year the state saw a loss in domestic migration, with 84,000 more moving out of California than moved here from elsewhere in the U.S., most likely related to the state's weakening economy.[9] Foreign immigration more than offset this loss, with net migration accounting for one quarter of the population gain in 2008.//2010//

The population increase is the result of the natural increase (the difference between the number of births and deaths), which accounts for a little over half of the total population increase, plus net migration to the state. Foreign immigration to the state far exceeded domestic migration for the period 2000-2005, with net foreign immigration totaling 1,165,624 and net domestic migration totaling 220,165. [10]

California residents are younger on average than the nation as a whole. The median age for the state in 2004 was 34, which is significantly lower than the median age in the US of 36. [11]

In 2003, there were almost 7.6 million women of childbearing age (15-44) in California. Women of childbearing age represent 22 percent of the state's total population. The 10.2 million children under age 19 account for 29 percent of the population, including 2.5 million under the age of 5 (7 percent), and over 500,000 under one year (1.5 percent). [12] Nationally, children ages 19 and under make up 28 percent of the population, and those under 5 make up 7 percent. [13] Between 2003 and 2009, the female teen population (ages 15-19) in California is projected to increase by 14 percent, and the Hispanic teen female population is projected to increase by 28 percent. [14]

Although the overall teen birth rate has declined steadily since 1991 (from 71 in 1991 to less than 38 in 2004), the decline among Hispanic teens has been slower, and Hispanics are disproportionately represented in the number of California's teen births. [15] Hispanics

accounted for 71 percent of teen births in 2004 [16], while only accounting for 42 percent of the total teen population (age 15-19). [17]

The aging of the state's population is having an impact on the health and well-being of mothers and children. In California, 16 percent of all households contain at least one caregiver for someone aged 50 or older. Three quarters of those caregivers are women, and 31 percent have their own children living at home. This can pose a financial and emotional burden on families, particularly those who are low-income and/or have working mothers. [18] Addressing this growing stress on families is likely to become an increasing challenge in the future, as the proportion of the population over age 50 grows and the cost of living forces many households to consolidate and increase in size.

Diversity

In addition to its overall population expansion, California continued to experience growth in its ethnic diversity. The fastest growing group is Hispanics. Hispanics, as a proportion of the state population, increased from 26 percent in 1990 to 32 percent in 2000. [19] By the year 2050 the percentage of Hispanics is projected to reach 54 percent, making it the majority ethnic group in the state, as well as the majority ethnic group for twenty counties. [20] In 2000, Whites comprised 47 percent of California's population, followed by Hispanics (32 percent), Asian/Pacific Islanders (12 percent), African Americans (7 percent), and American Indian/Alaska Natives (1 percent). [21]

In 2004, 27 percent (9.5 million) of California's population was foreign-born. [22] In 2002, 27 percent of the nation's immigrants (291,191) settled in California. Nearly half (49 percent) of these immigrants were born in Latin America and the Caribbean, primarily Mexico, and 39 percent were born in Asia. [23]

In California, Hispanics are younger on average than members of other racial/ethnic groups, and this age differential is increasing. The median age of Hispanics in California in 2004 was 26, eight years younger than that of the total population (34). Among Whites, the median age was 40, and for Asians, the median age was 36. [24] Hispanic children comprised the largest proportion of school children during the 2004-05 school year, making up 47 percent of students in California. [25]

Racial/ethnic diversity and a large immigrant population contribute to linguistic diversity in California. In 2004, 41 percent of California residents over the age of five spoke a language other than English at home, compared to 19 percent nationwide. Most often this language is Spanish, however, a variety of Asian and Pacific Island languages are also spoken. [26]

Geography

California is comprised of 61 local health jurisdictions (LHJs), including 58 counties and three incorporated cities. These LHJs vary widely in geographic size, number of residents, and population density. In terms of geographic area, San Bernardino is the largest county, and San Francisco, San Mateo, and Marin Counties are the smallest. Los Angeles County is the largest in terms of population, with over 10 million residents, 28 percent of the state's total population. Alpine County has the smallest population, with fewer than 1,300 residents. [27]

Most of the state's population (98 percent) resides in urban areas [28]. Los Angeles, San Diego, Orange, Santa Clara, and San Francisco Counties all have large urban populations. Some counties, such as Fresno, Monterey, and Santa Barbara, are primarily rural but contain urban centers where most of the population resides.

Most counties in the state experienced population growth between 2000 and 2004, although the rate of growth appears to be slowing. Riverside and Placer Counties grew at the highest rate, increasing in population by approximately 4 percent each year. [29] Other counties projected to experience large increases in population include San Joaquin, Merced, and Madera. [30]

Economy

In 2004, California's gross product ranked eighth in the world. [31] This is in spite of the fact that California has not shared completely in the economic growth the nation has experienced recovering from the recent economic recession. California's unemployment rate in 2005 was 5.4 percent, compared to the national rate of 5.1 percent. The drop in the unemployment rate in Fiscal Year (FY) 2003-04 was the first drop in unemployment since FY 1999-00. [32] The forecast through 2008 projects that California's unemployment rate will not fall or change significantly, suggesting that the slow pace of economic growth in the state will continue. [33]

The stagnant economy in the state has resulted in budget cuts that have affected maternal and child health programs and services. The state has experienced restrictions on the creation of new contracts, purchasing of equipment, hiring of staff, and travel. This has curtailed the ability of State programs to provide technical assistance and training to local health jurisdictions, compromising the ability to improve and sustain program quality.

Restrictions on State programs and services compound existing challenges faced by California's residents who live near or below the federal poverty level (FPL). The US Census Bureau estimates that in 2004, 13.3 percent of California residents lived below the FPL. This is worse than the national rate of 13.1 percent and ranks California as the 20th worst state in terms of percent of residents in poverty. [34] Three counties in California's Central Valley ranked among the most impoverished counties in the nation: Tulare, with 20.3 percent of residents living below the federal poverty level, Kern, with 19.3 percent, and Fresno, with 17.9 percent. [35]

The federal definition for low-income is household income of less than 200 percent of the FPL; however, in parts of California, the high cost of living creates stress for families whose incomes are not necessarily low by this definition. In 2004, California had the highest median monthly rental housing costs (\$914 per month) in the nation, and ranked 49th for home ownership among residents. [36] The population growth occurring in California only compounds this problem, as the construction of new housing units cannot keep pace with increasing demand.

While the actual cost of housing varies between different regions in California, the problem exists throughout the state. Even in lower-cost areas, affordable housing is becoming increasingly scarce. In California's rural counties, a family would need to earn at least \$10.33/hour (153 percent of minimum wage) working full-time in order to afford a Fair Market Rent apartment (\$537/month for a two bedroom apartment). [37]

Homelessness is also an ongoing problem for the state. For example, in Alameda County an estimated 12,000 people are homeless on a given night, and approximately 40 percent of those are families with children. [38]

Of the 4.6 million households with one or more children under 18 in California, 22 percent are headed by a single female parent. [39] These households are more likely to struggle to support themselves with less than adequate income.

Single parenthood, low income, and high housing costs, along with welfare reform, force most women with children into the labor force. Of the almost 6.5 million women in California between the ages of 20 and 44 (as of March 2004), 70 percent participated in the labor force. [40]

The proportion of women in the labor force, coupled with the number of single-parent households in California, creates an enormous need for childcare for working parents. Unfortunately, licensed childcare is available for only 26 percent of children with parents in the labor force. The cost of childcare for a preschooler typically consumes 53 percent of a parent's income if the parent is working full time at minimum wage. [41]

Hispanics and African Americans are disproportionately low income. The 2003 median household income was \$36,000 for Hispanics and \$40,000 for African Americans, both well below the state's median household income of \$49,320. The median household income for Whites and Asians was \$71,474 and \$67,064 respectively. The proportion of California residents living in poverty (<100 percent FPL) shows similar racial/ethnic disparities: 22 percent for African Americans, 21 percent for Hispanics, 11 percent for Asians, and 8 percent for Whites. Fifty percent of Hispanics and 43 percent of African Americans were classified as low income (<200 percent FPL). [42] Hispanic students comprise the largest and fastest growing racial/ethnic group in California schools. Of the student population, 49 percent receive subsidized school lunches. Over one quarter are classified as English learners; most of these English learners' first language is Spanish. [43]

/2009/ The outlook for the California economy is for little growth in 2008 followed by slow growth in 2009 and moderate growth in 2010. [44] Due to the slower rates of economic growth, decreasing state revenues and increased costs the estimated budget deficit for California is over \$14 billion. In response to the State deficit, the 2008-2009 Governor's budget proposes 10 percent across-the-board State General Fund reductions resulting in a greater than dollar for dollar impact for local health jurisdiction as less monies will be available to obtain matched program funds. //2009//

/2010/ Decreasing home prices, shrinking equity values, the tightening of credit availability and the increase in job losses delivered a crushing blow to the state's economy, which has a projected budget deficit of \$ 41.6 billion. [45]

Access to Health Care

In California, 18 percent of the population did not have health insurance in 2002, compared to 15 percent of the US population. Among California's Hispanic population, 31 percent were uninsured. Among California children under the age of 18, 14 percent were uninsured. Among California children, 28 percent were covered by Medicaid or Healthy Families, compared to 25 percent for the US. [46] Among the poor and low-income population in California, children were more likely to be covered by public programs than adults. Continuing to raise the rates of

enrollment in public insurance programs, especially among immigrants and non-English speaking populations, remains a challenge for the state.

Another challenge for the state is meeting the health care needs of the large number of undocumented immigrants, many of whom are migrant workers. While the number of undocumented immigrants in California is difficult to measure, a recent study suggested that 2.4 million undocumented immigrants were in the State of California in 2002, over a quarter of the nation's estimated 9.3 million. Forty percent of these undocumented immigrants are women. [47] In one sample of undocumented immigrants in Fresno and Los Angeles Counties, half were between the ages of 18 and 34, and one quarter were children under 18. [48]

It is not surprising that, given the complicated nature of eligibility for public assistance coupled with fear of the consequences of having to reveal one's status as undocumented, access and participation in available services among the undocumented population is very low. Still, the most common reason given by undocumented immigrants for not seeking health care was that it was too expensive. [49] Other complications arise for undocumented immigrants who seek services in one county and move on to another region for work. Frequent moving for employment makes it difficult to provide consistent and comprehensive services and to track services for this population.

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

/2009/ In January 2007, the Governor unveiled comprehensive plans to reform California's healthcare system. The governor's healthcare proposal was rejected by the California State Senate in January 2008. Ultimately senators said the \$14.9 billion plan was too risky a financial commitment when California faces a \$14.5 billion budget gap. //2009//

/2010/ The unemployment rate jumped to 10.6% as of January 2009 [50]—the highest since 1983—and threatens to restrict access to care since employer-based insurance is the usual source of health coverage for most families. Unemployment also results in a decrease in state revenues and will affect California's ability to pay for state health programs, much less the increased cost due to the greater need for health coverage.

Of concern is the shrinking network of care for children even as the population has grown. In 2007, 28.2% (140/496) hospitals had pediatric beds, down from 34.7% (202/582) in 1998. [51] Hospitals have either eliminated their children's units or shut down altogether. In all, about 740 inpatient pediatric beds were lost from 1998 to 2007. Faced with shrinking budgets, many hospitals have been forced to shift resources toward adults, for whom they receive higher state and federal subsidies. In late 2008, voters approved \$980 million in bonds be authorized for construction and expansion of children's hospitals. //2010//

Major State Initiatives (Unabridged Version)

Reorganization of CDHS

/2007/ Governor Schwarzenegger has called on the Legislature to work with him to reorganize the existing California Department of Health Services into two departments: a California Department of Public Health (CDPH) and a Department of Health Care Services (DHCS). The new CDPH would protect and promote health through a focus on population-wide interventions,

while the DHCS would focus on the financing and delivery of individual health care services. The target implementation date for the reorganization is July 2007.

In the current proposal for reorganization, the MCAH/OFP Branch is in the CDPH, and the CMS Branch is split between the two new Departments, but is primarily in DHCS. The MCAH/OFP and CMS Branches currently have joint responsibility for carrying out Title V functions; it is not clear if, or how, this partnership would be affected by the proposed reorganization. //2007//

/2008/ The CMS Branch will be located in the Systems of Care Division of DHCS. CMS Branch programs will be included in the new Division, together with Medi-Cal programs (coordinated Care managements, Disease Management and Medical Case Management). The Division Chief, Luis Rico, will report to the Deputy Director, Health Care Operations. //2008//

/2009/ The CDPH and DHCS continue to work closely together to insure the many programs and organizations under MCAH work collaboratively and continue to provide for the health and well being of mothers, infants, children, families, and children with special health care needs. //2009//

/2008/ The reorganization of CDHS was implemented July 1, 2007. In preparation, CDHS created management and transition teams to collaborate with organizational development consultants to develop the guiding principles of CDPH and DHCS, perform a SWOT analysis, create an operational plan, and promote leadership development. These efforts were successful in assessing program placement, distributing administrative functions, developing new organization charts, and promoting budget neutrality throughout the reorganization process. The reorganization is expected to bring to CDPH a new strategic focus, positive culture change, improved business practices, and enhanced infrastructure. //2008//

/2009/ The CDPH has developed a strategic plan with a vision that focuses on healthy individuals and families in healthful communities. Core values include collaboration, competence, equity, integrity, respect, responsibility, trust and vision to encourage innovation and creativity. 'We work in the present and focus on the future.' One of the major goals in the strategic plan is to: Increase the quality of life, reduce disparities and promote health equity. MCAH is the lead agency for the objective: Reduce deaths of infants under one year of age. //2009//

/2008/ A Public Health Advisory Committee (PHAC) is also being formed to provide expert advice and make recommendations on the development of policies and programs that seek to promote the public's health. The first PHAC meeting is scheduled for September 2007. //2008//

/2009/ Members of the PHAC were selected and announced in February 2008. //2009//

Safe Motherhood

Each maternal death is tragic and represents a premature loss of life. Much of maternal morbidity and "near miss" mortality goes unnoticed by traditional public health surveillance systems and can impact maternal, fetal, and infant health.

Modeled on the California Perinatal Quality Care Collaborative (CPQCC), the MCAH/OFP Branch has developed a Maternal Quality Collaborative (MQC) to address maternal morbidity. CPQCC uses data-oriented quality improvement activities to improve perinatal and neonatal

outcomes. The MQC is a collaborative effort between the CPQCC and the UCLA Maternal Quality Improvement (MQI) Group. The MQC Leadership Council includes members from CCS, MCAH/OFP, Medi-Cal Managed Care (MCMC), and Medi-Cal Policy Section. MQC measures maternal quality of care and has begun to identify hospital-level outcomes for maternal/neonatal infections and postpartum hemorrhage.

/2007/ The Maternal Quality Collaborative is now named the California Maternal Quality Care Collaborative (CMQCC). Dr. Elliott Main of the California Pacific Medical Center chairs the CMQCC Advisory Committee and is leading the collaboration and coordination of the CPQCC and the UCLA Maternal Quality Improvement (MQI) group. The third- and fourth-degree laceration rate of hospitals has been chosen as the first indicator for which the CMQCC will implement best practices while development and validation of other indicators proceed. //2007//

/2009/ Several indicators have been proposed and discussed among the UCLA MQI work group and key stakeholders. It was decided that the best indicators are those that can be linked to processes of care or specific quality improvement initiatives. CMQCC has selected "hemorrhage" as the first indicator for the quality improvement initiatives. A Hemorrhage Task Force has been convened to create and disseminate protocols and guidelines for earlier detection of hemorrhage and a rapid response team approach to intervention. //2009//

/2010/The CMQCC Hemorrhage Task Force has developed a Post Partum Hemorrhage Toolkit that includes decision-tree wall posters, management guidelines, equipment lists and quality improvement measures. The tool kit will be available online and through hospital learning collaboratives.

The MQI work group is conducting morbidity analysis on OSHPD 1999, 2002, and 2005 data, as this is when maternal deaths increased most dramatically. Data will be stratified by county and hospital, looking at rates of cesarean delivery, peripartum hysterectomy, and complications such as chorioamnionities, gestational diabetes, preeclampsia and premature labor.//2010//

In 2006, the MCAH/OFP Branch began developing the Pregnancy-Associated Mortality Review Project. Maternal mortality ratios remain much higher than the Healthy People 2010 objective and racial and ethnic disparities in mortality are large. The goal of this project is to examine the medical and psychosocial events leading up to death for women who died from pregnancy-related causes or within one year of pregnancy (pregnancy-associated deaths) so that MCAH/OFP Branch and its stakeholders can develop a public health component to reduce such deaths.

The MCAH/OFP Branch is partnering with UCSF and the Public Health Institute (PHI) to identify sample cases, and abstract medical records for the antenatal, peripartum, and postnatal periods using forms based on models provided by the CDC. A Case Review Team will review de-identified case summaries and determine whether deaths were due to pregnancy-related factors or linked to the period after pregnancy by time only. MCAH/OFP Branch, UCSF, and PHI will report findings and work with stakeholders to disseminate findings and develop next steps for action.

/2009/ CMQCC has been working with maternal care leaders statewide to draw attention to maternal morbidity and mortality, and establish an effective collaborative. The CMQCC Executive Committee met in June and October 2007 and will meet in February and June 2008. The Maternal Quality Improvement Panel (MQIP) has been meeting to determine priority topics for quality improvement intervention. Task Forces proposed include Intrapartum Hemorrhage,

Obstetric Emergencies and Rapid Response Teams, Post-Partum Depression, Third and Fourth Degree Lacerations, Labor Induction, and Quality Improvement Leadership Capacity. CMQCC has been meeting with state and national hospital reporting systems, including the California Hospital Assessment and Reporting Taskforce (CHART) and the National Quality Forum, to determine obstetric quality indicators to add to these established systems. CMQCC established a website (www.CMQCC.org) that provides an extensive overview of maternal morbidity and mortality issues.//2009//

/2010/ The CMQCC Executive Committee continues to meet on a quarterly basis. Most recently, invited expertise worked with the Committee to identify strategies to address the alarming data regarding racial disparities in California's maternal mortality rates. There are three functional arms to the CMQCC: Data, Programs and Policy. The Data arm is exploring rising rates of cesarean section; the Program arm is about to release the Obstetrical Hemorrhage Toolkit; and the Policy arm is planning a legislative briefing in June 2009.

CMQCC successfully introduced four new quality measures, and CPQCC introduced one quality measure and strongly influenced a second. Between CMQCC and CPQCC, they were instrumental in introducing and supporting six National Quality Forum Perinatal Measures that are also being implemented as standards for Joint Commission of the Accreditation of Healthcare Organizations (JCAHO). These measures include: Elective Delivery Prior to 39 Completed Weeks Gestation; Cesarean Rate for Low-Risk First Birth Women; Appropriate Use of Antenatal Steroids; Exclusive Breastfeeding at Hospital Discharge; Nosocomial Blood Stream Infections in Neonates; and Infants Under 1500 g Delivered at Appropriate Site. The Regional Perinatal Programs of California (RPPCs) were instrumental in championing the latter measure, which has maternal health policy implications for perinatal transport.//2010//

/2009/CMQCC has also been working with the MCAH Program to implement a Local Maternal Care Quality Improvement Project (LMCQI). Eighteen Local Health Jurisdictions (LHJs) indicated to the MCAH Program that they intend to submit a proposal to implement a maternal care quality improvement project. CMQCC was contracted to develop the guidelines for the proposals and to give technical assistance and data to the LHJs. Proposals are due on April 30, 2008. The MCAH Program will select 2 to 4 LHJs to begin a two year pilot project beginning in July 2008. CMQCC will provide technical assistance to the chosen LHJs. //2009//

/2010/MCAH contracts with CMQCC to oversee the Local Assistance for Maternal Health (LAMH) programs (previously called LMCQI). Four pilot projects have been funded to address quality improvement in maternal health care by: 1) reducing fragmentation in maternal care through promotion of patient carried prenatal records; 2) improving measurement and recording of obstetrical hemorrhage through standardized methods; 3) improving baseline health of women by increasing enrollment in interconception care programs; and 4) reducing non-medically indicated rates of labor induction.//2010//

/2007/ The MCAH/OFP Branch also collaborated with the CDC Unexplained Deaths and Critical Illnesses Project, the CDC Division of Reproductive Health and the CDHS Unexplained Deaths Project to investigate the deaths of four women in California who died after medical abortions in 2003-2005. These deaths were attributed to infection by Clostridium sordellii, and warnings about medication and route of administration were issued by the CDC and the U.S. Food and Drug Administration during this investigation. //2007//

/2007/ The MCAH/OFP Branch is implementing the Pregnancy-Associated Mortality Review Project (PAMR). Chart review abstraction forms have been developed and approved by the

relevant institutional review boards. Administrative data necessary for case identification has been linked. Sixty of the 194 cases identified through this linkage file have been selected for in-depth review. PHI is communicating with hospital medical records personnel to obtain permission to abstract data for these cases in the summer and fall of 2006. The MCAH/OFP Branch, UCSF and PHI have made a 5 year commitment to the continuation of this project. //2007//

/2008/ The MCAH/OFP Branch is continuing implementation of the PAMR Project. In July 2006, PHI began abstraction for the 60 cases selected for the first year's review. PHI is on schedule to complete 60 cases by June 30, 2007, as planned. Death certificates for the 2002 cohort were reviewed for all 194 cases eligible for this year's review and coroner's reports were obtained for available cases in the sample. //2008//

/2008/ On February 2, 2007, the PAMR Advisory Committee held its first case review meeting. Committee members include experts in maternal and perinatal care throughout the state, including nurses and physicians affiliated with both research and community hospitals and representatives to the American College of Obstetricians and Gynecologists and the Association of Women's Health, Obstetric and Neonatal Nurses. The initial cases reviewed brought to light a number of areas for clinical and public health intervention. The Advisory Committee will meet every 2-3 months to continue reviewing case summaries and develop recommendations for CMQCC and the MCAH/OFP Branch. //2008//

/2009/ The PAMR Advisory Committee completed reviewing the 60 cases selected for the first year's cohort over four meetings. A report of the findings and recommendations is being prepared by MCAH, CMQCC and PHI and is expected to be released in the summer of 2008. //2009//

/2008/ The MCAH/OFP Branch and UCSF are currently planning for the next round of case abstractions to begin in July 2007, including linking the administrative data needed, reviewing death certificates, and obtaining coroner's reports. Data abstraction forms will be revised prior to abstraction of data for the second year of cases to reflect possible improvements and efficiencies identified in the first year's review. //2008//

/2009/ The MCAH Program has identified 50 pregnancy-related cases for the next cohort of pregnancy-related cases (2003) and 194 pregnancy-associated cases of which a sample will be reviewed. The MCAH Program has reviewed death certificates and requested coroner's reports for those cases. PHI began abstracting data in January 2008. Data abstraction forms were revised to reflect efficiencies identified in the first year's review. The PAMR Advisory Committee will meet in March and May 2008 to begin reviewing the 2003 cohort of maternal deaths. //2009//

/2010/The sample cases from both the 2002 maternal death cohort (194 deaths; 20% pregnancy related) and the 2003 cohort (192 deaths; 26% pregnancy related) have been abstracted and reviewed by the PAMR Advisory Committee, and numerous opportunities for quality improvement were identified. Preliminary recommendations include the need for improved pre-conception care, the need to explore a regionalized approach to risk-appropriate levels of maternal care, and continued monitoring of the rates of cesarean section and non-medically indicated labor induction as contributing factors to mortality. Given the extent of the data, the report of the first Pregnancy Associated Mortality Review is delayed until the latter part of 2009.

The 2004 cohort (171 deaths; 29% pregnancy related) and the 2005 cohort (251 deaths; 27% pregnancy related) are now being abstracted by PHI and will be reviewed over the next two years. The Committee has been expanded to include specialists in emergency medicine/critical care and anesthesiology. A process evaluation meeting held in December 2008 identified minor methodologic issues during the pilot period, which will be addressed this year.//2010//

Preconception Health

/2008/ Despite major improvements in access to prenatal care enhanced with nutrition and psychosocial education, no definite progress in the improvement of pregnancy outcomes has occurred in the United States over the past decade. In California, despite 87% of women receiving prenatal care in the first trimester, the low birthweight rate has remained constant for the past 10 years. In addition, California's infant and maternal mortality rates remain significantly higher than the Healthy People 2010 objective goals. Several evidence-based interventions recommended for implementation during pregnancy may be more effective and beneficial if implemented before conception. Supporting healthy lifestyles and providing access to care are essential to reducing these preventable complications. //2008//

The MCAH/OFP Branch is collaborating with and supporting the efforts of the American College of Obstetricians and Gynecologists (ACOG), the California Academy of Family Physicians, the March of Dimes (MOD), the UCSF Center for Health Policy Studies, and Sutter Medical Center Sacramento to improve the practice of preconception care in California.

The MCAH/OFP Branch is cognizant of the importance of developing and implementing preconception care policies that are internally consistent within CDHS programs, as well as being congruent with regional and national initiatives external to the Department. Within the CDHS, an important strategy will be to integrate preconception care initiatives and patient educational programs among primary care services, family planning services, and pregnancy care services, since each of these sites of clinical care may be utilized by the same individual woman, but at different times in her life. A lesson learned from the unsuccessful preconception care initiatives carried out in the 1990s is that isolated initiatives targeted at single provider types are not enough. Instead, the integrated, consistent, and clear guidance that a woman receives from each type of health care provider that she sees, as well as the public health educational messages that she encounters, are critical motivators in leading to the behavioral changes that are necessary to achieve the goals of preconception care.

Through the California Preconception Care Initiative, a provider/patient resource packet has been developed to assist health care providers in the provision of preconception care. A summary of the literature provides an overview of the evidence for preconception care. Patient education handout topics include: smoking cessation; medical conditions and genetic counseling; domestic violence; folic acid use; diabetes control; infections and immunizations; and healthy lifestyle choices. In addition to the packet, clinical information has been disseminated through the Internet, regional conferences, DVD, and audio presentations.

Other states are adapting materials from California's provider/patient resource packet for their own use. The materials were distributed across the country by the National Birth Defects Prevention Network in January 2006 and are currently available for download on the March of Dimes California Chapter website. Plans are in place now to update the packet.

//2010/The production and dissemination of this patient/provider resource packet laid the groundwork for further efforts to promote preconception health in California, including the MCAH Division's Preconception Health and Healthcare Initiative (PHHI). In lieu of updating the packet, MCAH has collaborated with the Preconception Health Council of California (PHCC), one of the key components of the PHHI, to develop a comprehensive preconception health website called EverywomanCalifornia, which is available at <http://www.everywomancalifornia.org>. The website features electronic versions of the revised patient education handouts and additional information for consumers, as well as resources for providers such as toolkits, clinical guidelines, best practice models and links to scholarly journals.//2010//

Over the past year, the MCAH/OFP Branch has taken a leading role in promoting preconception health and healthcare. In November 2005, the Branch convened a meeting of representatives from city, county, and state health agencies, as well as representatives from MOD and Sutter Medical Center, to discuss areas of potential collaboration.

The California Preconception Care Advisory Committee was represented by one of its members on the CDC's Select Panel on Preconception Care. This group is providing recommendations for the nation on preconception health and healthcare. The recommendations were released in April 2006.

The California Chapter of MOD, together with the MCAH/OFP Branch, convened the Preconception Care Advisory Committee (now called the Preconception Health Council of California) meeting in May 2006 to discuss a comprehensive, statewide plan of action to promote and ensure access to preconception care for women of childbearing age in California. The lead program officer from the CDC and lead author of the recommendations for the nation were featured speakers. Several senior managers from MCAH/OFP participated. The committee will be meeting quarterly to prioritize the recommendations, develop a plan of action, and oversee implementation. Several members of the committee will be serving on CDC workgroups to further develop national strategies for preconception care.

Local MCAH health jurisdictions have also undertaken activities related to preconception care. A prime example is the Los Angeles (LA) Collaborative to Promote Preconception/Interconception Care, which is comprised of Los Angeles County MCAH Programs (LA MCAH), LA Best Babies Network (LABBN), and the local chapter of the March of Dimes (MOD).

//2008/ Another example is the CityMatCH, AMCHP, CDC-initiated Healthy Women's Weight Action Learning Collaboratives in Los Angeles and Sonoma counties; these are co-facilitated by the MCAH/OFP Branch nutritionist. //2008//

//2010/ The Healthy Women's Weight Action Learning Collaboratives were featured in a report entitled "Promoting a Healthy Weight in Women of Reproductive Age: Experiences & Lessons Learned from Eight State/Local Health Department Teams," published by AMCHP and CityMatCH. Achievements of the collaboratives include development of new materials, promotion of worksite wellness programs, teen cooking classes and integration of healthy weight messaging into promotores de salud training curricula.//2010//

The LA County Preconception Health Collaborative is serving in a leadership role to implement and monitor the success of various preconception/interconception care models including 1) convening a policy roundtable to discuss financing of care for women at highest risk; 2) developing a Care Quality Framework; 3) providing case management for the highest risk

women who have had an adverse birth outcome; 4) providing funding for prevention interventions; 5) surveying family needs and challenges to accessing interconception care; 6) promoting pregnancy and family friendly policies for employers; 7) implementing an evaluation framework that demonstrates the health and cost benefits of providing preconception/interconception care, as well as the elements critical for replication in other areas. This effort is largely supported by First 5 LA Healthy Births Initiative (\$28 million) and LA MCAH.

/2010/ The LA County Preconception Health Collaborative produced a curriculum for public health providers called the "ABCDEs to Envisioning a Healthy Future." About 100 nurses, physicians and health educators received training in the curriculum. Collaborative members are involved in other projects such as: integration of preconception and interconception health messages into family planning clinics; development of a reproductive life planning toolkit for providers and patients; and interconception care coordination for WIC clients with a previous poor pregnancy outcome.//2010//

/2008/ The Contra Costa Preconception Care Work Group was represented at the CDC's Preconception Care Conference in Atlanta during June 2006. CDC guidelines are utilized as a framework to expand efforts related to preconception and interconception care.

Another example of preconception care is Contra Costa County's focus on the Life Course Model developed by Dr. Michael Lu, et al. The model suggests that a complex interplay of biological, behavioral, psychological and social protective and risk factors contribute to health outcomes across the span of a person's life. The Contra Costa Maternal Child Health staff incorporates this philosophy into their MCAH, BIH, and CPSP programs and collaborates with other county and community agencies to improve the health and socioeconomic status of the community.

A comprehensive approach to improving the health and well being of individuals throughout the lifespan has included mental health assessments and interventions for preschoolers, comprehensive school-based health centers, the development of a Youth Power Curriculum designed for high school youth to promote self actualization, improved access to health care, emergency preparedness within schools and the community, programs designed to improve family relationships, and improved access to prenatal care for pregnant women and medical care for their children. //2008//

/2010/Contra Costa County Health Services' Family, Maternal and Child Health (FMCH) Programs launched a 15 year Life Course Initiative (LCI) in 2005. In 2008, FMCH Programs launched Building Economic Security Today (BEST) as a new component of the LCI. BEST promotes financial security and stability as protective factors that may help achieve health equity and improve birth outcomes. In 2009 existing staff duties were shifted to provide a coordinator for this initiative. 2010//

/2008/ The Lift Every Voice project, created by the MCAH Program, was designed to address the needs of pregnant and incarcerated women in juvenile hall. Upon leaving the detention facility, women are linked to a home visitation program which supports them through pregnancy and during the baby's first year. //2008//

/2010/ Through the PPHI, MCAH collaborates with the California Family Health Council (CFHC) to develop reproductive life planning tools for consumers and providers. These will be integrated into services provided at Title X family planning clinics. //2010//

The MCAH/OFP Branch applied to the CDC for a Prevention Specialist (PS) for a period of two years to serve as the lead for a Statewide Preconception Health Task Workgroup.

/2007/ The request for the PS was not funded. //2007//

/2008/ The California Preconception Care Advisory Committee, convened in May 2006, changed its name in 2007 to the Preconception Care Council of California (PCCC). The PCCC will provide direction for: integration of preconception care in clinical and public health practice; development of financial and public policy strategies to support and sustain preconception care; and promotion of key preconception care messages to women of reproductive age in California. The PCCC formed three workgroups that are developing action plans: Research and Clinical Practice; Finance/Public Policy, and Public Health/Community. //2008//

/2009/ Each of the three workgroups of the PCCC has developed an action plan for its particular area of focus. Workgroup members are collaborating with local partners to implement these plans. Current activities include:

- *Develop provider education tools, such as PowerPoint presentation templates and explore the possibility of local pilot research projects;*
- *Clarify the role that existing MCAH programs play in preconception health promotion and develop a framework and messaging to support and expand these efforts; and*
- *Educate the legislature about preconception health, advocacy for related bills, and development of recommendations for the integration of preconception and interconception healthcare services into proposed healthcare reform packages.*

The workgroup plans have been combined into a set of comprehensive recommendations that will inform the preconception activities outlined in the State MCAH Program's Title V Implementation Plan. //2009//

/2010/ The PCCC changed its name to the Preconception Health Council of California (PHCC) to reflect a focus on not only clinical interventions but also on health education and promotion efforts and community-based health improvement strategies. The workgroups remain active. Current activities include:

- *Development of clinical guidelines to optimize the post partum visit as a first step in the provision of interconception care, especially for those women who have had a poor pregnancy outcome.*
- *Launch of a comprehensive website on preconception health for the state in Spring 2009. The website will feature information and low literacy fact sheets for consumers, as well as provider resources such as toolkits, best practice models and links to other websites.*
- *Ongoing education of policymakers about preconception health, and advocacy for inclusion of preconception health in state and federal health care reform proposals.//2010//*

/2008/ In an effort to move toward these goals, the PCCC partnered with the CDC to plan and host the second annual National Summit on Preconception Care. The 2nd Annual National Summit, scheduled to take place in Oakland in October 2007, will bring together leaders from across the country to present best practices addressing the implementation of the CDC objectives for preconception care. Funding for this Summit will come partly from the CDC, the MOD, CDPH and private donations. In preparation for this summit, the MCAH/OFP Branch has

composed a fact sheet detailing the state of preconception health of non-pregnant women aged 18-44 in California. //2008//

/2009/ The Second National Summit on Preconception Health and Health Care was held in Oakland on October 29-31, 2007. In addition to the Summit sponsors, numerous public and private partners were represented. The MCAH Program distributed the publication entitled "Preconception Health: Selected Measures, California, 2005" which detailed the state of preconception health in California. MCAH staff served as volunteers, room monitors, and presented poster and break out sessions. //2009//

/2010/ MCAH Division staff are participating in a CDC-sponsored work group to develop a list of preconception health indicators, culled from existing nationally-administered surveys, that can be used by all states to assess the preconception health status of women of reproductive age in their communities.

MCAH organized a full-day training for LHJ MCAH Directors on preconception health.

MCAH was awarded a First Time Motherhood grant of \$500,000 a year for two years from HRSA/MCHB for the development of a preconception health social marketing campaign.

In response to an analysis of California data showing decreased folic acid consumption among Latina women, MCAH sponsored a multi-pronged folic acid awareness campaign targeting Latinas of reproductive age in the spring of 2009. This campaign included radio public service announcements (PSAs), mini-dramas and talk shows; revised folic acid brochures and posters; development of a training curriculum for health promoters; a small-scale vitamin distribution campaign at selected WIC centers and family planning clinics; and a provider education campaign about folic acid being a covered benefit under Medi-Cal. //2010//

/2008/ The MCAH/OFP Branch also participated in the Association of Maternal and Child Health Programs 2007 annual conference March 3-7 by leading the preconception care plenary session. MCAH/OFP staff conducting the session entitled "Preconception Care: Achieving Healthy Communities" covered three major objectives: 1) establish preconception care as an approach for achieving healthy communities; 2) discuss successful strategies for connecting leadership to implement national recommendations by showcasing the preconception care initiative planning and implementation strategies; and 3) explore opportunities for and challenges to adopting a new paradigm by sharing with other states the experiences of the LA Collaborative to Promote Preconception/Interconception Care. //2008//

/2010/ MCAH presented on the Preconception Health Council of California in a breakout session at the 2009 AMCHP meeting.//2010//

/2008/ To quantify the impact of preconception health status on perinatal outcomes, the MCAH/OFP Branch is conducting a study examining the association of preconception hospitalizations (2000-2002) on subsequent pregnancy and birth outcomes among women 15-44 years of age in California who delivered in 2003. This study will 1) identify major causes of hospitalization for the study population; 2) identify maternal and infant health outcomes among women who were hospitalized for these major causes; and 3) compare maternal and infant health outcomes among women who were hospitalized during the three years prior to infant birth with women who were not hospitalized. //2008//

/2009/ Preliminary findings of the above study were presented at the 2nd National Summit.
//2009//

/2010/The manuscript for the above study is being prepared for publication.//2010//

Prenatal Screening Services, Umbilical Cord Blood Banking, and Pregnancy Blood Banking

/2008/ Legislation passed in September 2006 will expand the California Department of Public Health's capacity to discover causes, develop prevention strategies, and increase surveillance of birth defects and genetic diseases throughout the state.

For over 20 years, the California Birth Defects Monitoring Program (CBDMP) has helped to support research and surveillance of birth defects in California and maintained a birth defect registry that contains medical and demographic information on over 88,000 children with birth defects by monitoring 334,000 births per year. CBDMP has employees under contract through the March of Dimes. This new legislation will move CBDMP from Prevention Services to the MCAH/OFP Branch, thereby augmenting resources used to evaluate and analyze factors associated with infant and fetal morbidity and mortality. CBDMP will continue to collaborate with the Genetic Disease Branch (GDB) to maintain the Pregnancy Blood Bank, which stores prenatal screening blood samples from GDB's Prenatal Screening Program. Under this screening program, the blood samples are screened for specific diseases and disorders in a cost-effective manner in order to identify women who may be at high risk for having a fetus with a birth defect and may benefit from follow-up diagnostic tests. //2008//

/2009/ GDB is now known as the Genetic Disease Screening Program (GDSP), and MCAH/OFP Branch is now the MCAH Program and OFP Program. Legislation in January of 2007 has authorized CBDMP to expand its repository capabilities to collect and store umbilical cord blood with appropriate funding; however, no funding is available at this time for this activity.
//2009//

/2010/ Planning is underway to create policies and procedures for a true biomedical repository with data and biological specimens that can be made available to researchers from around the world.//2010//

/2008/ A prenatal screening fee increase implemented in 2007 will enable CBDMP to collect, process, and store more blood samples than prior capacity, as well as to expand the birth defect registry. These improvements will allow for increased research opportunities using pregnancy blood specimens and provide more representative statistics on birth defects occurring in the state. MCAH/OFP Branch and CBDMP staff will be developing a database linking resource in which the birth defect registry and stored pregnancy blood samples can be linked with state health outcome data. This will provide scientists from a variety of disciplines the opportunity to test hypotheses about genetic and environmental causes of many children's and women's diseases. //2008//

/2009/ CBDMP links birth defects registry data with the pregnancy blood sample inventory as well as with other databases of vital statistics live birth file, birth cohort file, and fetal death file. A link to GDSP's Test Request Form (TRF) database of prenatal genetic screening results has also been validated. CBDMP is analyzing its pregnancy blood collection areas, and is changing the areas assigned for blood collection. //2009//

//2010/ CBDMP has begun working with a link to hospital discharge data. A link to GDSP's TRF database of prenatal genetic screening results also needs to be reinstated. CBDMP is analyzing its pregnancy blood collection demographics and considering changes in the counties assigned for blood collection.//2010//

//2008/ The increased screening fees will also modernize and expand GDB's Prenatal Screening Program to include all prenatal screening tests that meet or exceed the current standard of care. In particular, a fourth maternal serum marker test (inhibin A) will be added to the tests available within the Program. This addition will provide pregnant women with an improved detection rate for Down syndrome. Earlier detection and diagnosis may help reduce the economic and emotional burden on families potentially affected by this disorder. //2008//

//2009/ First trimester testing is expected to begin January 2009.

MCAH worked collaboratively with GDSP to add educational information to GDSP's prenatal screening booklet regarding women's options for public and private umbilical cord blood banking.

Legislation passed in 2007 authorizes CDPH to develop an umbilical cord blood banking program, if funds are available. The program would focus on funding qualified cord blood banks to collect cord blood for use in research and to contribute genetically diverse cord blood units to the national inventory. No funds were available for these activities in FY 07/08. *//2009//*

//2010/GDSP initiated first trimester screening at the end of March 2009. No funds have been available for cord blood activities, although new legislation has been introduced that would provide a revenue stream for this program.//2010//

Teen Birth Rate Resource Project

//2008/ The Branch is collaborating with the UCSF and the Office of Statewide Health Planning and Development to develop comprehensive maps of teen birth rates using geographic information system (GIS) tools. This Teen Birth Rate Resource Project (TBRR) will identify geographic locations in California with higher or lower teen birth rates so organizations can apply for resources and target interventions to locations with greater need. The TBRR will also show whether teen birth rates have changed over time, and whether this change varies by race/ethnicity and location. //2008//

//2010/The TBRR analyses were completed, and in May 2009 MCAH, OFP and UCSF released "Teen Births in California: A Resource for Planning and Policy." This resource presents teen birth rates for the state, with breakdowns by race/ethnicity and comparisons at the Medical Service Study Area (MSSA) level. MSSAs are subcounty areas comprised of contiguous census tracts that do not cross county boundaries. This resource identifies California locations with higher or lower teen birth rates in 2004-2005, and also compares rates to 2001-2002. Maps and tables, available by county and MSSA, will support improved targeting of teen pregnancy and teen birth programs.//2010//

Perinatal Care Quality Improvement

/2008/ The California Children's Services (CCS), in collaboration with the Regional Perinatal Programs of California (RPPC) have developed strategies to improve the quality of perinatal care through Regional Cooperation Agreements (RCA).

The RCA requires written agreements between Regional Neonatal Intensive Care Units (NICUs) and Community and/or Intermediate NICUs specifying mutual responsibilities for activities such as education, consultation, referrals and transports, development and review of policies and procedures, and review of outcome data. The primary purpose for the RCA is to improve perinatal outcomes by coordinating systems between all levels of care in the NICUs and delivery hospitals in California.

CCS requires all hospitals participating in the program to develop and implement the RCA. In addition, all hospitals providing perinatal services in California must have written transfer/transport agreements with facilities offering a higher level of care as required by Title 22.

The RPPC have created a toolkit to assist hospitals in implementing the RCA in order to become compliant with the standard. The toolkit, which CCS approved, entitled "Agreements for Provision of Perinatal and Neonatal Care: A Step-by-Step Guide", contains detailed information on setting up a RCA, including sample documents.

CCS and RPPC published and distributed 600 toolkits to the 118 CCS-approved hospitals throughout the state. The toolkit is available on the CMS website at <http://www.dhs.ca.gov/pcfh/cms/ccs/>. //2008//

/2009/ The new CMS website location for the toolkit is: <http://www.dhcs.ca.gov/formsandpubs/publications/Pages/CCSPubs.aspx>. //2009//

/2008/ CCS, together with the RPPC, conducted a series of workshops throughout the state from January to April 2007 to assist hospitals in the development and implementation of the RCA.

The local CCS office and the RPPC are available to the hospitals to provide technical assistance for the development and implementation of the RCA. //2008//

Neonatal Quality Improvement Initiative

/2008/ Children's Medical Services (CMS) Branch and California Children's Hospital Association (CCHA) are jointly sponsoring a statewide Neonatal Quality Improvement Initiative (NQI), which includes an experienced multidisciplinary project team, to improve neonatal care by working toward eliminating catheter related blood stream infections in NICUs. The NQI hospital and NICU participants are neonatologists, nurses, and administrators from the eight CCS-approved California children's hospitals and the six CCHA associate members which are the CCS-approved University of California medical centers and Sutter Memorial Medical Center (Sacramento). The Initiative is also partnering closely with the California Perinatal Quality Care Collaborative (CPQCC) for assistance with data outcome measures and to build upon their significant efforts in the area of neonatal nosocomial infections.

The approach of the NQI to improving quality at the point of care is the Institute for Healthcare Improvement (IHI) Breakthrough Series (BTS) model. In the BTS model, clinicians, administrators and other experts identify best practices and potential change strategies. A group of clinicians is then convened with the goal of testing these change strategies, learning from one another, and implementing the best demonstrated practices. Similarly, the NQI is delineating evidence-based processes of care to reduce neonatal nosocomial infections with the goal of eliminating catheter related blood stream infections; participants are receiving training and technical assistance to implement the agreed-on change package; and lessons learned are shared among participants via learning sessions with regular conference calls and focused site visits.

Outcomes, as well as observational process data, are being tracked from baseline through the course of the 9-month Initiative, ending in July 2007. A major focus of the evaluation will be a detailed analysis of the processes each site uses to implement and maintain evidence-based best practices. The most efficient and effective practices will be shared with all sites. This information can then be used to improve processes and outcomes in other CCS-approved NICUs throughout the state (118 total); benefiting all hospitalized infants, regardless of payer source. After the end of the 9-month Initiative, aggregated outcomes will be distributed to a variety of stakeholders, including the state legislature, large commercial payers, and the public. //2008//

/2009/ In the first year of the NQI, the 13 Regional NICUs collectively reduced their catheter associated bloodstream infections (CABSIs) by 29% for all weight groups. This initiative, now called the CCHA-CCS QI Collaborative, partnering closely with CPQCC, has begun a second year with all 22 CCS-approved Regional NICUs participating, and aided by a grant from the Blue Shield Foundation. Kick-off face-to-face meetings were held in January 2008 for the 9 new NICUs, for all the northern California NICUs, and for all the southern California NICUs. The consensus was to continue to work on reducing CABSIs using the IHI QI model and to also form special interest groups (SIGs) focused on vascular access devices, antibiotic use, checklists and root cause analysis, surgical infections, and ventilator associated pneumonia. Each NICU elected to participate in one or more of these SIGs. Baseline data for 2007 for CABSIs have been reported and will be compared with monthly data reports for 2008. Annotated run charts for each NICU allow participants to determine which changes are contributing to reductions in their CABSIs. NICUs apprise their staff of the number of days between line infections and celebrate successes. //2009//

/2010/The CCHA-CCS QI Collaborative completed its second year and is continuing for the first 6 months of 2009 through a no-cost extension of the grant provided by Blue Shield. Many NICUs have indicated they want to continue the collaborative, and other funding is being pursued that would begin July 2009. The CABSIs rate for 2008 was 2.33/1000 line days in a NICU cohort that provided 109,000 line days per annum; however, trend analysis with the prior year could not be completed due to the change in the CABSIs diagnostic criteria by the Centers for Disease Control and Prevention (CDC) beginning January 1, 2008. The work of the Collaborative was presented at the annual Neonatal Vermont Oxford Network (VON) Meeting in December 2008 and at the March 2009 8th Annual National Initiative for Children's Healthcare Quality (NICHQ) Meeting.

In 2008, there were 3 face-to-face meetings, semimonthly conference calls with all NICUs, and weekly leadership team conference calls. These contacts helped keep the collaborative engaged and were important for sustainability, which was the greatest challenge in the second year. In 2009, due to limited funds remaining from 2008, the conference calls are held once per

month and the leadership calls twice per month. The collaborative's mailbox, listserv and website www.dhcs.ca.gov/provgovpart/initiatives/nqi/Pages/default.aspx are helping to keep all sites engaged and interactive with one another. Early data for 2009 are showing improved CABS rates for all weight groups compared to 2008.//2010//

Pediatric Critical Care

/2008/ The CCS Program has structured a system of 19 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.

The CMS Branch, in collaboration with the University of California, Davis (UCD) School of Medicine is developing an infrastructure for Pediatric Critical Care quality care improvement. This project will assess the need for statewide benchmarking standards to direct quality improvement efforts; conduct key informant interviews with recognized leaders in pediatric critical care; analyze existing quality improvement efforts related to pediatric critical care; and develop a methodology and reporting tool to analyze pediatric intensive care quality improvement activities.

This planning effort will identify optimal approaches to the design of future database and data collection methodologies from California PICUs to meet the needs of quality improvement efforts. //2008//

/2009/ The CMS Branch maintains an ongoing collaboration with the UCD School of Medicine in the development of a Pediatric Critical Care Quality Improvement Structure for CCS-approved PICUs. The qualitative and quantitative data assessment of PICU medical directors identified a large range of opinions stressing the importance of benchmarking and quality improvement efforts, as well as changes in the available PICU reporting systems. CMS in collaboration with the CCS PICU Technical Advisory Committee is reviewing the reporting systems currently available, both nationally and in California, to evaluate, assess and develop a single reporting system to meet the quality improvement needs of CCS-approved PICU medical directors and the need of the CMS Branch to assess the care and outcomes. //2009//

/2010/CMS staff working with the CCS PICU Technical Advisory Committee began efforts to identify pediatric critical care data elements. These data elements would be key in structuring and identifying quality improvement activities for the CCS-approved PICUs. Due to the staffing shortage and budgetary constraints, further work on this project has been on hold.//2010//

Pediatric Palliative Care

/2008/ A major activity of the CMS Branch is to submit a palliative care waiver to the federal government. The goal of the waiver is to promote the development of comprehensive Pediatric Palliative Care demonstration programs for selected children with life limiting or life threatening conditions who are enrolled in the California Children's Services program. These demonstration programs should improve the quality of life for these children and their family members. In

addition, by providing well-coordinated, comprehensive, continuous care, cost neutrality should be achieved by reducing hospital stays and other unnecessary services.

To provide guidance on the development and implementation of the waiver, the Branch has formed a group of over 65 stakeholders that includes representatives from a variety of professional agencies, community based programs, parents, and other Divisions of DHCS.

The stakeholders have been split into 3 subcommittees to develop the specifics of the Pediatric Palliative Care program. These subcommittees include Eligibility, Service Delivery, and Outcome Data and Analysis. The Branch has also developed a Pediatric Palliative Care website and a stakeholder listserv to increase communication between the Branch and these stakeholders. The website has pertinent references on palliative care, details about the waiver, and committee minutes.

The waiver will be submitted to the federal government by January 2008 and will be implemented 6-12 months after approval. Finally, the Branch will hire an additional Public Health Medical Officer and Research Analyst to assist in the monitoring and analysis of the waiver.
//2008//

/2009/ CMS Branch staff met with stakeholder groups and county CCS offices to review the progress on the development of the waiver and to seek feedback. CMS Branch staff submitted the waiver application to Federal CMS in May 2008 with a planned starting date of January 10, 2009. //2009//

/2010/ The stakeholders were instrumental in identifying the eligibility criteria, the benefit package and the support system for delivery of the services offered in the waiver. The waiver is designed to provide a range of new services that are intended to improve the quality of life for the child and family, including care coordination and additional support services; respite care; bereavement counseling for caregivers; art, music and play therapy; and family training. The three-year pilot program will be implemented over a three-year period, with 300 participants in five counties (Alameda, Monterey, Santa Cruz, Santa Clara, and San Diego) in the first year of operation, expanding to 1,800 participants in 13 counties in the third year. The waiver was approved by Federal CMS in December 2008.

The CMS Branch has worked with stakeholders in developing marketing and training materials. In collaboration with other branches and the Department of Public Health, the CMS Branch developed new enrollment and assessment tools to be used by local CCS programs and waiver providers. A billing methodology has been developed by identifying appropriate Healthcare Common Procedure Coding System (HCPCS) codes and requesting changes to California Medicaid Management System (CA-MMIS) to allow waiver eligible providers to bill on a fee-for-service basis. New CCS aid codes have been identified in order to track services, utilization and participation. A database that will allow monitoring of local programs and waiver providers to ensure that federal assurances are met is being finalized. //2010//

Mental health

The MCAH/OFP Branch is working to address the mental health needs of infants, children, adolescents, and mothers. The Proposition 63 Mental Health Services Act (MHSA) provides funding for the expansion of mental health services for adults and children using revenue from an additional 1 percent tax on income over \$1 million. MCAH/OFP staff participate in the MHSA

stakeholder group.

Many MCAH/OFP Branch programs include a mental health component, including AFLP, BIH, CDAPP, CPSP, and DV. All include assessment and referral, and some include treatment as well. Interventions may include counseling for an individual, family or group, and may address psychiatric illness, marital and family problems, alcohol and substance abuse, smoking cessation, depression, and eating disorders.

The MCAH/OFP Branch participates in statewide efforts to implement coordinated mental health services. Three such efforts currently underway are the Behavioral, Emotional, and Social Screening and Treatment for Primary Care Providers (BEST-PCP) Project; the State Early Childhood Comprehensive Systems (SECCS); and the School Readiness Initiative (SRI).

BEST-PCP brings together state agencies, including the MCAH/OFP and CMS Branches, and stakeholders to improve access to services promoting healthy mental development for children age 0-3 who are enrolled in MCMC. A model quality improvement project (including a training tool) is being implemented in two counties.

/2008/ The BEST-PCP Project, which ended in early 2007, implemented developmental/mental health screening tools and referral protocols in the two primary care pilot projects. //2008//

/2009/ The ABCD Screening Academy is building on lessons learned through its predecessor BEST-PCP. Policy activities are focused on recommending use of standardized screening tools within the revised CHDP Health Assessment Guidelines. //2009//

/2010/ Although the ABCD Screening Academy project ended in July 2008, work to standardize the use of validated screening tools for young children continues through the Statewide Screening Collaborative. Multiple key partners are working to leverage resources, staff and policies once a child is identified with a developmental or mental delay or disability.//2010//

The SECCS project, funded through a HRSA grant, provides state-level leadership for programs that will help California's children to be emotionally, socially, and physically ready for kindergarten. The project coordinates various health-related programs of state and local government with organizations such as the American Academy of Pediatrics (AAP), March of Dimes, Easter Seals, and representatives of faith-based organizations.

/2010/ SECCS staff is involved with several early mental health activities as a member of 1) the First 5 Association's initiative to support early childhood mental health; 2) two grant writing teams working to obtain funds to train child care education staff on social-emotional learning and autism; 3) the Child Welfare Early Education Work Group; and 4) the Infant/Toddler Mental Health Work Group.//2010//

The SRI is the signature initiative of First 5 California. Mental health counseling is one of the five "essential and coordinated elements" of SRI. It is anticipated that the SECCS initiative will strengthen the health component of the SRI, including mental health.

/2008/ In January 2007, the Maternal and Child Health (MCH) Program of the University of California, Berkeley School of Public Health, in collaboration with the MCAH/OFP Branch, the California chapter of the March of Dimes and the Department of Mental Health, submitted a grant to HRSA. Entitled Bright Beginnings: Innovative Approaches to Improving Mental Health in California, this grant aims to provide continuing education activities to MCH professionals in the

area of maternal mental health over a three-year period. The grant is awaiting funding approval from HRSA. //2008//

/2009/ The Bright Beginnings grant was approved for funding by HRSA in June 2007. Following the grant award, a planning workgroup of major stakeholders and partners was established to determine the goals and objectives of the continuing education activities for MCH professionals. On November 16, 2007, the members of the planning workgroup attended a teach-in on maternal mental health issues and best practices at the UC Berkeley campus. The workgroup plans to hold the northern California continuing education conference in 2008 and a subsequent conference in southern California the following year. //2009//

/2010/ The first Bright Beginnings Conference was held on November 21, 2008 in Berkeley, with over 100 participants. Its objectives included examining women's current experiences in dealing with mental health issues during pregnancy and the postpartum period, exploring current approaches to integration of mental health and primary care services, and identifying successful ways to address barriers and implement promising practices.

Participants of the first Bright Beginnings Maternal Mental Health Conference increased their knowledge on the following topics:

- *The impact of mental disorders on maternal health and pregnancy outcomes;*
- *Current practices related to screening, assessment, referral and treatment for addressing maternal mental health during pregnancy and postpartum;*
- *Innovative models that integrate mental health and primary care services, and ways to adapt these models to fit individual organizations' available resources;*
- *Successful models that have addressed barriers to mental health treatment for women during pregnancy and the postpartum period; and*
- *Procurement and blending of funds from the Mental Health Services Act and other sources to address prevention and primary care collaboration at the local level.*

Planning is ongoing for the second continuing education conference to be held in November 2009 in Los Angeles.//2010//

Human Stem Cell Research and Women's Reproductive Health

/2008/ California is leading the nation in its support of the advancement of stem cell research that seeks to develop treatments and cures of childhood and adult diseases. New legislation that promotes the ethical and legal conduct of human stem cell research, as well as furthers protections for women's reproductive health, has led to an influx of stem cell scientists and biotechnology companies to California. In accordance with the legislation, the MCAH/OFP Branch created the Human Stem Cell Research Unit to manage stem cell issues for the Department and to fulfill the legislative mandates related to human stem cell research (HSCR).

The HSCR Unit was formed in 2004 following the passage of Senate Bill (SB) 322. This stem cell research legislation required the Department to 1) establish a Human Stem Cell Research Advisory Committee; 2) develop statewide guidelines for research involving human embryonic stem cells and revise these guidelines as necessary; 3) collect mandated progress reports from all Institutional Review Boards (IRBs) in California regarding the status of approved projects and proposals involving stem cell research; 4) review all IRB reports; and 5) report annually to the Legislature on human embryonic stem cell research activity in California.

In February of 2006, the MCAH/OFP Branch convened the HSCR Advisory Committee. The HSCR Unit facilitated several Advisory Committee meetings to deliberate the legal, scientific, and ethical issues surrounding stem cell research. As the Advisory Committee began developing the HSCR guidelines, new stem cell research legislation (SB 1260) was introduced and passed in September 2006.

This legislation indefinitely repealed the sunset date of SB 322 and added additional stem cell research requirements including 1) greater health protections for women donating oocytes for medical research; 2) increased state reporting requirements for researchers procuring oocytes and for review committees; 3) new research oversight mandates that require Stem Cell Research Oversight Committee (SCRO) review and approval of most HSCR; and 4) biennial reviews from the Branch to the Legislature detailing stem cell research activities in California.

The HSCR Unit collaborated with the Advisory Committee to incorporate these additional provisions into the guidelines. The Unit and Advisory Committee also consulted with the California Institute for Regenerative Medicine (CIRM) to promote consistency between its stem cell regulations and those of the CDPH. Guideline consistency was an important achievement because if HSCR projects are partially funded by CIRM, then the projects must abide by both the CIRM regulations and Department guidelines.

The Advisory Committee submitted the final guidelines to the HSCR Unit in February 2007. The Department is in the process of approving the guidelines. After approval, the guidelines will be distributed to all IRBs, SCRO Committees, and applicable research institutions in California, along with state reporting forms and supporting materials developed by the Unit. The Unit has extended the tenure of the Advisory Committee through 2008 and will continue to consult with the members to address any necessary revisions to the guidelines and evaluate the related provisions for women's health. //2008//

/2009/ The HSCR Unit is now the HSCR Program.

The Department approved the statewide guidelines for human stem cell research in June 2007. The guidelines are posted on the HSCR Program website. In an effort to remain current with recent advancements in stem cell research methods, the HSCR Program expects to update the guidelines later this year.

The Advisory Committee met in September and December 2007 to review the HSCR Program's proposed reporting forms for research involving human embryonic stem cells and human oocyte retrieval. The reporting forms also benefited from feedback during several public comment periods. After final review and approval, the HSCR Program will distribute the forms to research institutions and scientific review committees in the spring of 2008. The first round of annual reports are expected in August 2008. The Program will use these reports to develop a biennial review of stem cell research activity in California, due to the Legislature in December 2008. //2009//

/2010/ The HSCR Program finalized the reporting forms for research involving human embryonic stem cells and human oocyte retrieval in spring 2008 and distributed these to research institutions and scientific review committees for their use. The forms were also posted on the HSCR Program's website. The HSCR Program worked with researchers on the first round of data submission, collecting reports from 15 different SCRO Committees covering a total of 244 human embryonic stem cell research projects. The HSCR Program analyzed the data and developed a draft Legislative Review report, which will be submitted to the Legislature

in late spring 2009. Updated reporting forms for the next period will be distributed to researchers in late spring 2009.

Recognizing the rapid scientific advances within the HSCR field, the Program further extended the tenure of the HSCR Advisory Committee. The Committee met twice in 2008 and again in February and May 2009. The statewide guidelines were revised once in 2008 to address emerging issues in HSCR, and the Committee is deliberating additional revisions. The Program and the HSCR Advisory Committee continue to collaborate with CIRM to promote research guidelines compatibility. //2010//

Preventing Childhood Obesity

California, like the nation, is experiencing an increase in the prevalence of obesity and related health problems. The CDHS Director has established a CDHS Nutrition and Physical Activity Action Team with representatives from both MCAH/OFP and CMS. The Action Team has proposed a \$6 million Obesity Prevention Initiative consisting of community action projects, a health quality collaborative, tracking and evaluation of data, worksite interventions, and public awareness and education activities. Both MCAH/OFP and CMS are also involved in the Physical Activity and Nutrition Coordinating Committee (PANCC).

/2008/ The Nutrition and Physical Activity Action Team was disbanded in FY 2006-2007. //2008//

The California Nutrition Network for Healthy, Active Families is a public/private partnership led by CDHS. The purpose of the Network is to promote healthy eating and a physically active lifestyle among low income Californians by using social marketing techniques to reach large numbers of people. In addition to CDHS, Network partners include the Department of Social Services (DSS), the Department of Education (CDE), the Department of Food and Agriculture, and the University of California (UC) Cooperative Extension.

/2010/The California Nutrition Network for Healthy, Active Families is now known as the Network for a Healthy California. MCAH collaborated with the Network for a Healthy California to develop a proposal for a preconception health social marketing campaign, funded by a HRSA/MCHB First Time Motherhood grant.//2010//

/2008/ The Governor has joined the Alliance for a Healthier Generation. The Alliance seeks to prevent childhood obesity through collaborations with schools, food industry and healthcare professionals, such as CDPH and DHCS staff. //2008//

/2010/ In late 2008, California became the first state in the nation to require major restaurant chains to post calorie information on menus and indoor menu boards. This will make it easier for consumers to make more informed, healthier food choices. Earlier in 2008, California became the first state to ban trans-fats from restaurants and locally-baked products.//2010//

/2008/ MCAH/OFP is participating as one of eight CDPH representatives on a new Obesity Prevention Group (OPG) created by the CDHS Director's Office to coordinate obesity policy and program efforts across the Department. OPG's action items include advocating for funding and providing obesity prevention concepts to the Governor's Office.

CDPH has developed a comprehensive strategic plan to address the obesity epidemic in California. The plan includes creating a central point of contact within state government to coordinate efforts by various sectors, such as schools and healthcare that promote active living and healthy eating environments. The plan also involves developing a statewide media campaign that frames healthy eating and healthy lifestyles as synonymous with California. Lastly, CDPH will be actively involved in supporting local assistance grants and implementing policy strategies to reduce and prevent obesity in children and adults. //2008//

/2009/ MCAH has been working with the California Health Interview Survey to expand the physical activity questions for all age groups. MCAH continues to analyze nutrition, physical activity and Body Mass Index (BMI) questions in the California Women's Health Survey and the Maternal and Infant Health Assessment Survey. MCAH continues to promote optimal weight and weight gain before, during and after pregnancy via partner organizations and MCAH programs. //2009//

/2010/The California Physical Activity, Nutrition, and Obesity Prevention Collaborative brings together multiple efforts within CDPH that are working towards the common goal of increasing physical activity, improving nutrition, and preventing obesity among all Californians. The CDPH Coordinating Office for Obesity Prevention (CO-OP) 1) ensures department-wide coordination on obesity prevention efforts; 2) serves as the single point of contact for organizations looking to partner with CDPH on obesity prevention; and 3) enhances the capacity of CDPH partners to address and prevent obesity in their own work. With CDC funds, a connector team was hired and placed in the [Epidemiology and Prevention for Injury Control Branch \(EPIC\)](#) in Fall 2008. MCAH and CMS participate in an advisory capacity in their efforts to obtain stakeholder input and develop a Strategic Plan that leverages resources and coordinates multi-partner statewide efforts to address all of the following target areas: 1) increased physical activity; 2) increased consumption of fruits and vegetables; 3) decreased consumption of sugar-sweetened beverages; 4) increased breastfeeding initiation, duration and exclusivity; 5) reduced consumption of high-calorie, energy-dense foods; and 6) decreased television viewing.//2010//

/2007/ Childhood obesity in low-income children is surveyed through the Pediatric Nutrition Surveillance System (PedNSS) data that are now on-line on the CMS Branch website. Data for 2004 show that the percentage of low-income children under 5 years receiving healthcare through the Child Health Disability Program (CHDP) who are overweight is essentially unchanged from the prior two years at 16.3 percent. For children 5-20 years, the percent overweight has continued to increase annually and is 22.4 percent for 2004 (21.7 in 2003). [State of California, Department of Health Services, Children's Medical Services Branch. Sacramento, California, 2003. Available at: www.dhs.ca.gov/pcfh/cms/onlinearchive/pdf/chdp/informationnotices/2003/chdpin03q/contents.htm] //2007//

/2009/ The new website address for CHDP data can be found at <http://www.dhcs.ca.gov/services/chdp/Pages/PedNSS.aspx>. //2009//

/2010/ Current PedNSS data are available at the CHDP webpage: <http://www.dhcs.ca.gov/services/chdp/Pages/PedNSS2007.aspx>.

New this year is a sample format for sharing county and State PedNSS data with CHDP providers. The CHDP providers provide the data used in PedNSS reports when they submit billing for health screens. By providing a visual presentation of county and State surveillance

data, providers are sensitized to the increased incidence of childhood obesity in the low income population, as well as the recommended intervention messages.//2010//

/2009/ 2006 PedNSS prevalence reports on BMI for age is obtained from the Confidential Screening/Billing Report form completed by CHDP medical providers. 2006 PedNSS reports indicate statewide childhood overweight prevalence rates for children 2-5 years of age (16.2% overweight and 17.0 % obese) and children/adolescents 5-20 years of age (18.4 % overweight and 23.1 % obese) are essentially unchanged from recent years. California continues to rank third highest in overweight/obesity rates among states participating in PedNSS for ages 2-5 years. Additionally, California has 2006 PedNSS data for the 99th percentile BMI (sever obesity) by age. This report indicates a statewide prevalence rate of 6.1% for all ages, and a prevalence rate as high as 17.6% for Pacific Islander adolescents, ages 15-19 years.//2009//

/2010/ 2007 PedNSS rates for children 2-4 years of age are comparable to 2006 rates, with 16.2% overweight and 17.4% obese. 2007 PedNSS rates for children/adolescents who are 5-19 years of age is identical to 2006 at 18.4% for overweight and 23.1% for obesity. This surveillance provides reliable tracking of obesity rates over time. Childhood obesity continues to present as a significant public health problem in California, as evidenced by PedNSS prevalence rates.//2010//

/2009/Local CHDP programs have program performance measures related to monitoring and sharing county specific PedNSS data. More CHDP programs are using PedNSS data to determine prevalence rates of overweight in target populations and various county jurisdictions and for promoting action to enhance nutrition and physical activity behaviors and environments. The California Department of Education (CDE) plans to use PedNSS county data to orient over 5000 child care providers who participate in the Child & Adult Care Food Program (ages 0-13 years) to the increasing rates of childhood overweight and to promoting obesity prevention efforts. //2009//

/2008/ The percentage of low-income children under 5 years receiving healthcare through CHDP who are overweight continues to be higher than national prevalence rates, at 17.4% in 2005. Additionally, the percent of children 5-20 years who are overweight has continued to increase annually and is higher than estimates from the National Health and Nutrition Examination Survey (NHANES) III, at 22.7% in 2005.

In California, the CHDP program obtains nutrition status data from CHDP providers' Confidential Screening/Billing Report. California receives prevalence reports on more than 1.5 million children and adolescents, from birth to age < 20 years. Both county and statewide prevalence rates are available. Since California is one of the few states that provide data on older age children, national prevalence data is not comparable. //2008//

MCAH/OFP programs, including AFLP, BIH, California Diabetes and Pregnancy Program (CDAPP) and CPSP, promote healthy eating, physical activity, and breastfeeding. The MCAH in Schools Program promotes a comprehensive school health system, including physical education and healthy food choices.

/2007/ Nutrition Network funding for CHDP local programs ended in 2005. However, collaboration between MCAH agencies and local school districts has resulted in improved nutritional standards for school meals and campus snack machines, increased physical education activities and incorporation of healthy lifestyles education into school curricula. Outreach and education regarding healthy lifestyles are commonly presented to community

groups, parents, caregivers and staff at child care centers and incorporated into protocols for home health visits. Walk-to-school days have been organized in several counties. //2007//

/2008/ Obesity and breastfeeding continue to be high priority areas for county Title V block grants.

The MCAH/OFP Branch is co-chairing two Women's Healthy Weight Collaboratives in Los Angeles and Sonoma County. The collaboratives are technically supported by AMCHP, CityMatCH, and CDC. Many of the projects will have statewide influence; for example, Los Angeles is developing two handouts, one on breastfeeding and one on preconception weight, which will be used in state-sponsored Nutrition Network Workplace grants. //2008//

/2009/ Collaborative activities include developing workplace materials on women's weight and breastfeeding to go into the California Fit Business Kit, developing California leaders in this topic, holding vegetable tastings in a Latino community, providing adolescent cooking classes, working with redevelopment projects and coordinating public messages.

MCAH has been working with the MCAH jurisdictions to identify liaisons for the "walk to school" initiative and work with their school districts to have more participation in the Governor's and President's Physical Activity Challenges.

MCAH has been actively promoting healthy worksite practices within state and local MCAH programs including healthy snacks and physical activity breaks at meetings, healthy vending machines and worksite breastfeeding accommodation. //2009//

/2010/ In November 2008, MCAH implemented the "Here is Where Healthy Starts" Campaign, a worksites of excellence certification program. The campaign offers "Certificates of Excellence" to MCAH LHJs that implement a comprehensive worksite wellness initiative including nutrition, physical activity, injury prevention, and breastfeeding promotion. This certificate program was modeled after a healthy hospital award program coordinated by MCAH in response to the Governor's obesity summit.

The CHDP program collaborated with Kaiser Permanente to co-brand a poster with evidence-based messages regarding childhood obesity. This poster has been disseminated to local CHDP programs, CHDP providers and health plans, with the intent that it will be used as a provider prompt to deliver evidence-based counseling when obtaining a Body Mass Index percentile during the CHDP health screen. This provider tool will facilitate provider counseling and disclosure of BMI percentile. This poster is also used in a counseling module for CHDP provider offices to promote brief counseling techniques in the pediatric healthcare setting regarding childhood obesity. //2010//

/2008/ The fourth California Childhood Obesity Conference was held in January 2007. MCAH/OFP took an active role in planning for the conference and was instrumental in the inclusion of breastfeeding, the life-cycle, adolescent interventions, as well as a preconference for county obesity teams. The MCAH/OFP Branch convened a perinatal women's weight meeting in conjunction with the conference and took away recommendations for the Branch on improving perinatal weight. //2008//

/2010/ The MCAH Division and the CMS Branch are actively participating in the planning of the 2009 Childhood Obesity Conference entitled "Creating Healthy Environments For All Children" to be held June 9-12 in Anaheim, California. MCAH and CMS will moderate conference

sessions and present posters. CMS is instrumental in planning the health care track, while MCAH is working on the research track. The conference will build upon the past four conferences by promoting collaboration, showcasing evidence-based prevention interventions, accelerating the obesity prevention movement, and featuring community efforts. This year, a pre-conference session targets medical providers and is entitled, "Pediatric Obesity: Provider Skill Sets for Improved Care." Scholarships will be provided for CHDP and Medi-Cal providers who provide medical care to low income children.

The MCAH Division has taken a leadership role related to preconception, prenatal and postpartum nutrition and physical activity policy development for the nation. MCAH has staff on the Board for the Women's Health Dietary Practice Group of the American Dietetic Association; on a team that is establishing an MCAH Nutrition Focus Area of the Association of State and Territorial Public Health Nutrition Directors; and on the nutrition committee for revising the "Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs" developed by the AAP, the American Public Health Association (APHA), and HRSA's MCH Bureau.

The Alliance for a Healthier Generation has targeted California as one of the states to receive funding for medical nutrition therapy for low income children who are overweight. Anthem Blue Cross, one of the identified collaborators with the Alliance for a Healthier Generation, has partnered with CHDP on provider training on BMI percentile, and there is potential for additional partnering regarding access to medical nutrition therapy for low income children. //2010//

Breastfeeding

/2008/ Staff representing the MCAH/OFP Branch actively participate in the Breastfeeding Promotion Advisory Committee (BPAC) to develop strategies, recommendations, and implementation guidelines to promote, support, and protect breastfeeding in California. Throughout 2006, BPAC developed the CDPH's report of recommendations for promoting breastfeeding in California. MCAH/OFP Branch staff have provided both literary content and state, county and hospital level breastfeeding surveillance data tables and charts. The report is expected to be released in the summer of 2007. MCAH/OFP Branch is currently participating with the Women, Infant and Children Branch (WIC) to develop a CDPH Strategic Plan to address recommendations from the report.

As part of the UC Davis Breastfeeding Data Committee meeting held September 14-15, 2006, and sponsored by a CDC grant, MCAH/OFP Branch staff worked in collaboration with a variety of private and public stakeholders, including the BPAC, WIC Branch, the Genetic Disease Branch (GDB), the Office of Statewide Health Planning and Development, the California Hospital Assessment and Report Task Force (CHART), as well as private providers, such as Kaiser Permanente, Loma Linda and the UC Davis Medical Centers, and MCAH directors from Orange and San Diego counties, to review and revise the methodology for computing in-hospital breastfeeding rates. The MCAH/OFP Branch is currently revising in-hospital breastfeeding surveillance data tables (dating back to 1994) using the new methodology and will continue to annually publish county and hospital level breastfeeding surveillance tables by race/ethnicity. In addition, MCAH/OFP will provide hospital level breastfeeding rates to the CHART in support of its ongoing efforts to collect hospital performance measures for public reporting.

In order to more accurately measure in-hospital breastfeeding rates, MCAH/OFP Branch staff in consultation with various private and public stakeholders (listed above), worked to revise infant

feeding categories (used to derive in-hospital breastfeeding rates) and instructions on the Newborn Screening Test form maintained by the GDB. The infant feeding categories and instructions were revised through an iterative process based upon the results of pilot testing at selected hospitals. Conference calls were held in the fall of 2006 and three rounds of pilot testing of over 200 forms were conducted. The recommended changes were reviewed and approved by the full statewide BPAC. The revised Newborn Screening Test form will be released in late 2007, with full statewide implementation expected by 2008.

Questions to assist in estimating breastfeeding duration continue to be a part of the MIHA survey and are updated in consultation with BPAC and MCAH/OFP staff.

The MCAH/OFP Branch continues to provide consultation to hospitals on developing policies which promote and support breastfeeding. The breastfeeding page of the MCAH/OFP website has expanded its hospital breastfeeding policy toolkit, Emergency Preparedness links, Infant and Young Child Care and Feeding links, Medications and Breastfeeding links, and Family Planning and Contraception during Breastfeeding links. //2008//

/2009/ MCAH is partnering with WIC on developing an 8-hour hospital administrator training to promote the use of the model hospital policies.

MCAH has developed two new breastfeeding webpages: 1) for the MCAH Breastfeeding Program, and 2) for the CDPH Breastfeeding Initiative. Breastfeeding data is now more accessible and interactive. MCAH has also included additional resources in the Hospital Breastfeeding Policy toolkit.

MCAH has initiated Birth and Beyond California, a quality improvement project that works through three Regional Perinatal Programs to provide training, technical assistance and resources to hospitals with low in-hospital exclusive breastfeeding rates.//2009//

/2010/The 3 RPPC Regions included in the Birth and Beyond California (BBC) quality improvement project were selected due to their cumulative low rates of exclusive breastfeeding. 2006 breastfeeding initiation data for local hospitals demonstrated that these regions were in the lowest quartile of exclusive breastfeeding rates. At the same time, they accounted for over half of the births in the state.

A total of 27 hospitals are currently participating in this program, and more are added each 6-month cycle. All hospitals are in the process of implementing one or more evidence-based breastfeeding policies. To date, 110 "Decision Makers" have attended a BBC Introductory Session and 369 staff from 27 hospitals have received training. Of these, 87 attended "Train the Trainer" sessions so they can be BBC trainers for their own hospitals. The training materials, currently undergoing revision, are expected to be posted to the CDPH Breastfeeding website in order to make them available to all counties, not just those participating in the BBC Project.

In addition to working in the three RPPC regions noted above, MCAH assisted a group of six hospitals in San Joaquin County to attend trainings in RPPC Region 6(Los Angeles County) and pattern their training using the Birth and Beyond California materials.

The creation of "Networks" in each of the RPPC Regions as part of this project has been particularly valuable, facilitating collaboration among agencies that normally do not share information, tools and methods. All hospitals have needed assistance developing Quality

Improvement programs, as Maternity Services are usually not included in QI projects in most hospitals. In order to accomplish this, they have found they need to include their QI staff in the Interdisciplinary Teams created to implement breastfeeding policies.

CCS is partnering with CPQCC in a 2009 quality improvement collaborative to improve breastmilk nutrition in NICUs around the state. The expert panel is working to determine the number and levels of NICUs that will be invited to participate. This collaborative, similar to the Community NICU Hospital Associated Infection collaborative, will utilize the IHI model for quality improvement.//2010//

/2008/ The MCAH/OFP Branch provides information and support on ways to meet the requirements of the Lactation Accommodation Law and the right to breastfeed in public via website and telephone consultation. //2008//

/2009/ MCAH has continued to have a staff person attend the US Breastfeeding Committee and be involved in its national promotion of workplace lactation support. This work overlaps with another initiative of California's Office of Women's Health (OWH). Along with OWH and WIC, MCAH has met with the California Labor Commissioner to develop a plan to increase awareness and enforce the California Workplace Accommodation Law. Additionally, MCAH has been advocating for better lactation accommodation within CDHCS and CDPH. //2009//

Comprehensive Black Infant Health (BIH) Program Assessment

/2008/ The University of California San Francisco (UCSF) Center for Social Disparities in Health has completed and submitted to the Branch a comprehensive literature review of interventions for African American infant health outcomes, including infant morbidity and mortality reduction programs. UCSF is developing recommendations for the equitable method of distributing BIH resources among local BIH programs. The final BIH intervention recommendation report and the creation of a BIH data and evaluation work group are expected by the summer of 2007. Additionally, in collaboration with the Branch and data work group, UCSF will develop a process and outcome evaluation for the BIH program. //2008//

/2009/ "The Black Infant Health Program: Comprehensive Assessment Report and Recommendations" conducted by the UCSF Center for Social Disparities in Health was completed and distributed to California BIH and MCAH programs in April 2008. The report recommended the development and implementation of a single core model for all 17 local BIH program sites to enhance its impact on Black maternal and infant health. MCAH developed a workgroup of key stakeholders including local BIH and MCAH staff, state MCAH staff, and UCSF Center for Social Disparities in Health staff to develop the new model and a comprehensive evaluation plan. Once developed, the model will be presented at regional meetings to solicit feedback. //2009//

/2010/ MCAH has convened the BIH Program Development Workgroup to develop the single core model for all 17 local BIH program sites. The workgroup consists of representatives from the MCAH Division, the UCSF Center for Social Disparities in Health, and local BIH and MCAH programs. The workgroup has developed a new conceptual framework for BIH that integrates the most current scientific findings and state and national best practices. An outline of the revised model has also been developed, which includes eight major components. The revised model was presented at the Statewide BIH Meeting and was overwhelmingly approved.

Utilizing experts within local BIH programs, the workgroup is in the process of completing the revised model. //2010//

Black Infant Health / Fetal Infant Mortality Review (FIMR)

The BIH/FIMR Program was undertaken by the MCAH/OFP Branch in response to the persistent disparity between African American and white infant mortality rates. The goal of BIH/FIMR is to reduce African American fetal and infant deaths through review of these deaths at the community level. Eight BIH jurisdictions were selected for participation; all had an African American combined fetal and infant death rate above the average for the 17 BIH jurisdictions statewide, and all had a FIMR program.

BIH/FIMR uses the national FIMR model to collect detailed information about African American fetal and infant deaths beyond vital statistics. Data will be centrally collected and reportable at the state and county level. /2007/ The Branch is finalizing a contract with BASINET for a centralized BIH/FIMR data collection system. BIH/FIMR coordinators will be trained in its use. //2007//

/2007/ Utilizing data obtained from BIH/FIMR, the Los Angeles MCAH Program implemented the LA Mommy and Baby Survey (LAMBS) in the Antelope Valley. While the African American infant mortality rate decreased from 2002 to 2003, it still remains high when contrasted with the infant mortality rate for other ethnicities. Also of concern is the increase in infant mortality for Hispanic babies evidenced by the survey. LA MCAH has undertaken efforts to reduce infant mortality in both African American and Hispanic communities through enhanced access to quality, culturally sensitive obstetric care for at-risk women, including home visitation and assistance with psychosocial issues. //2007//

/2008/ The Los Angeles MCAH Program piloted LA HOPE (Los Angeles Health Overview of a Pregnant Event), a population-based survey that serves as a data collection tool for maternal interviews for the LA County FIMR program. The LA HOPE survey asks women who have suffered a fetal/infant loss about a variety of topics, including preconception, interconception medical history, psychosocial factors, risk-taking behaviors, nutrition, prenatal care, environment, and grief and bereavement services. //2008//

/2009/ The MCAH Program is assessing the BASINET system and comparing it with LA HOPE in an effort to determine an effective, streamlined process for centralized data collection. Convenient and effective data collection will assist the BIH/FIMR jurisdictions in the determination of appropriate community action to address the factors contributing to fetal/infant deaths in their communities. //2009//

Implementation of BASINET for BIH/FIMR

/2008/ The MCAH/OFP Branch contracted with GO Beyond LLC to use the Baby Abstracting System and Information NETwork (BASINET) for the Black Infant Health/Fetal Infant Mortality Review (BIH/FIMR) Project. BASINET is a web-based project management system for fetal and infant mortality review that combines data abstraction, deliberations, and detailed on-demand reporting. In-person training of BASINET was provided by GO Beyond LLC in August 2006 for the eight BIH/FIMR jurisdictions that are pilot testing this data collection system with in-person follow-up trainings in January 2007. The first reports from the eight jurisdictions are expected in

August 2007. Depending on the effectiveness of BASINET as a data collection system for BIH/FIMR, BASINET may be used in other counties with Branch-supported FIMR projects to provide more centralized and higher quality fetal and infant mortality data at the state and local level. //2008//

/2009/ A survey of the eight jurisdictions using BASINET was conducted in September 2007. Valuable feedback and suggestions to improve the BASINET data collection system were obtained. MCAH is working with Go Beyond LLC to implement the suggested improvements to the system. //2009//

High-risk Infants

/2007/ The CCS Program has structured a system of regional affiliation among the 114 CCS-approved neonatal intensive care units (NICUs) to assure that infants have access to appropriate quality specialty consultation and intensive care services throughout the state. CCS-approved NICUs are designated as Intermediate, Community, and Regional NICUs. NICUs that provide basic level intensive care services to infants in their communities are required to have established affiliations with NICUs that provide more extensive services, to facilitate consultation and patient transfers as needed. CCS sets standards for all CCS-approved NICUs and periodically conducts NICU site visits to help ensure standards are followed. Included in the standards is a requirement to submit annual morbidity/mortality data to CCS. The CMS Branch began requiring all CCS-approved hospitals to submit CCS NICU annual data through the California Perinatal Quality Care Collaborative (CPQCC) beginning with Calendar Year (CY) 2004 data. Reporting through the CPQCC facilitates data submission and analysis, provides feedback to the NICUs, and improves reporting accuracy. //2007//

/2007/ Each CCS-approved NICU facility is required to have an organized High-Risk Infant Follow-Up (HRIF) program or a written agreement for the provision of these services by another NICU facility to ensure follow-up. After reviewing functions and responsibilities of the NICU HRIF program and the contractual Medically Vulnerable Infant Program (MVIP), CMS is combining these two programs into one program that addresses the needs of high-risk infants. In the formative phase of combining the programs, a group of 30 stakeholders was convened and invited to provide input to CMS on ways for delivering services, defining the eligible population, defining data collection elements, and evaluating the outcomes of the program. The newly formed HRIF program will begin in July 2006, building upon the NICU HRIF programs already in place throughout the state. CMS is working with CPQCC to build upon the data that all CCS-approved NICUs currently submit. The ability to collect expanded data elements will give the HRIF programs and the NICUs the opportunity to evaluate the outcomes of their NICU high-risk infant graduates. //2007//

/2008/ The HRIF programs began submitting data using the new reporting requirements July 1, 2006. Currently the programs are submitting the data to CMS to be entered. Future planning includes electronic transmission of data for analysis and reporting through CPQCC. Some of the data reported are birthweight, gender, gestational age at birth, medical criteria, rehospitalization, visual and sight impairment, as well as several other socio-economic factors. //2008//

/2008/ The HRIF data support program evaluation and quality improvement activities. In addition, the HRIF team visit summary report provides information for case management to the county CCS programs. The data will also be a valuable adjunct to the neonatal morbidity quality

improvement projects conducted by CPQCC at all CCS-approved hospitals in California. //2008//

/2009/ The HRIF Executive Committee is in the final phase of developing the new electronic reporting form. This reporting tool will be required to be used by all HRIF programs throughout the state and is designed to enhance program consistency, efficiency, and be linkable with other data sets to inform quality improvement activities. //2009//

/2010/ Goals and objectives in the development of the HRIF Quality Care Initiative (QCI) were established after meetings of the HRIF QCI Executive Committee and sub-committees. Recommendations were made by the HRIF QCI Executive Committee as to the data elements necessary and appropriate to report in order to achieve stated outcomes of the HRIF QCI. A web-based data reporting system was designed and developed under the direction of the Director of Informatics System Development, Center for Clinical Informatics, Stanford University, School of Medicine. Seven training sessions on the new data system were held statewide in February 2009, with 250 participants attending from 91 centers. The HRIF electronic reporting system began April 1, 2009. Training materials and a users/data entry manual were developed and disseminated to HRIF programs in the state. Technical assistance will be available to all web users. Between May 16, 2008 and February 19, 2009, 5,886 registration forms were submitted by 60 HRIF programs. //2010//

Use of Data and Geographic Information System (GIS) in Policy and Planning

/2008/ The MCAH/OFP Branch is participating in the Departments' GIS Working Group to establish centralized GIS tools for the Departments. This will allow for interdepartmental use of the same GIS server and will enable sharing of Departments GIS maps and data sets. //2008//

Improving Quality of Vital Statistics Data

/2008/ The MCAH/OFP Branch promoted changes to birth, death, and fetal death certificates to increase the data collection quality of vital statistics collected by the state. Using the birth certificate as an example, Branch efforts led to the addition of 1) obstetric estimate of gestation at time of delivery; 2) infant hearing screening; 3) maternal smoking assessment; 4) pre-pregnancy maternal weight and height measurements; and 5) APGAR scores at 1, 5, and 10 minutes.

In a complementary action, the Branch's Regional Perinatal Programs of California Coordinators (RPPC) teamed up with the Office of Vital Records (OVR) staff to provide local trainings of birth certificate clerks to improve birth certificate data collection methods, resulting in significant improvements in data completeness and quality. Some birth clerk trainings scheduled in 2006-2007 were cancelled by OVR. The need for ongoing birth clerk training remains a priority for accuracy of data. In order to address this, RPPC staff and OVR are collaborating to do an additional training session that will be videotaped and made into DVD recordings to be distributed to local hospitals.

Additionally, the Branch is working with OVR to determine whether the Branch's Sudden Infant Death Syndrome and Fetal Infant Mortality Review data collection can be incorporated into the OVR electronic death registry system. //2008//

/2009/ MCAH and RPPC were unable to make a video presentation, but in collaboration with OVR, there are eight birth clerk workshops scheduled in 2008 throughout the state. The focus is to reduce the number of unknown or missing data items and to share best practices. //2009//

/2010/ MCAH is fortunate to continue collaborating with OVR and RPPC to provide an additional seven Birth Clerk Trainings from April through October 2009. In addition to focusing on missing data, the RPPC will provide some simple explanations for technical medical terms that are not reported or are under reported. Examples will be provided to demonstrate the extensive use of vital statistics data. They will assist birth clerks to determine where this information may be obtained in the medical records as well as from the patients. Birth clerks will receive copies of the recently developed information sheets from the California Birth Defects Monitoring Program, as well as instruction in the use of gestational wheels—supplied by March of Dimes—to assist in more correctly determining the date of the last menstrual period for birth certificates. The birth clerks will also learn how to handle gathering data from mothers who are reluctant to respond or uncooperative in providing information. //2010//

Early Childhood Development

Proposition 10, the Children and Families First Act of 1998, imposes a surtax on cigarette sales, which generates revenues of about \$600 million a year. The state-level commission, First 5 California, receives 20 percent of the funds, while local First 5 Commissions in each of the 58 California counties receive 80 percent. First 5 California devoted \$207 million over four years (2002-2006) to its signature School Readiness Initiative (SRI). /2007/ First 5 recently reauthorized the SRI for another four years (2006-2010), with funding of \$400 million. //2007//

/2007/ First 5 has several other efforts addressing early childhood health and development: 1) Health Access for All Children, a gap insurance product for children who are ineligible for Medi-Cal or Healthy Families and whose family income is below 300 percent of FPL; 2) Early Childhood Oral Health Initiative; 3) Early Childhood Obesity Prevention media campaign; and 4) Child Care Health Linkages Project. The MCAH/OFP Branch follows the activities of First 5 and helps local staff prepare SRI proposals and identify the connections between their programs and First 5 activities. //2007//

/2007/ MCAH/OFP has received a multi-year grant beginning in 2003 from the federal Health Resources and Services Administration (HRSA) for the State Early Childhood Comprehensive Systems (SECCS) project. MCAH/OFP provides state-level leadership for early childhood health programs to help California's children be emotionally, socially, and physically ready for kindergarten. Two years of planning culminated in a statewide needs assessment and strategic plan to address critical components of early childhood health care systems. The project is now in the implementation phase. //2007//

/2008/ The current focus of the SECCS project includes identification of recommended screening tools and associated best practices, as well as recognition of critical partners and funding opportunities to provide a seamless delivery of services. //2008//

/2009/ CA ECCS supports the Los Angeles County Early Identification and Intervention Collaborative (EIIC) to improve and expand timely identification of, and intervention for, children with or at risk of delays, disabilities and other barriers to development. //2009//

/2008/ The National Academy for State Health Policy (NASHP) awarded CDHS a technical assistance only grant to participate in a 15 month national consortium to develop policy and improve early identification of young children with developmental problems. The Assuring Better Child Health and Development (ABCD) Screening Academy Initiative's goal is to integrate valid and standardized tools of children's development into preventive health care practices. MCAH, CMS, Medi-Cal, AAP, the First 5 California Commission are the Core Leadership Team members who will work with public-private partners. //2008//

/2009/ The ABCD Screening Academy policy activities are focused on recommending use of standardized screening tools within the revised CHDP Health Assessment Guidelines. //2009//

Newborn Hearing Screening Program Expansion

/2008/ New legislation expands the Newborn Hearing Screening Program (NHSP) to all general acute care hospitals with licensed perinatal services, effective January 1, 2008. The program currently is operational in 175 hospitals that deliver over 411,000 infants per year. This expansion will include 95 more hospitals and result in an additional 130,000 infants receiving hearing screening each year. It is expected that a total of 1000 infants will be identified with hearing loss every year after full implementation.

The NHSP has numerous infrastructure building blocks in place. These include standards for inpatient and outpatient screening providers, certification criteria for participation in the program, guidelines for infant audiological diagnostic evaluations, and Hearing Coordination Centers (HCCs). The HCCs are an integral component of the California program. Each one is responsible for a specified geographic service area to assure compliance with standards, tracking and monitoring of infants who need outpatient follow-up, and linkage of families of children identified with hearing loss to early intervention, medical, and support services. This infrastructure will support a seamless expansion of the program.

The biggest challenge for the NHSP during this final implementation phase will be to address the increased workload in the data management arena. The program currently collects all infant data through a paper reporting process. The NHSP is in the process of procuring a data management service that will be utilized by the hospitals, HCCs, and state office for tracking and monitoring, quality assurance, program evaluation, and statewide reporting. The service will enhance the operations of the program and improve the accuracy and reliability of the data. //2008//

/2009/ The program initiated a competitive procurement process to identify HCCs to perform the expanded scope of work associated with 95 additional hospitals and 130,000 additional infants receiving hearing screening each year. There were three successful bidders for the four geographic service areas. Each HCC has already begun the work of certifying the new hospitals. As of March 2008, there were 187 hospitals certified, 12 of which were new expansion hospitals. It is estimated that all new hospitals will be certified by the end of 2008.

The program is finishing a Request for Proposals (RFP) to procure a data management service to support the work of the hospitals, HCCs, and state staff. The tentative release date for the RFP is April 2008. //2009//

/2010/ As of December 2008, 224 hospitals were certified to participate in the NHSP, including 48 new expansion hospitals. It is expected that all California hospitals with licensed perinatal

services will be certified during CY 2009. In June 2008, Neometrics, a division of Natus Inc., was selected through a competitive bidding process to provide a data management service to the NHSP. Due to the fiscal crisis in California, the execution of this contract has been delayed. It is anticipated that the contract will begin July 1, 2009, with statewide implementation of the service completed by June 30, 2010.//2010//

Child Health Insurance Coverage

Another major state initiative is improving the health of the Title V population through expanded health insurance coverage.

/2007/ Since the inception of the CHDP Gateway in July 2003 and through February 2006, over 1.9 million children receiving CHDP assessments have been pre-enrolled for up to two months of no cost full-scope Medi-Cal benefits. Families of 70 percent of these pre-enrolled children have requested joint applications from Medi-Cal/HF. Of these, 20 percent had their eligibility extended for Medi-Cal/HF. //2007//

/2008/ From July 2003 through December 2006, over 2.5 million children receiving CHDP assessments have been pre-enrolled for up to two months of no cost full-scope Medi-Cal benefits. Of these children, 76% requested joint applications from Medi-Cal/HF and 18% had their eligibility extended. //2008//

/2009/ From July 2003 through December 2007, over 3.5 million children receiving CHDP assessments have been pre-enrolled for up to two months of no cost full-scope Medi-Cal benefits. Of these children, 69% requested joint applications from Medi-Cal/HF and 8% had their eligibility extended. //2009//

/2007/ Effective June 2004, the CHDP Gateway was enhanced to allow deeming of Medi-Cal eligibility for infants if their mother's eligibility for Medi-Cal at the time of birth was confirmed. Eligibility is extended until the first birthday without requiring their parent(s) to complete a joint Medi-Cal/HF application. From June 2004 through February 2006, 102,449 infants were automatically enrolled in Medi-Cal as the result of a Gateway transaction. //2007//

/2008/ From June 2004 through December 2006, 157,378 infants were automatically enrolled in Medi-Cal as the result of a Gateway transaction. //2008//

/2009/ In FY 2006-07, 57,118 infants were automatically enrolled in Medi-Cal as the result of a Gateway transaction. //2009//

/2010/From June 2004 through December 2008, 285,027 infants were automatically enrolled in Medi-Cal. In FY 2007-08, 69,903 infants were automatically enrolled in Medi-Cal as the result of a Gateway transaction.

In December 2008, First 5 California provided emergency funding to the Healthy Families Program to continue to enroll infants and children, ensuring them access to much needed health care services.//2010//

Oral Health Promotion

CDHS is responding to the high prevalence of dental disease among California's children with a variety of strategies to increase awareness of oral health. MCAH/OFP Branch staff work to ensure the inclusion of oral health promotion activities within existing programs of the Branch. Comprehensive Perinatal Services Program (CPSP) guidelines have been revised to include oral health guidelines for pregnant and postpartum women. Toothbrushes and children's fluoride toothpaste have been distributed to domestic violence shelters as well as local MCAH programs including the Adolescent Family Life Program and the Black Infant Health Program.

/2010/ In FY 2007-2008, a total of 1,683,900 children received dental screenings through the CHDP program, a decrease of 4.4 percent from the previous year. Although dental screenings have decreased, CHDP is working with local program staff to increase dental referrals and access to care. A brochure has been developed to make providers and families aware of the need for a "dental home." A handbook is being developed for CHDP providers to encourage dental referrals beginning at age one and to establish the dental home early. CHDP providers have also been encouraged to provide fluoride varnish at CHDP health assessment visits and other visits to total three times each year for children ages 0-6 years. //2010//

The MCAH/OFP Branch is contracting with University of California San Francisco (UCSF) for an oral health epidemiologist and a dental hygienist to serve as MCAH/OFP Oral Health Policy Consultants to meet the growing demand for technical assistance at both the state and local levels. The contract is awaiting state approval. The Oral Health Policy Consultants will work with Branch programs as well as being involved with the state First 5 Commission.

/2007/ The contract was approved, but has subsequently been reduced due to budget cuts. The epidemiologist position has been eliminated. //2007//

The First 5 California Commission has developed an Oral Health Initiative, which consists of 1) a \$7 million Early Childhood Oral Health Education and Training Project, and 2) a \$3 million Insurance-Based Oral Health Demonstration Project. Provider training began in 2004 and will continue through 2008; the demonstration project ends in 2006.

/2007/ In FY 2004-05, 1,839,706 children received dental screenings through the CHDP program, an increase of 2.9 percent from FY 2003-04 (1,788,460). CMS Branch staff continues to meet with Denti-Cal to work on solutions for improving access to dental/orthodontic care for children enrolled in the California Children's Services program. //2007//

/2010/ The Early Childhood Oral Health Education and Training Project ended in 2008, with a total of 15,230 dental and medical providers and an additional 883 staff from community service organizations attending trainings focused on preventive education and services for children aged 0-5 years. The training curriculum, with supporting documents and references, continues to be available on the First 5 Oral Health website.//2010//

/2009/ In FY 2005-2006, 1,795,731 children received dental screenings through the CHDP program and in FY 2006-2007, 1,760,500 children received dental screenings through the CHDP program, which represents a 4% and 2% decrease respectively. //2009//

/2008/ To assess the oral health status of elementary school children in California, the Office of Oral Health (OOH) and MCAH/OFP, along with California Department of Education (CDE), Dental Health Foundation and numerous other partners conducted dental screenings in 186

elementary schools throughout the state on over 21,000 students in kindergarten and third grade in 2005. In February 2006, the results of the assessment were published in a report entitled "Mommy, It Hurts to Chew – The California Smile Survey – An Oral Health Assessment of California's Kindergarten and 3rd Grade Children". This report showed that nearly three-quarters of California's low-income third graders have suffered from tooth decay. Even more distressing, 28% of children surveyed had untreated decay, and 4% of children needed urgent dental care because of pain or infection. //2008//

/2008/ The Community Water Fluoridation Program of the OOH provides scientific and technical expertise to communities interested in fluoridating their drinking water. CDPH contracts with the UCSF School of Dentistry to oversee the OOH's California Children's Dental Disease Prevention Program (CDDPP) which serves more than 342,000 California preschool and elementary school children annually. Currently, the CDDPP operates 33 school-based programs in 32 counties throughout the state, providing fluoride rinses and supplements, oral home care instruction, and dental sealants. Plans to expand this Program into more schools in Northern California are being finalized through a grant provided by the Sierra Health Foundation. //2008//

/2009/ Information has been collected regarding the extent of selected oral health programs within MCAH jurisdictions in California. OOH has renewed all 33 contracts for the 2007-10 funding cycle in CDDPP. However, the number of children being served was reduced by 9000 from the previous 3-year cycle. In 2007, Sierra Health Foundation funded new 3-year BrightSmiles grants for 5 existing CDDPP programs and 5 new programs modeled on CDDPP. The BrightSmiles programs propose to serve 9500 children per year. MCAH local programs continue to address oral health needs in 21 jurisdictions. Ten of these programs have an oral health coordinator on staff. //2009//

/2010/The Fresno County CDDPP program was discontinued due to budget constraints. Riverside and Santa Barbara Counties are considering the transfer of their CDDPP programs to local educational departments. All remaining CDDPP contracts were amended to reflect a 10% budget cut mandated by the state. BrightSmiles lost one local program but continues to monitor the other nine, which served 9078 children. MCAH has 24 jurisdictions that have selected oral health as a priority. Thirteen of these programs have a minimum of one part-time oral health coordinator/consultant on staff.//2010//

/2009/ Under the guidance of the Community Water Fluoridation Program of the OOH, the Metropolitan Water District (MWD) of southern California began fluoridating its water supply in the fall of 2007. MWD is a consortium of 26 cities and water districts that provides drinking water to nearly 18 million people in parts of Los Angeles, Orange, San Diego, Riverside, San Bernardino, and Ventura counties. Other locations, such as Yolo and Sacramento counties, have secured funding to implement water fluoridation. OOH and CDPH developed a position statement to address safety concerns about reconstituting powdered or liquid infant formula with fluoridated tap water for infants younger than the age of one year. The position statement is posted on the OOH website with additional links. //2009//

/2010/The MCAH Oral Health Program webpage was completely redesigned and updated with resources and information for both providers and the public.//2010//

/2008/ The MCAH/OFP Branch has contracted with UCSF School of Dentistry for a dental hygienist to serve as the MCAH/OFP Oral Health Policy Consultant. Early tooth decay prevention among children aged 6 months to 5 years is being stressed throughout the state. In June 2006, the application of fluoride varnish by doctors and nurses was added as a

reimbursable Medi-Cal benefit for children younger than six years of age. Current oral health information, such as the advantages of fluoride varnish in preventing tooth decay, has been distributed among Branch program staff, as well as local jurisdictions. The First 5 California Commission is continuing the First Smiles program to train medical/dental providers to examine and assess their young patients' dentition and to provide fluoride varnish applications and anticipatory guidance. //2008//

/2008/ Based on a recent survey, 29 of the 61 MCAH local jurisdictions have identified oral health as one of their priorities in their 5-year implementation plans. These jurisdictions have community dental health advisory boards comprised of members from medical, dental and educational professions. The boards develop and implement local dental screening and prevention programs such as Give Kids a Smile Day in February, where volunteer dentists, hygienists and assistants provide dental screenings and treatment to low-income children. They also increase access by encouraging more pediatric and general dentists to become Denti-Cal providers. In one case, three counties have teamed up to build and staff a pediatric dental clinic that will treat low-income children that have extensive tooth decay and require general anesthesia. Other jurisdictions enlist the services of local dental and dental hygiene schools to screen and provide treatment. Fourteen jurisdictions are able to refer clients to mobile van preventive and/or treatment services. //2008//

/2008/ Five MCAH programs have a dental coordinator on staff. Other jurisdictions rely on local CDDPP and/or CHDP coordinators to integrate oral health outreach programs into MCAH target populations. Local agencies, such as Head Start, First 5, CHDP, and WIC, work to incorporate screenings, provide fluoride varnish applications, and promote preventive oral health practices to pregnant women, new parents, and children. MCAH case management programs, such as CPSP, BIH, and AFLP, enroll women and their families into Medi-Cal and Healthy Families insurance, and provide them with necessary dental referrals. //2008//

/2008/ MCAH continues to collaborate with a number of organizations concerned with promoting oral health throughout the state. These organizations include Head Start, CHDP, Oral Health Access Council and the CDPH Dental Workgroup, which is made up of members from OOH, CHDP, and Medi-Cal, as well as First 5, UCSF, Dental Health Foundation and California Dental Association. MCAH also participates with the Best Practices for Oral Health Access: California State Action Plan, which actively seeks to reduce early childhood caries in children age 0-5 years. //2008//

/2010/ The California State Action Plan committee has ended as a result of budget cuts and resultant staff reductions.//2010//

/2009/ Local MCAH programs continue to encourage pediatric medical providers in both fee-for-service and managed care health plans to perform oral health assessments, fluoride varnish applications and provide referrals for dental services to their patients. Fluoride varnish is a reimbursable Medi-Cal benefit for children younger than six years of age and has been shown to be highly effective in reducing tooth decay. With funding from a 2007 HRSA 3-year grant, the Dental Health Foundation (DHF) and WIC are collaborating to begin providing these same oral health preventive services to children enrolled in selected WIC agencies in California. This project will start with two pilot sites in Alameda and Humboldt counties, with additional sites to be added later. //2009//

/2010/ Alameda and Humboldt have begun their programs integrating oral health assessments, education, fluoride varnish applications, and linkage to dental providers for children 1 year old

and their siblings. Three more sites have been added across the state under the HRSA grant.//2010//

/2009/ State legislation (AB 1433) implemented in 2007 requires that children have a dental check-up by May 31 of their first year in public school, at kindergarten or first grade. If a dental check-up cannot be obtained, parents may get an excuse from this requirement by filling out a form provided by the child's school. Data collected from these check-ups and forms by the CDE will indicate children who need further examination and dental treatment and will identify barriers to receiving care. The ultimate goal of this program is to establish a regular source of dental care for every child. //2009//

/2010/Budget concerns threaten the capacity of local school districts to continue the data collection and reporting on oral health assessments, as required under AB 1433. //2010//

/2009/ MCAH is collaborating with other state and advocacy groups to educate medical/dental providers about the importance of proper oral health care before and during pregnancy. Children Now along with DHF presented a policy brief to the state Legislature recommending prenatal and early childhood best practices and guidelines. This was followed by a session at the Second National Summit on Preconception Health and Health Care about integrating oral health into primary and obstetric care as well as dental care programs. Plans are now going forward to obtain funding for a statewide conference of oral health experts and other health providers to develop and distribute guidelines about appropriate oral health care practices for women to reduce pregnancy complications caused by poor maternal oral health. //2009//

/2010/ A Perinatal Oral Health Consensus Conference with an expert panel was held in February 2009. The conference advisory committee members and the technical writer are developing a set of oral health clinical guidelines for medical and dental providers engaged in the care of pregnant women and their children. Distribution of these guidelines is planned later in this year. MCAH has a representative on the advisory committee.

The state budget calls for the elimination of optional benefits under Medi-Cal, including adult dental services. However, under federal law, the state must continue certain services to eligible Medi-Cal beneficiaries such as EPSDT services for recipients under age 21 and pregnancy-related services. A budget proposal to eliminate the state and local First 5 Commissions and reduce local funding by 50% and redirect these funds to existing children's health and childcare programs was rejected by voters in the May 2009 special election. Currently all local health jurisdictions rely on First 5 funding for their oral health programs, which support direct services, oral health education, fluoridation, clinic infrastructure and provider capacity. Eliminating the control to address and fund local oral health needs would be devastating to these jurisdictions. //2010//

Eliminating Racial and Ethnic Disparities in Health

Racial and ethnic disparities continue to exist in the areas of infant mortality, neonatal mortality, preterm delivery, low birthweight and maternal mortality in California. The MCAH/OFP Branch makes cultural sensitivity a cornerstone of every program activity, including AFLP, the Battered Women's Shelter Program (BWSP), BIH, CDAPP, and CPSP.

/2009/ Increasing the quality and years of healthy life, reducing disparities and promoting health equity is one of the goals identified in the CDPH Strategic Plan. The MCAH Program is taking

the lead on the proposed objective for reducing infant mortality by developing an action plan to directly address the persistent disparity between African American and White infant mortality rates.

MCAH plans to conduct a comprehensive review of existing MCAH programs to assure that health disparities are addressed. In addition, MCAH will work with various state agencies and community partners to develop a more comprehensive approach to reducing health disparities by expanding existing relationships, as well as securing other partners as gaps arise. //2009//

/2010/ The Black Infant Health program, which was established due to disparities in birth outcomes between African Americans and Whites, is central in efforts to eliminate racial health disparities. The program's goal is to decrease these disparities by providing women, their families and the community with services that address the factors that negatively impact birth outcomes.

On February 19, 2009, the California Maternal Quality Care Collaborative hosted a special discussion on racial and ethnic disparities at its Executive Committee Meeting. The rate of pregnancy-related deaths among African-American women in California is three times higher than rates for Whites or Hispanics (37.6 deaths per 100,000 live births for African-Americans versus 12.0 and 11.9 for Whites and Hispanics, respectively). Invited presenters included Paula Braveman, MD, MPH, Professor of Family & Community Medicine and Director, Center on Social Disparities in Health, UCSF; Michael C. Lu, MD, MPH, Associate Professor, Department of Obstetrics & Gynecology, David Geffen School of Medicine Department of Community Health Sciences, School of Public Health, UCLA; Amani Nuru-Jeter, PhD, MP, Assistant Professor, UC Berkeley School of Public Health; and Paul Wise, MD, MPH, Professor of Child Health and Society, Stanford University. This discussion generated considerable interest and engagement among Executive Committee members to develop strategies for further action. //2010//

CDAPP incorporates cultural competence awareness in all CDAPP trainings and materials. At-risk women, including Hispanic, African American, and Asian/Pacific Islander women, are targeted. Direct services are provided by a well-trained, ethnically diverse work force of diabetes and pregnancy specialists. Food plans are developed to include foods that are compatible with the dietary customs of each client.

/2009/ To raise awareness of the disparities in diabetes among women of color, MCAH prepared a CDAPP and gestational diabetes fact sheet to post to the CDAPP website titled "The Percentage of Resident California Women by Race/Ethnicity Hospitalized for Labor and Delivery in California with a Diagnosis of Gestational Diabetes in 2005." //2009//

California's BIH programs have served as a national model by successfully identifying and enrolling the highest risk population, pregnant and parenting African American women, for focused interventions. Comprehensive services offered to this population include the development of client-centered, culturally sensitive education, case management, and prenatal and pediatric care.

State outreach efforts have been designed to reduce the disproportionately high rates of uninsured among California's ethnically diverse populations. To improve access to Medi-Cal services, all Medi-Cal Managed Care materials are to be made available in ten threshold languages: Spanish, Chinese, Vietnamese, Cambodian, Hmong, Laotian, Korean, Russian, Farsi, and Tagalog.

HIV/AIDS disproportionately impacts African Americans in California. To address some of the needs among pregnant African American women, CDPH Office of AIDS is sponsoring regional HIV trainings for BIH providers. These trainings will cover basic science and HIV prevention to be used by BIH providers when discussing HIV risk with clients.

/2009/ Initiatives in preconception care include California's effort to curb neural tube defects, such as spina bifida, which are found in about 1 in 1,480 pregnancies in California. Although publication show that Hispanic infants fare well at delivery (even without prenatal care), MCAH data shows that Hispanic infants are 1.5 to 2 times more likely than infants of other races in California to be born with a neural tube defect. //2009//

/2010/ In response to an analysis of California data showing decreased folic acid consumption among Latina women, MCAH sponsored a multi-pronged folic acid awareness campaign in the spring of 2009.//2010//

/2009/ Infants who are not breastfed have been found to suffer greater infant morbidity and mortality and have a higher risk of obesity and diabetes. Newborn screening data indicates a great disparity in exclusive breastfeeding rates between White mothers (64%) and Hispanic (32.1%) and African America (34.2%) mothers. MCAH and RPPC, collaboratively, offer training through a pilot project to staff in hospitals with the lowest exclusive breastfeeding rates. The trainings focus on hospital policies that provide mothers with appropriate, evidence-based support and raising awareness that mothers of all ethnicities and races are choosing to breastfeed. The training materials will be made available on the CDPH website. //2009//

/2009/ A new study shows that dental care utilization is an economic issue rather than a racial/ethnic one. Since African Americans and Hispanics have a higher poverty rate than Whites, it is a major contributor to racial/ethnic differences. In addition, more children and families of minority populations suffer from untreated tooth decay. Increasing awareness of Denti-Cal benefits among Medi-Cal recipients continues to be a challenge and priority of MCAH and our oral health partners. //2009//

Adolescent Family Life Program Report

/2008/ In February 2007, the MCAH/OFP Branch released a report on the Adolescent Family Life Program. The report contains a history and description of the program; information about providers and funding, including fiscal challenges; a profile of female clients; and a discussion of process and outcome indicators, including early prenatal care, birthweight, repeat births and contraceptive use, education continuation, and service referrals. It also includes some client stories.

This report is not intended to be a formal evaluation of the AFLP Program. An evaluation would require comparison of outcomes to a control group that did not participate in the AFLP Program, and such a comparison was beyond the scope of this project. However, comparative data were included when they were available. For some indicators, such as birthweight, comparisons were made to teen births statewide. For other indicators, such as contraceptive use and educational continuation, comparisons were made of client behavior at entry into AFLP and at the most recent follow-up visit. Data comparing California to other states were also included. //2008//

Adolescent Health Promotion

The state has formed the California Initiative to Improve Adolescent Health, based on the National Initiative to Improve Adolescent Health by the Year 2010. In response to the interest among county MCAH directors and local agencies, the MCAH/OFP Branch contracted with the National Adolescent Health Information Center (NAHIC) at UCSF to work with local programs to promote the plan and provide technical assistance in the development of activities.

/2007/ Due to Title V budget cuts, the adolescent health improvement contract with NAHIC has been eliminated. //2007//

/2009/ MCAH has again contracted through UCSF/NAHIC with the California Adolescent Health Collaborative (AHC) to: 1) provide information, resources and expertise to support the provision of quality health care services to adolescents; 2) increase the capacity of local MCAH jurisdictions and their adolescent health practitioners to promote the health of adolescents and 3) influence policy with the intent of improving the health and well being of California's adolescents. AHC's intended activities include: 1) assisting MCAH programs in promoting and strengthening infrastructures and policies that support adolescent health; 2) increasing the availability and utilization of adolescent health data and supporting the data integration efforts of ASHWG; 3) increasing health providers' sexual health knowledge by promoting the ASHWG Core Competencies for Adolescent Sexual and Reproductive Health through curriculum development and training; 4) increasing the capacity of healthcare providers working with adolescents in foster care and 5) improve the ability of healthcare systems to provide appropriate mental health services to adolescents. //2009//

NAHIC produced the Guide to Adolescent Health Data Sources to assist local MCAH directors and others interested in adolescent health to better assess the needs of youth in their community. In addition, a California Adolescent Data Update on Intentional and Unintentional Injury was developed for dissemination at the Conference on Childhood Injury Control.

/2008/ The California Adolescent Sexual Health Workgroup (ASHWG) is a standing workgroup with leadership comprised of program managers from the California Departments of Education and Public Health (MCAH/OFP Branch, STD Branch, Office of AIDS), the California Family Health Council which administers the Title X funds for California, and a local MCAH director. The workgroup is committed to working more effectively to address the sexual and reproductive health of adolescents in California. Two priority areas are currently being addressed: core competencies have been developed for the provision of adolescent sexual health education and counseling. These are being widely disseminated for feedback to assure they meet the needs of intended users. Secondly, a data integration subcommittee is working to assure easy access by local jurisdictions to sexual health and behavior data that is typically only accessible from multiple sources. //2008//

/2009/ MCAH continues to have an active role on the ASHWG Steering Committee and the workgroup's two major activities:

- ASHWG's Data Integration Subcommittee is in the process of finalizing and posting online standardized statewide data sets for HIV, STD, and teen births that will be updated annually. In addition, similar data sets will be created for high-priority LHJs in California.
- ASHWG's Core Competencies Subcommittee finalized the competencies endorsement through a process that has involved: California experts from various disciplines and programs; a Web-based survey of teachers and STD, HIV and family planning

practitioners; and a panel of national experts in adolescent sexual and reproductive health, who are providing final revisions for the 2008 edition of the Core Competencies. //2009//

/2010/ ASHWG is disseminating the Core Competencies for Adolescent Sexual and Reproductive Health through the websites of the California Adolescent Health Collaborative (CAHC) and MCAH Division. The workgroup is now looking at developing a curriculum, as well as a user's guide and tools for applying the core competencies.//2010//

/2009/ ASHWG partnered with the Center for Research on Adolescent Health and Development, Public Health Institute, to implement the Across the Map survey. ASHWG provided input on survey questions addressing parents' opinions about comprehensive sexuality education in California public schools as well as opinions about HPV vaccination. ASHWG was acknowledged for consultation and review in the resulting publications. //2009//

/2010/The CAHC just completed a statewide, county-level review of adolescent health indicators. CAHC will next conduct qualitative assessments of services and youth support in these communities in order to correlate these with adolescent health indicators, and will develop a tool for LHJs to use in assessing local community elements that support positive youth outcomes.//2010//

Foster Care

California has over 84,000 foster children. To improve access to and oversight of health care for these children, the Health Care Program for Children in Foster Care (HCPCFC), a collaboration between DSS and CMS, was initiated in January 2000. This program, administered locally by the CHDP program, places public health nurses (PHNs) in administrative care coordination positions in welfare service agencies and probation departments to serve as a resource and to assure delivery of comprehensive preventive, diagnostic and treatment health services to children and youth in foster care.

/2007/ California now has approximately 93,000 foster children. For FY 2005-06 HCPCFC has 255 public health nurses in administrative case management and supervisory positions in welfare service agencies and probation departments. //2007//

/2008/ California now has approximately 86,000 foster children. For FY 2006-07 HCPCFC has 271 public health nurses in administrative care coordination and supervisory positions in welfare service agencies and probation departments. The number of children in foster care is decreasing primarily due to DSS efforts to keep families together and work with the whole family. //2008//

/2009/ The number of children in foster care in California remains consistent with the 2008 data report. The primary emphasis of DSS continues to support the effort to keep families intact, thereby working with the rehabilitation of the family as a whole. The PHNs working in the HCPCFC arena require highly specialized skills. Recognizing the need for specialty training, the CDSS and CDHCS joined forces this fiscal year, and, in a collaborative effort, offered a statewide one-day training conference for HCPCFC PHNs and their respective CHDP Deputy Directors. The conference emphasis was on the practice of universal HCPCFC policies in a statewide uniform manner. The CMS Nurse Consultant for HCPCFC also collaborates with the Training Academies, contracted by the counties on a regional basis, to present an annual

Nursing Symposium for the foster care nurses working in the CWS arena. This year's symposium will provide specialized training in obesity and nutritional issues as it pertains specifically to foster care children. //2009//

The foster care PHNs have formed a Statewide Foster Care Executive Subcommittee (of the CHDP Executive Committee) which serves the function of providing leadership to promote standardization of nursing practice in Child Welfare and Juvenile Probation in California. The Subcommittee advises the Executive Committee on program issues relating to the goal of increasing access to preventive health, dental, developmental and mental health services for children and youth in foster care. The Subcommittee provides a link to the five Regional Foster Care PHN groups through its membership, dissemination of minutes, and sharing of information relevant to health services for children and youth in foster care.

/2007/ The Subcommittee has developed four best practice guidelines for HCPCFC PHNs statewide: 1) assurance of continuity of care and case coordination among PHNs; 2) universal review and updates of the content for the Health and Education Passport (HEP) or its equivalent; 3) consultation and care coordination for out-of-county placement; and 4) guidelines for the PHN working in the juvenile probation departments. //2007//

The HCPCFC PHN directory (including state staff) and other information are online at www.dhs.ca.gov/pcfh/cms/hcpcfc/.

/2009/ The new CMS website location for the HCPCFC PHN directory is at <http://www.dhcs.ca.gov/services/hcpcfc/>. //2009//

Fetal Alcohol Spectrum Disorder (FASD) and Perinatal Substance Use

The MCAH/OFP Branch aims to improve birth outcomes for women at risk of alcohol use/abuse, including screening and referral for treatment services. Community-based prevention programs, including CPSP, BIH, AFLP, DV, and CDAPP, provide clients with information about FASD, identify those at high risk, and refer them for alcohol treatment services.

The MCAH/OFP Branch participates in a Statewide FASD Task Force. The Task Force meets quarterly and consists of representatives from state agencies and local communities. Their mission is to encourage best practices for prevention and provide intervention to those affected by FASD.

/2010/ A five-year Strategic Plan was approved in 2005, to be carried out by 2010. On March 13, 2009, the FASD Task Force held a Strategic Planning Meeting to review its objectives and strategies, re-examine its focus, and identify action steps for completing specified objectives.//2010//

Many local health jurisdictions are also active in FASD prevention. Fresno County uses federal Healthy Start funds to identify and intervene in the lives of potentially alcohol dependent women. About half of Fresno County's CPSP providers screen for alcohol abuse using Dr. Ira Chasnoff's 4 P's Plus screening instrument. This brief, nationally-recognized tool identifies pregnant women at risk for alcohol and illicit drugs. Fresno County's Black Infant Health and Nurse Family Partnership programs also screen clients for use of alcohol.

/2007/ In addition to Fresno County, Dr. Chasnoff currently works with the California counties of Ventura, Madera, Alameda, Butte, San Luis Obispo, Humboldt, Kern, Riverside, and San Bernardino. Dr. Chasnoff came to Sacramento in February 2006 to present an update on his 4 P's Plus program to MCAH/OFP Branch staff, local MCAH directors, and representatives of the State Office of Women's Health, Department of Rehabilitation, and Department of Social Services. //2007//

/2009/ The 4 P's Plus screening tool is being used by 22 local MCAH jurisdictions (as of July 30, 2007). In July 2007, the MCAH Program contracted with Dr. Chasnoff to produce a comprehensive report on perinatal substance use screening in California. //2009//

/2010/ Dr. Ira Chasnoff's report on perinatal substance use screening in California was completed and released in October 2008. It is available on the MCAH Division's website on the Perinatal Substance Use Prevention web page. As of early 2009, 22 local MCAH jurisdictions continue to use the 4P's Plus screening tool to identify pregnant women at risk for alcohol and illicit drugs.//2010//

/2008/ The report, Local MCAH Jurisdiction Survey on Prenatal Substance Use Screening Data, was completed by Renato Littaua of the Epidemiology and Evaluation Section, Karen Ramstrom, and Maria Jocson of the Policy Section on September 22, 2006. In collaboration with the Alcohol and Other Drug (AOD) Work Group of the State Interagency Team (SIT), MCAH/OFP conducted this survey to assess the availability and format of local MCAH data on prenatal substance use. This survey provides an inventory of existing local data that can be used to complement and augment other efforts to quantify prenatal substance use statewide. //2008//

/2008/ The California Department of Alcohol and Drug Programs (ADP) in collaboration with CDPH has implemented the State Epidemiologic Outcomes Workgroup (SEOW) which is creating an ongoing method and infrastructure that will provide assessments of the prevalence and consequences of substance use throughout the State. They are particularly focused on creating a system that will provide county jurisdictions with the local data they need, and the analytic capacity to use these data effectively for prevention planning, design, and program evaluation. //2008//

/2008/ ADP has convened an expert advisory panel to serve as the SEOW and identify potential data sources. The MCAH/OFP Branch provided data to help assess the prevalence and consequences of alcohol and drug use during pregnancy, among women of reproductive age, and among children under the age of 18. The SEOW is evaluating the data sources in terms of providing meaningful and timely indicators of substance use and consequences at both the state and local levels and creating a data source summary, which served as the basis for the State EPI Profile in February 2007. //2008//

/2008/ Local health jurisdictions have partnered with public and private agencies within their county and in some cases have formed multi-county coalitions to develop and implement strategies to combat substance abuse within their communities. The partnerships provide opportunities to maximize resources, share lessons learned and expand and improve availability of services. Strategies include community education, public awareness campaigns, the expansion of school curricula and identification of potential problems by school nurses, case managers and health care providers. Efforts to improve the scope and availability of school-based health clinics have also met with some success. Interagency collaboration has resulted in

improved detection and resource identification for substance abusing pregnant women and their children. //2008//

/2009/ MCAH representatives continue to participate in the Alcohol and Other Drug Workgroup of the State Interagency Team. This body meets quarterly and consists of members from the Departments of Public Health (MCAH), Social Services, Mental Health, Education, Developmental Services, and Alcohol and Drug Programs (lead). The goal 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. The task of the workgroup is to assess and prioritize ways to strengthen services to children and families where there is a nexus between AOD and child safety, education, and workforce readiness/success, maternal and child health, and mental health. //2009//

/2010/ The Alcohol and Other Drug Workgroup of the SIT completed its task in April 2008, and will reconvene in April 2009 to begin examining ways to lower the incidence of FASD in California. The same partner agencies will be involved.//2010//

/2009/ Using data points from the California Women's Health Survey (CWHS) and the Maternal Infant Health Assessment Survey (MIHA), MCAH epidemiology staff compiled data on alcohol consumption among California women 18-44 years of age (CWHS), and alcohol consumption during pregnancy among California women 15-44 years with a recent live birth (MIHA). In September 2007, these data were presented at the 36th Semi-Annual Substance Abuse Research Consortium Meeting in Sacramento, CA and the presentation made available on the MCAH program website. //2009//

Governor's Healthcare Proposal

/2008/ According to the California Health Interview Survey, more than 6.5 million Californians were uninsured for all or part of the year last year. This represents 20% of children and non-elderly adults. In January 2007, Governor Schwarzenegger unveiled comprehensive plans to reform California's health care system.

The Governor's proposal is built on "shared responsibility, shared benefit" where every segment of the healthcare system (government, doctors and hospitals, health plans, employers, and individuals) has some responsibility and realizes a benefit. The three essential elements in the Governor's proposal are: 1) Prevention, health promotion, and wellness; 2) Coverage for all Californians; and 3) Affordability and cost containment.

Highlights of the proposal of specific interest to MCAH professionals and policy makers include:

- Expand Healthy Families/Medi-Cal for all children in families earning under 300% of the FPL
- \$4 billion increase in Medi-Cal reimbursement rates

The Governor's emphasis on disease prevention, health promotion and healthy lifestyles promote a public health approach to improve health outcomes and help contain health care costs. Initiatives included in the Governor's proposal support the MCAH/OFP Title V priorities identified through the 2004 needs assessment process. The related Governor's initiatives are:

Diabetes (prevention and control); Health Care Quality; Tobacco Control; and Obesity Prevention. //2008//

/2009/ Governor Schwarzenegger's healthcare proposal was rejected by the California State Senate in January 2008. The \$14.9 billion plan was voted down by the Senate Health Committee. Ultimately senators said it was too risky a financial commitment when California faces a \$14.5 billion budget gap. //2009//

Impact of California budget deficit

/2009/ In response to an estimated State budget deficit of over \$14 billion, the 2008-2009 Governor's budget proposes 10 percent across-the-board State General Fund (SGF) reductions. The reduction of SGF produces a greater than dollar for dollar loss to LHJs, since reduced county allocated SGFs combined with the loss of state program funding means less available monies to garner matched activity funds.//2009//

/2010/ [Note: This section to be further updated by MCAH in June 2009.]

CMS has lost 30 positions over the last 18 months as the result of the 2007 reorganization of the CDHS into separate Public Health (CDPH) and Health Care Services (DHCS) departments, as well as budget-balancing staff and operating expense reductions required to address the state's current fiscal crisis. These cuts have resulted in unmet workload and backlogs in all CMS Branch programs including CCS, where cuts have been exacerbated by the lay-off of clerical and administrative staff who support CCS care coordination, utilization management, and prior authorization of services. Backlogs for some CCS eligibility determinations and service authorizations in CMS Branch Regional Offices that support small, dependent county CCS programs now exceed three months. Additionally, the California Legislature and the State Controller implemented delays and holds on provider payments to address cash flow shortfalls.

The state fiscal crisis is also adversely impacting the CCS program at the county level. As county revenues from sales and property taxes have plummeted, counties have been unable to support baseline levels of services in their public health, public assistance, and safety net health care programs. The State's actions to contain expenditures, including capping allocations of local assistance funds for CCS county administration and the CCS Medical Therapy Program (MTP), have exacerbated challenges. County CCS programs maintain that the reimbursement they receive under these funding caps is inadequate to maintain levels of eligibility, care coordination, utilization management, and service authorization staff necessary to serve the children in their caseloads. Some providers report that eligibility determination and authorization delays, along with the unavailability of CCS staff to assist them with claiming and reimbursement problems, may force them to stop participating in the CCS program. County CCS programs across the state are cutting staff through attrition and layoff. One county is closing a Medical Therapy Unit (MTU), and others are considering similar actions. The hardship that the State of California fiscal crisis has caused for CCS providers is unsustainable over time and is adversely impacting access to necessary health care for CCS children.

Generally, health care delivery is in crisis in California as it is across the nation. As with many other essential safety net programs, CCS is in turmoil. The specter of increased morbidity and mortality looms for California's CYSHCN.//2010//

Impact of federal Title V reductions on California programs

/2009/ Due to cuts in Title V funding in FY 2006-07, several MCAH programs have been eliminated or had their funding substantially reduced. The following programs and projects have been eliminated: Adolescent Sibling Pregnancy Prevention Program; technical assistance to LHJs for adolescent health improvement; and the training program for AFLP case managers. The following have received funding reductions of more than \$85,000/year each: AFLP; support services for the Childhood Injury Prevention Program; staff support for the Oral Health Program; staff support for MCAH program development; and technical assistance to LHJs from the Family Health Outcomes Project.

LHJs, particularly rural, are now experiencing the impact of these cuts. Cumulative funding cuts are decimating local MCAH leadership capacity for linking programs, leveraging resources and applying science to address concerns such as rising teen pregnancy rates, resurging teen sibling pregnancies as well as emerging issues such as long-term consequences of childhood obesity.

In 2008, the amount of Title V funding has been reduced by \$1.5 million in California. This reduction will not impact the current year program funding due to the two year availability of the allocations and the timing of the funding. Funding at the reduced level will have an impact in the upcoming years. Title V funding cuts have reduced or eliminated LHJ ability to continue work in preconception care, obesity prevention, childhood injury prevention, breastfeeding, oral health and collaboration with community partners on these topics.//2009//

//2010/ [Note: This section to be updated in June 2009.] //2010//

Impact of the federal Deficit Reduction Act (DRA) on California programs

/2009/ Several of the DRA of 2005 provisions are expected to have a negative impact on MCAH programs. The provision regarding verification of citizenship is likely to be particularly burdensome. In addition to affecting Medi-Cal, increased documentation requirements may impact other Medi-Cal-related programs including Family PACT and CPSP.

Low-income applicants may not have the needed documentation and may find their health coverage delayed or denied while they attempt to obtain it. For teens who are eligible for confidential services (e.g., family planning), parental intervention may be necessary for obtaining verification of citizenship, thereby effectively eliminating teens' access to confidential services. Finally, some providers may stop providing services because the verification requirement is too onerous.

The effect of this requirement may ultimately be reflected in an increasing teen birth rate, an increasing number of poor birth outcomes, and a decline in access to healthcare for pregnant women and children. California is in the early stages of implementing the DRA. There is yet to be any data available to evaluate.//2009//

III. STATE OVERVIEW

B. AGENCY CAPACITY

Programs affiliated with the MCAH/OFP and CMS Branches include the following:

Adolescent Family Life Program (AFLP)
AFLP Management Information System
Adolescent Health Program
Advanced Practice Nursing Program (APN)
Battered Women's Shelter Program (BWSP)
Black Infant Health (BIH)
BIH Management Information System
Breastfeeding Promotion
California Birth Defects Monitoring Program (CBDMP)
California Children's Services (CCS) Program
California Diabetes and Pregnancy Program (CDAPP)
California Perinatal Quality Care Collaborative (CPQCC)
California Perinatal Transport System (CPeTS)
Child Health and Disability Prevention Program (CHDP)
Childhood Injury Prevention Program (CIPP)
Comprehensive Perinatal Services Program (CPSP)
Comprehensive Perinatal Services Provider Training
Emergency Triage Transport System (ETTS)
Family Health Outcomes Project (FHOP) and Local MCAH Data
Family Planning, Access, Care and Treatment (Family PACT)
Fetal Infant Mortality Review Program (FIMR) and BIH FIMR
Genetically Handicapped Persons Program (GHPP)
Health Care Program for Children in Foster Care (HCPCFC)
High Risk Infant Follow-up (HRIF)
Maternal Child and Adolescent Health Program (MCAH)
MCAH in Schools (formerly named School Health Connections)
Medical Therapy Program (MTP)
Newborn Hearing Screening Program (NHSP)
Oral Health
Perinatal Profiles and Improved Perinatal Outcomes Data Reports Website
Regional Perinatal Programs of California (RPPC)
Sudden Infant Death Syndrome (SIDS) Program
Teen Pregnancy Prevention Programs
Youth Pilot Program (YPP) and Integrated Health and Human Services Pilot

/2008/

In the last two years, the above list of programs changed as follows:

-The Adolescent Sibling Pregnancy Prevention Program (ASPPP) eliminated in 2006 due to Title V funding cuts.

-The Adolescent Health Program eliminated in 2006 due to Title V funding cuts; reinitiated in 2008 with redirected funding.

-Effective January 2007, California's Birth Defect Monitoring Program moved from Prevention Services to the MCAH/OFP Branch.

-The Emergency Triage Transport System is a new project funded through an Inter Agency Agreement with the CA Emergency Preparedness Office; HRSA grant.

-The Youth Pilot Program (YPP) and Integrated Health and Human Services Pilot removed from the list of MCH programs as MCAH/OFP no longer has responsibility for it. Oversight responsibility for this effort moved to another Branch of the Department.

-The Medically Vulnerable Infant Program combined into the High Risk Infant Follow-up Program in July 2006.//2008//

/2009/ The California Early Childhood Comprehensive Systems (CA ECCS) is in the final year of the five year grant period. //2009//

/2010/The CA ECCS grant was extended through May 2009.

Three contracts for the Advance Practice Nurse (APN) program will be renewed in July.//2010//

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

Support to local infrastructure

Several system-wide programs, including MCAH, CCS, and CHDP, are administered by local health departments under the direction and guidance of the MCAH/OFP and CMS Branches.

The Youth Pilot Program (YPP) facilitates integration of CDHS services for youth in six counties. These pilots allow counties to make decisions on use of state and local human services funds without a reduction of state and federal funds.

/2010/The CPSP and California State University, Sacramento (CSUS) are finalizing an online provider training to supplement the existing face-to-face trainings.//2010//

Quality of maternity services

The California Perinatal Quality Care Collaborative (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.

/2008/ CPQCC membership has grown to 123 NICUs. These 123 hospitals represent over 90 percent of all neonates cared for in California neonatal intensive care units. //2008//

/2009/CPQCC membership is now at 126 NICUs, with 100% of the CCS-approved NICUs as members.//2009//

/2010/All 127 CCS-approved NICUs are CPQCC members.//2010//

/2007/CPQCC has developed a quality assurance tool for hospital use in evaluating the quality of neonatal services. A CPQCC team visits member hospitals to assist with the process.//2007//

The Perinatal Quality Improvement Panel (PQIP), a subcommittee of CPQCC, recommends quality improvement objectives, provides models for performance improvement, and assists providers with improving patient care via toolkits, workshops, and follow-up.

/2009/The CPQCC/PQIP updated the "Early Onset Sepsis Toolkit" in March 2007 (originally developed in 2002). CPQCC/PQIP has formed a quality improvement collaborative (CPQCC/CCS Hospital Associated Infection (HAI) Collaborative) in partnership with the CMS Branch addressing catheter associated blood stream infections in 19 Community NICUs. //2009//

/2010/The Early Onset Sepsis, Perinatal HIV Prevention, and Nutrition Support of the Very Low Birth Weight infant toolkits were updated.

The HAI Collaborative attained a conservative 25-50% reduction in CABSIs for all weight groups, although a change in CDC's CABSIs definition makes pre-post project data analysis difficult. For 2009, the Breastmilk Nutrition Quality Improvement Collaborative in NICUs is underway.//2010//

MCAH/OFP recently developed the Maternal Quality Collaborative (MQC), a joint effort with the CPQCC and UCLA's Maternal Quality Indicators group. The MQC Leadership Council will direct statewide maternal quality improvement activities utilizing the methodology developed by the CPQCC.

/2009/ MQC was renamed the California Maternal Quality Care Collaborative (CMQCC). The CMQCC has two major divisions: 1) data collection and analysis and 2) quality improvement initiatives. The quality improvement division identified and validated "hemorrhage" as a clinical indicator. A Hemorrhage Task Force convened to create guidelines for earlier hemorrhage detection.//2009//

/2010/CMQCC data and program committees are fully functioning. The CMQCC Hemorrhage Task Force provides a toolkit on early recognition and intervention in obstetrical hemorrhage through hospital learning collaboratives and CMQCC's website.//2010//

CDAPP works to promote optimal management of diabetes in at-risk women, before, during and after pregnancy. CDAPP care guidelines address everything from lab values to billing and data issues.

/2008/ CDAPP staff began the process for updating the CDAPP "Guidelines for Care" Manual. //2008//

/2009/Updates to the "Guidelines for Care" Manual continue.

The Statewide CPeTS program participated in the March of Dimes funded California Perinatal Summit, resulting in recommendations for policy changes that address hospital levels of obstetric care to assure risk appropriate maternal services. //2009//

/2010/The "Diabetes and Pregnancy Pocket Guide for Professionals" was published in 2008. Updated "Guidelines for Care" will be published in 2009. Standardized training for all affiliates, including webinars and videos, are being considered.//2010//

Infants' access to care

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

/2008/ As of July 2004, state law requires the Managed Risk Medical Insurance Board (MRMIB) to enroll infants of mothers who participate in the AIM program into the HF program. AIM linked infants between 250 and 300 percent of the FPL will be allowed to continue their HF coverage up to two years of age, at which time the family will be required to meet current HF eligibility. //2008//

/2009/ AIM now only provides coverage for pregnant women who qualify. //2009//

/2008/ In FY 2004-05, 615,204 infants under age one received health services through CHDP, a 9 percent increase over the previous year. Of these infants, 74 percent had Medi-Cal coverage and 26 percent were state funded, similar to the previous year. //2008//

/2009/ In FY 2005-06, 590,518 infants under one year of age received health services through CHDP, a 4 percent decrease from the previous fiscal year. Of these infants, 78 percent had Medi-Cal coverage and 22 percent were state funded.//2009//

/2010/ In FY 2006-07, 580,680 infants under one year of age received health services through CHDP. Nearly all (99%) had Medi-Cal.//2010//

Infant Health Promotion

CDHS promotes exclusive breastfeeding initiation at birth and breastfeeding during infancy across all MCAH/OFP programs. Breastfeeding information appears in CDAPP Guidelines for Care; disseminated regularly to AFLP, BIH, CPSP and RPPC providers. The MCAH/OFP website posts data on hospital breastfeeding discharge rates, local coalitions, links to resources, and model breastfeeding policies.

/2007/ In 2006 MCAH and CMS completed a chapter on infant feeding for the California Daily Food Guide. The chapter which promotes breastfeeding as the normal infant feeding method is available on the MCAH website and serves as the state-wide recommendation for infant feeding. //2007//

/2007/ MCAH offers hospitals technical assistance to improve their breastfeeding policies. A toolkit to assist in adopting model hospital policies was completed in 2006 and is available on the breastfeeding web page. MCAH staff worked with Kaiser staff to facilitate efforts to adopt the model hospital breastfeeding policies in all Kaiser's Northern California facilities. //2007//

/2008/ MCAH/OFP promotes exclusive breastfeeding for the first 6 months of life and the continuation of breastfeeding for the first year and beyond. The MCAH/OFP website's breastfeeding page includes updated hospital breastfeeding rates, a model hospital policy toolkit and links to other resources for health care providers and hospitals that offer support for mothers who choose to breastfeed and return to work, need information on contraception, take medications or face emergencies. //2008//

/2010//In response to California Senate Bill 22, WIC and MCAH are finalizing a web-based model curriculum on hospital breastfeeding policies.//2010//

Birth defects are the leading cause of infant deaths. While causes of many congenital defects are unknown, effective prevention measures for neural tube defects (NTDs) are known. MCAH/OFP activities that focus on reducing NTD-affected pregnancies include preconception and prenatal folic acid promotion, and participation on the National Council on Folic Acid.

/2008/In 2006, MCAH/OFP contributed a chapter entitled "Folic Acid Use Among California Women of Reproductive Age, 2004-05" to a report on the California Women's Health Survey by the Office of Women's Health.//2008//

/2009/ In October, 2007, the MCAH Program authored a CDC MMWR entitled: "Trends in Folic Acid Supplement Intake Among Women of Reproductive Age --California, 2002-2006". //2009//

/2010/MCAH hired a full time Preconception Health Coordinator in March 2008 to oversee the Preconception Health and Healthcare Initiative (PHHI) for the state.//2010//

The Newborn Screening Program (NBS) of California's Genetic Disease Branch (GDB) provides screening for primary hypothyroidism, phenylketonuria (PKU), galactosemia, sickle cell disease and other hemoglobinopathies to 99 percent of newborns. The NBS Program is including 40 additional metabolic conditions detectable via Tandem Mass Spectrometry, and classical congenital adrenal hyperplasia. CMS and GDB are making CCS-approved Special Care Centers (SCCs) and CCS County and Regional Offices aware of the expansion and importance of prompt referrals for screened-positive infants.

/2007/In July 2005, the Newborn Screening (NBS) Program expanded to include classical congenital adrenal hyperplasia (CAH) and over 40 additional metabolic conditions detectable via Tandem Mass Spectrometry (MS/MS). //2007//

/2008/From July 2005 through August 2006 (639,158 screens), there were 1,150 positive screens, and 198 cases of inborn errors (including PKU) diagnosed by MS/MS testing. From July 2005 through December 2006, 54 cases of CAH were diagnosed. The CAH cutoff for infants <1000g was increased in March 2006 resulting in the false positive rate dropping from 20 percent to 4 percent.//2008//

/2008/The NBS Program is expanding in August 2007 to include Cystic Fibrosis (CF) and Biotinidase Deficiency (BD).//2008//

/2009/ CMS disseminated guidelines on the authorizations for infants referred to CCS by the NBS Program for CF or BD. As of February 2008, 8 cases of profound BD and 17 cases of classical CF were detected. False positive rates for CAH in premature infants continue to concern neonatologists. In 2008, the NBS Program will add the extended MS/MS second tier

testing to the 1000-1500g birth weight group to reduce their 5 percent false positive rate. //2009//

MCAH programs address additional causes of infant mortality and morbidity, including the SIDS Risk Reduction campaign of the SIDS Program, known as Back to Sleep (BTS).

/2007/ Between 1999 and 2004 the rate of infant deaths due to SIDS in California declined 31 percent, from 45.7 per 100,000 live births to 31.4 per 100,000 live births. In 2004 African American infants had the highest rate of SIDS at 83.7 per 100,000 live births, followed by 40.2 for White/Other infants and 23.6 for Hispanic infants. //2007//

The Black Infant Health (BIH) Program, whose goal is reducing African American infant mortality in California, funds programs in 17 local health jurisdictions (LHJs), which account for 94 percent of the state's African American births.

California's Fetal Infant Mortality Review (FIMR) Program, which took a significant budget cut in FY 2002-03, was expanded this year. This reallocation of Title V funding established the Black Infant Health FIMR (BIH/FIMR) Program, whose goal is reducing African American fetal and infant deaths through community level review. Eight of the seventeen FIMR jurisdictions with the greatest proportion of African American births and fetal deaths have been selected for participation.

MCAH/OFP prepared a grant application to CDC for a Fetal Alcohol Syndrome Program, which was not funded. MCAH/OFP continues to network with counties to address Fetal Alcohol Spectrum Disorder (FASD).

/2008/ As of March 2007, there are 175 hospitals certified and participating in the NHSP, down from 177 in the previous year. The number decreased due to the closure of delivery units in some CCS approved hospitals. Of the babies born in CY 2005, over 411,000 received newborn hearing screening and 713 were identified with hearing loss, an incidence rate of 1.7 per 1000. Of those with hearing loss, 450 were identified before 3 months of age (63 percent), and 598 have been enrolled in Early Start, California's early intervention program (84 percent). Of those in Early Start, 403 enrolled before 6 months of age (67 percent). //2008//

/2009/ As of May 2008, there were 211 hospitals certified to participate in the NHSP, including 35 new expansion hospitals. Of the babies born in CY 2006, over 425,000 received newborn hearing screening and 919 were identified with hearing loss, an incidence rate of 2 per 1000. Of those with hearing loss, 515 were identified by 3 months of age (56 percent).

California was one of eight states to participate in the National Initiative for Children's Healthcare Quality (NICHQ) collaborative. Key outcomes include: improved hospital identification of primary care provider and collection of an additional contact person (to 100 percent), a decrease in no-shows for outpatient screening and diagnostic evaluation appointments (by 25 percent). The California team participated in panel presentations with NICHQ faculty at national meetings and is now focusing on improving age-appropriate language acquisition for infants and toddlers with hearing loss. //2009//

/2010/ 224 hospitals are certified to participate in the NHSP. Over 429,000 newborns were screened in CY 2007, with 717 identified to have hearing loss (1.7 per 1000). //2010//

Preventive and Primary Care for Children

Access to care

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 percent of FPL, children and adolescents ages 6 to 19 at up to 100 percent of FPL, and young adults ages 19 to 21 at up to 86-92 percent of FPL. HF covers children up to age 18 who are uninsured and in households up to 250 percent of FPL. Monthly premiums and co-payments for certain types of visits and prescriptions are required.

/2008/ As of April 2007, there were 807,782 children enrolled in HF, an 8.5 percent increase over enrollment in December 2005. //2008//

/2009/ As of January 2008, the HF caseload totaled approximately 866,000 children, approximately a 7 percent increase over enrollment in January 2007. Of those children, approximately 2.5 percent (22,000) are being served by CCS for their special health care needs. //2009//

/2010/As of January 2009, the HF caseload was 892,500 children. The 3.1 percent increase over 2 years is lower than expected, likely due to the uncertainty of SCHIP funding for FY 2008-09 and waiting lists and automatic dis-enrollments.//2010//

/2008/ LHJs increased efforts to ensure medical care for the MCAH population. Efforts include training certified application assistants to identify the most appropriate health insurance program for women and their children; training pediatricians to perform routine dental exams on their population; and encouraging dentists to accept Denti-Cal patients. //2008//

The CMS Branch administers the screening component of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, which is called the Child Health and Disability Prevention Program (CHDP) 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 percent of the FPL can pre-enroll in Medi-Cal through the Gateway process.

/2008/ In FY 2005-06, 2,038,833 children received screening and health assessments through the CHDP program, similar to the previous year. (The number receiving services declined by 3 percent in FY 2005-06, after having been quite stable at about 2.1 million for the previous five years.) The funding for the CHDP program remains the same as the previous year: 98 percent funded by Medi-Cal and 2 percent by state only funding. //2008//

/2009/ In FY 2006-07, 2,016,558 children received screening and health assessments through the CHDP program.//2009//

/2010/In FY 2007-08, 1,947,575 children received screening and health assessments through CHDP.//2010//

The CHDP Gateway, implemented in July 2003, pre-enrolled 1.2 million children as of February 2005, 80 percent of whom requested a joint Medi-Cal/HF application. CDHS modified the pre-enrollment process, allowing Gateway to identify and "deem" certain infants less than age one as eligible for ongoing, full-scope, no cost Medi-Cal.

/2008/ The CHDP Gateway program pre-enrolled 2.5 million children from July 2003 to December 2006; 76 percent have requested a joint Medi-Cal/HF application. From February 2005 to December 2006, 157,378 infants were "deemed" eligible for full-scope, no cost Medi-Cal as a result of the modified pre-enrollment process. //2008//

/2009/ The CHDP Gateway program pre-enrolled 3.5 million children from July 2003 to December 2007; 69 percent of whom requested a joint Medi-Cal/HF application. From January 2007 to December 2007, 67,232 infants were "deemed" eligible for full-scope, no cost Medi-Cal as a result of the modified CHDP Gateway pre-enrollment process. CA Early Childhood Comprehensive Systems (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.//2009//

Childhood/adolescent health promotion

To reduce injury-related mortality and morbidity among children and adolescents, MCAH/OFP 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. MCAH/OFP funds five local MCAH jurisdictions to increase injury prevention capacity within their community.

/2007/ Due to Title V budget cuts, funding for the MCAH/OFP contract with CIPPP has been reduced. The reduction eliminates funding for the annual statewide conference and reduces technical assistance provided to LHJs. //2007//

/2008/ Childhood injury prevention funding in five LHJs will be discontinued after June 2007. Counties are expected to continue to address childhood injury prevention issues with their general funding allotment. Counties have also received grants from the Office of Traffic Safety, enabling them to expand childhood injury prevention programs. //2008//

/2009/ In February 2008, MCAH staff participated in an injury prevention conference, cosponsored by California DSS and CDPH. MCAH staff provided input and review of proposals submitted to the California Kids Plates Programs to reduce childhood injuries.

/2009/Under the Federal Child Abuse Prevention and Treatment Act, children under the age of three with substantiated abuse or neglect are developmentally screened and referred for treatment. These children are included in Assuring Better Child Health and Development Screening Academy (ABCD SA) efforts.//2009//

As a part of the California Initiative to Improve Adolescent Health by the Year 2010, the National Adolescent Health Information Center (NAHIC) and the California Adolescent Health Collaborative (AHC) provide support to local adolescent health programs. Products of NAHIC and AHC efforts include a Guide to Adolescent Health Data Sources to aid locals in needs assessments in their community, a grant application template locals can use when applying to foundations and federal agencies, and an annual report card on key adolescent health indicators.

MCAH/OFP applied for a System Capacity for Adolescent Health Technical Assistance Grant from the Association of Maternal and Child Health Programs (AMCHP), but was not funded.

MCAH/OFP held an Adolescent Health System Capacity Assessment stakeholder meeting in April 2005, in addition to meetings with local MCAH Directors and other groups. Results of these meetings reveal a need to increase adolescent health efforts at MCAH/OFP, and increase partnerships in the areas of mental health, education, substance abuse, and juvenile justice. LHJs expressed a need for more financial and human resources to implement California's adolescent health strategic plan, and a desire for stronger partnerships between state and local programs.

/2007/ Due to Title V budget cuts, the contract with AHC has been eliminated. Technical assistance will no longer be provided to LHJs planning and implementing the recommendations provided by the Adolescent Health Improvement Plan. //2007//

/2008/ The adolescent health promotion project will be re-initiated in 2008 with redirected funding. //2008//

/2009/ MCAH again contracted through UCSF/NAHIC with the AHC to (1) provide expertise in support of quality health care services to adolescents, (2) increase the capacity of MCAH LHJs and their adolescent health practitioners, and (3) influence policy aimed to improve the health and well being of California's adolescents. //2009//

/2010/The California Adolescent Health Collaborative (CAHC) provides targeted technical assistance to LHJs based on adolescent health indicators.//2010//

MCAH/OFP participates in California Coalition for Youth Development to improve youth development. Participants include the Attorney General's Office, the Department of Education (CDE), 4-H Center for Youth Development, Friday Night Live, Department of Alcohol and Drug Programs (ADP), and the Department of Mental Health (DMH).

/2007/ MCAH/OFP provides state-level leadership for early childhood health programs to help California's children prepare for kindergarten emotionally, socially, and physically. MCAH/OFP received a multi-year HRSA grant for the State Early Childhood Comprehensive Systems (SECCS) project. Two years of planning culminated in a statewide needs assessment and strategic plan to address critical components of early childhood health care systems. The project is now in the implementation phase. //2007//

/2008/ SECCS staff visited eight LHJs to identify screening tools, best practices, models of service integration, and barriers to braiding of funds. Findings will be presented to stakeholders in 2007, and plans developed to address the findings. //2008//

/2009/ CA ECCS created a library of information that includes the practices of the eight LHJs. //2009//

MCAH/OFP participates in UCSF's Childcare Health Program Advisory Committee to strengthen linkages between health, safety, and child care communities and the families they serve. The program received a Healthy Child Care America (HCCA) Grant, now folded into the SECCS grant.

/2008/ MCAH/OFP did not participate on this Committee in 2007 due to staff changes. //2008//

The CMS Branch continues to participate in the Childhood Asthma Initiative (CAI) through the CAI CHDP project, consisting of asthma education, trainings, resource development, and implementation of Asthma Assessment Guidelines for CHDP providers.

/2007/ The Childhood Asthma Initiative grant ended July 2005. //2007//

/2009/The CA ECCS staff participates in the Head Start Collaborative Advisory Committee including development of their 5-year Work Plan.//2009//

Services for Children with Special Health Care Needs (CSHCN)

The CMS Branch administers the CCS program, providing case management and payment of CSHCN services. The program authorizes medical and dental services for the CCS eligible condition, establishes standards for providers, hospitals, and Special Care Centers (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.

/2007/ The CCS Medical Therapy Program (MTP) provides physical and occupational therapy services to children with CCS MTP eligible conditions. There is no financial eligibility requirement. The number of clients enrolled in the MTP has remained fairly stable for the past four years and is currently 26,698. //2007//

/2009/ The CCS MTP conducts multidisciplinary team conferences to support case management and care coordination. The number of clients enrolled in the MTP has remained fairly stable for the past 5 years and is currently 26,119. //2009//

/2010/MTP client enrollment declined 6% to 25,556.//2010//

/2008/ The estimated caseload for CCS in Federal Fiscal Year (FFY) 2005-06 was 182,800. This is a four percent increase from the prior year of 175,920. Approximately 80 percent of these children were enrolled in Medi-Cal, 10 percent were enrolled in HF and 10 percent were enrolled in state-only CCS. CHDP providers continue to facilitate referrals to CCS of children with CCS eligible or potentially CCS eligible conditions. //2008//

/2009/ The estimated caseload for CCS in FFY 2006-2007 is 163,845; 120,731 (74 percent) were enrolled in Medi-Cal, 23,653 (14 percent) were enrolled in HF, and 19, 461 (12 percent) enrolled in state-only CCS.//2009//

/2010/ The estimated CCS caseload for FFY 2007-08 is 164,656. This includes 121,778 (74%) enrolled in Medi-Cal; 23,768 (14%) in HF, and 19,110 (12%) enrolled in state-only CCS.//2010//

The CCS program is responsible for case management and Medi-Cal reimbursement for services related to the CCS eligible condition. Additionally, CCS case manages and authorizes payment of services for children enrolled in HF. Through a system of CCS-approved SCCs, quality specialty and subspecialty care is provided. 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. Through the Case Management Improvement Project, dependent counties are encouraged to assume activities for case management functions.

The CCS Program has structured a system of regional affiliation with 121 CCS-approved neonatal intensive care units (NICUs). NICUs providing basic level intensive care services to infants in their communities are required to establish affiliations with NICUs that provide more extensive services, to facilitate consultation and patient transfers as needed. The CCS approves the designated level of patient care (Intermediate, Community and Regional) provided in each NICU, and verifies that cooperative agreements are in place. In June 2001 the CPQCC initiated annual NICU data reporting to CCS, which improved reporting accuracy. The CMS Branch is requiring all CCS-approved hospitals to submit CCS NICU annual data through CPQCC beginning with CY 2004 data.

/2008/ The number of CCS-approved NICUs is currently 118. All but one CCS-approved NICU are submitting data to CPQCC for 2006. //2008//

/2009/ The number of CCS-approved NICUs is currently 118. All CCS-approved NICUs are submitting their data to CPQCC for 2007. //2009//

/2010/All 114 CCS-approved NICUs are submitting data to CPQCC.//2010//

The CMS Branch has two programs addressing the needs of high-risk infants. The first provides infants discharged from CCS-approved NICUs to be followed in NICU High Risk Infant Follow-up clinics. Three multidisciplinary outpatient visits are authorized by CCS up to age three to identify problems, institute referrals, and monitor outcomes. The second program, the Medically Vulnerable Infant Program (MVIP), uses a network of community-based contractors to provide home-based services to high-risk infants from NICUs. Services are provided to infants up to age three. Twelve contractors, including hospitals, community-based organizations and universities, have contracts until December 2005. As of March 2005, 4,282 infants were enrolled and 51,280 home visits were made since program inception in July 2000.

/2007/ After reviewing functions and responsibilities of the NICU High Risk Infant Follow-up (HRIF) program and the MVIP, CMS is combining these two programs into one program that addresses the needs of high-risk infants. The newly formed HRIF program will begin in July 2006, building upon the NICU HRIF programs already in place throughout the state. CMS is working with CPQCC to build upon the data that all CCS approved NICUs currently submit. The ability to collect expanded data elements will give the HRIF programs the opportunity to evaluate the outcomes of their NICU high-risk infant graduates. //2007// /2008/ The 43 HRIF programs submitted 3169 registration forms between July 1, 2006 and May 15, 2007. //2008//

/2009/ 53 HRIF programs submitted 4,446 registration forms between May 16, 2007 and February 19, 2008. //2009//

/2010/ 60 HRIF programs submitted 5,886 registration forms from May 16, 2008 to February 19, 2009.//2010//

The Genetically Handicapped Persons Program (GHPP) provides case management and funding for medically necessary services to people with certain genetic conditions. Most GHPP clients are adults, but 10 percent are children under 21 years. The GHPP serves eligible children of higher family incomes who are ineligible for the CCS program.

/2008/ Client enrollment in GHPP is stable at about 1,550 clients (2005-2007). //2008//

/2009/ GHPP client enrollment for 2006-2008 continues to be stable at about 1600 clients.//2009//

/2010/GHPP client enrollment is stable, with 1700 clients for 2007-08.//2010//

Rehabilitation services to Supplemental Security Income (SSI) beneficiaries under the age of 16

SSI beneficiaries with a CCS medically-eligible diagnosis are served by the CCS program. During FY 2003-04, CCS received 2,057 referrals of SSI beneficiaries, 52 percent of whom were medically eligible for the CCS program. Physical and/or occupational therapy, when needed, is provided in the CCS MTP. Children with mental or developmental conditions receiving SSI are served by DMH, Department of Developmental Services (DDS), and CDE.

/2008/ During FY 2006-07, CCS received 169 referrals; 72 of these applicants were medically eligible for CCS, and 97 were not medically eligible or were sent to the Social Security Administration for more information. //2008//

/2009/ During FY 2007-08, CCS received 25 referrals; 17 of these were medically eligible for CCS, and 8 were not verified. CCS is working with the Disability Evaluation Division (DED) to improve the referral process from DED. //2009//

/2010/In FY 2008-09, 36 of the 41 referrals CCS received were medically eligible for CCS. CCS worked with DED to develop screening criteria for counties to conduct eligibility evaluations, resulting in fewer referrals to state CCS.//2010//

Family-centered, community-based coordinated care for CSHCN

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

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

/2010/Many county CCS programs are terminating parent liaison contracts due to state budget cuts.//2010//

The Children's Regional Integrated Service Systems (CRISS) (a collaboration of family support organizations, pediatric providers, statewide organizations, 14 county CCS programs, and Family Voices of California) has a FCC Work Group that meets bimonthly. The group develops and sponsors annual conferences, assists with workshops, resource fairs, and with addressing issues regarding FCC. The 2004 conference theme was sexuality and youth with disabilities. */2007/ The conference for 2005 was entitled, "What Happens at 18? Conservatorship and Other Legal Rights for the CCS Client." //2007//*

/2008/ The 2006 Annual CRISS Conference, "Negotiating Multiple Transition Hurdles, One at a Time", was held in November. A CRISS mid-year workshop, "Maintaining Compassion and Avoiding Burnout", was held in June 2007. //2008//

/2009/The 2008 CRISS Annual Conference was entitled, "Hot Topics Arising in the Medical Therapy Program: Safe Transport, Complementary Therapies, and Spasticity Management". CRISS also convened regional meetings to promote care coordination for children who cross multiple systems and sponsored a regional workshop in September, 2008 entitled "Implementing Innovative Care Coordination Strategies for Children with Special Health Care Needs". //2009//

/2010/The 2009 CRISS Annual Conference focused on mental health issues for children in CCS.//2010//

The CMS Branch directed a Champions for Progress Center Incentive Award that convenes bimonthly with stakeholders to develop strategies and an action plan addressing CSHCN Title V performance measures and prioritize issues from the Title V Needs Assessment. The project builds on past efforts to develop a long-term strategic plan for serving CSHCN, and identifies resources within California to carry out the strategic plan activities. /2007/ 25-30 stakeholders consistently participate in these monthly meetings. //2007//

/2008/ The action plan was completed and disseminated. Implementation activities are being discussed by the Key Stakeholder Group for the MCHB grant described below. The Stakeholder Group will continue to meet quarterly, through June 2008. //2008//

/2009/ The Stakeholder Group continued to meet to review progress on the strategic plan. //2009//

/2010/The Stakeholder Group met May 2008, but with county CCS staffing cuts and poor representation from agencies serving CYSHCN, further meetings were cancelled.//2010//

A federal Maternal and Child Health Bureau (MCHB) grant has been awarded to the University of Southern California's University Center for Excellence in Developmental Disabilities at Children's Hospital Los Angeles (CHLA), collaborating with CRISS and Family Voices of California, for a three-year project to implement integrated community systems of care for CSHCN.

/2009/The MCHB project to implement integrated community systems of care for CSHCN launched a number of new activities, including: 1) a Youth Advisory Council, 2) a statewide newsletter (CaCSHCNews) produced quarterly, 3) a website (CSHCN) launched in March 2008, 4) production and distribution of medical home materials for providers, agencies and families throughout the CRISS region, and 5) development of a Medical Home Initiative for CSHCN to be implemented in 2008. //2009//

/2010/The Medical Home Initiative is on hold due to county CCS staffing cuts.//2010//

/2009/ In April 2008 the Los Angeles Partnership for Special Health Care Needs Children (LAPSNC) in collaboration with a consortium of organizations is presented a conference on Emergency Preparedness and Disaster Planning for CSHCN.//2009//

CCS is collaborating with CHLA and the California Epilepsy Foundation on a HRSA grant for Improving Access to Care for Children and Youth with Epilepsy. The goal is to improve access to health and other services and to facilitate the development of state-wide community-based interagency models of comprehensive, family-centered, culturally-effective care and state-wide standards of care.

/2009/ Collaboration with CHLA and the Epilepsy Foundation will continue in 2008 through participation in a federally sponsored Medical Home Learning Collaborative focused on epilepsy. CRISS will participate as the convener of the California Learning Collaborative and organizer of a pilot medical home project for children with epilepsy in rural Northern California. //2009//

/2010/CRISS organized a pilot medical home project for children with epilepsy in Sonoma County.//2010//

LA County CCS produced a "Handbook for LA County CCS Families" in English and Spanish after working for two years with low-income, English and Spanish-speaking parents, Family Resource Centers, TASK (Team of Advocates for Kids), providers, Regional Centers, and LA CMS staff.

Transition of Care for Children with Special Health Care Needs (CSHCN)

The CMS Branch recognizes the importance of transitioning care for CSHCN from pediatric to adult services. During site reviews of new SCCs and county CCS programs, transition issues are emphasized.

/2009/ During site reviews of SCCs and county CCS programs, the issue of health care transition planning and age and developmentally appropriate care for CSHCN is reviewed and defined as the purposeful, planned preparation of patients, families, and caregivers for the transfer of a client from a pediatric to adult medical or health care services. //2009//

CCS staff in Southern California participate in the Special Education Local Planning Areas (SELPA) Interagency Coordinating Transition Council. Local county transition committees receive input from parents and young adult clients on ways to infuse the concept of transition into CCS services and functions. A matrix of transition activities of each of the fourteen represented counties is maintained

The CMS Branch formed a transition workgroup comprised of healthcare professionals, experts in transition care, and family representatives who began developing transition policy and guidelines for the CCS program.

/2010/CMS, in collaboration with the Statewide Workgroup on Transition of Care for CSHCN, drafted Transition Planning recommendations for county CCS program staff. They were released April 30 as a CCS Information Notice. <http://www.dhcs.ca.gov/services/ccs/Documents/ccsin0901.pdf>//2010//

/2009/ The CMS Branch chairs the Statewide Workgroup on the Transition of Care for CSHCN (Workgroup). The Workgroup consists of members from the State, Local County CCS programs, parent organizations (Family Voices), former CCS clients (Kids as Self-Advocates), Genetically Handicapped Persons, and other transition experts. The Workgroup convened in July 2007 to develop minimum statewide guidelines for the transition of care for CSHCN. //2009//

/2007/ The transition workgroup completed a survey to better understand what local and state CCS programs are doing to foster transition services and what the needs are for transition resources, technical assistance and training. This workgroup will also be reviewing the

transition strategies from the Champions stakeholder group to help determine an implementation plan for these strategies. //2007//

/2008/ Questionnaires regarding self-rating of four MCHB core performance measures were distributed to all county CCS programs. Survey data from 51 of the 58 counties are summarized. The counties were asked the degree to which the local CCS program provides the services necessary to effectively transition to adult health care, work and independence for youth with SHCN. Rural dependent counties scored higher than larger urban and/or independent counties in the area of transition. There was almost 100 percent compliance with the counties reporting of durable medical equipment needs, self-help needs and timely assessment of other MTP skills. In contrast, many counties outside the CRISS counties and LA, where transition has been a focus, reported no development or adaptation of transition materials for use with their exiting young adults.

A final report was submitted to CMS in August 2006 and distributed to all county CCS programs. The survey results are being discussed in quarterly meetings of the State Key Stakeholder Group overseeing implementation of the State CCS Plan. //2008//

/2007/ CHLA, UCLA Child and Family Health Program, LA Partnership for Special Needs Children, CRISS, CCS, and CMS Branch collaborated on a conference entitled "Family-Centered Strategies for Effective Transition for Youth with Special Health Care Needs: A Training for Providers and Families" in April 2006 in Los Angeles. Experts in the field provided information to agency staff, providers, youth and their families about the system of care for transitioning youth, transition resources, and strategies for assisting youth and their families. //2007// /2008/ The CRISS Project and Family Voices of California presented a workshop in English and Spanish on "Negotiating Multiple Transition Hurdles, One at a Time" in November 2006 in Oakland for nurses, physicians, CCS staff, regional center service coordinators, and youth and families. //2008//

/2009/ CMS staff collaborated with Kids as Self-Advocates (KASA), a group of former-CCS clients who focus on the transition of care for CSHCN and issues around transition into adulthood. In August 2007, CMS staff presented at KASA's quarterly meeting in San Francisco on transition planning.

CMS staff presented at the Family Voices of California 2nd Bi-Annual Parent Health Liaison Conference outlining the overall project plan for transition, the draft standards and guidelines prepared for local county CCS programs. //2009//

/2010/CMS continued to collaborate with KASA on transition issues.//2010//

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D. TABLES

National and State Performance and Outcome Measures

NOTE: The reporting year for the Federal Fiscal Year 2009-2010 Title V Block Grant Application/Annual Report is 2008. The 2008 data shown in italics below are provisional data based on 2007 final data. Proposed annual objectives in this report are for the 2009-2013 time period.

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
		<i>2008</i>	<i>100.0</i>	2008	100.0
				2009	100.0
				2010	100.0
				2011	100.0
				2012	100.0
				2013	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.	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
	^a National Survey of Children with Special Health Care Needs (CSHCN) 2001	2008	46.6 ^b	2008	52.5
	^b National Survey of CSHCN 2005-06			2009-13	52.5
3.	The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.	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
	^a CSHCN Survey 2001	2008	42.2 ^b	2008	51.0
	^b CSHCN Survey 2005-06			2009-13	51.0

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 2003 2004 2005 2006 2007 2008	59.3 ^a 59.3 ^a 59.3 ^a 59.3 ^a 59.3 ^a 59.6 ^b 59.6 ^b	2002 2003 2004 2005 2006 2007 2008 2009-13	98.0 60.5 62.5 64.5 66.5 68.5 65.5 65.5
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 2003 2004 2005 2006 2007 2008	65.9 ^a 65.9 ^a 65.9 ^a 65.9 ^a 65.9 ^a 85.3 ^b 85.3 ^b	- 2003 2004 2005 2006 2007 2008 2009 2010 2011-13	- 67.0 68.0 69.0 70.0 71.0 85.5 86.0 86.5 87.0
6.	The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life. ^a CSHCN Survey 2001; sample size too small for CA, therefore no state objective at this time ^b CSHCN Survey 2005-06	2002 2003 2004 2005 2006 2007 2008	5.8 ^a 5.8 ^a 5.8 ^a 5.8 ^a 5.8 ^a 37.1 ^b 37.1 ^b	- 2003 2004 2005 2006 2007 2008 2009 2010-11 2012-13	- - - - - - 37.5 37.5 38.0 38.5

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. a) Based on 4:3:1:3:3 series.	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	79.4 ^a	2007	78.4
		2008	79.4 ^a	2008	78.9
				2009	79.4
				2010	79.9
				2011	80.4
				2012	80.9
				2013	*
8.	The birth rate (per 1,000 females) for teenagers aged 15 through 17 years. <i>Note: 2000-2006 data had previously been re-calculated using new Dept. of Finance population projection estimates.</i>	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	19.9	2008	19.7
				2009	19.4
				2010	19.1
				2011	18.8
				2012	18.5
				2013	*
9.	Percent of third grade children who have received protective sealants on at least one permanent molar tooth. a) New data source based on Oral Health Needs Assessment Survey. 2003 data based on preliminary survey results.	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	28.6
				2010	29.1
				2011	29.6
				2012	30.1
				2013	*

* In development at the time of report

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	2.6	2000	2.7	
		2001	2.7	2001	2.6	
		2002	2.6	2002	2.8	
		2003	3.2	2003	2.6	
		2004	2.7	2004	2.6	
		2005	2.8	2005	2.9	
		2006	2.4	2006	3.0	
		2007	2.3	2007	3.1	
		2008	2.3	2008	3.0	
					2009	2.9
					2010	2.9
					2011	2.8
					2012	2.7
					2013	*
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	69.1 ^a	2004	-	
		2005	70.2 ^a	2005	-	
		2006	69.4 ^a	2006	69.6	
		2007	60.7 ^b	2007	71.0	
		2008	60.7 ^b	2008	71.5	
				2009	72.0	
				2010	72.5	
				2011	73.0	
				2012	73.5	
				2013	*	
12	Percentage of newborns that have been screened for hearing impairment before hospital discharge.	2002	52.2	2002	40.0	
		2003	56.2	2003	60.0	
		2004	68.6	2004	70.0	
		2005	75.0	2005	70.0	
		2006	75.7	2006	75.0	
		2007	73.3	2007	75.0	
		2008	73.3	2008	85.0	
				2009-13	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	11.2	2008	13.3	
					2009	13.1
					2010	12.9
					2011	12.7
					2012	12.7
			2013	*		
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	33.6	2008	33.6	
				2009	33.5	
				2010	33.5	
				2011	33.4	
				2012	33.4	
				2013	*	
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	2.6	2008	3.6	
				2009	3.5	
				2010	3.4	
				2011	3.3	
				2012	3.2	
		2013	*			

* 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	4.1	2008	4.7	
					2009	4.6
					2010	4.6
					2011	4.5
					2012	4.5
			2013	*		
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	67.3	2008	67.5	
					2009	67.8
					2010	68.1
					2011	68.4
					2012	68.7
			2013	*		
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	82.9	2008	86.9	
					2009	87.1
					2010	87.3
					2011	87.5
					2012	87.5
			2013	*		

* In development at the time of report

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
				2009-13	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
				2009-13	1:350
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	13.4	2008	12.7
				2009	12.6
				2010	12.5
				2011	12.4
				2012	12.3
				2013	*
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	15.0	2008	16.9
				2009	16.7
				2010	16.5
				2011	16.3
				2012	16.0
				2013	*

* 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	13.5	2008	16.4
				2009	16.2
				2010	16.0
				2011	15.8
				2012	15.8
		2013	*		
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	7.0 ^a	2006	5.2
		2007	6.0 ^a	2007	6.4
		2008	6.0 ^a	2008	6.2
				2009	6.0
				2010	5.8
				2011	5.6
				2012	5.6
		2013	*		
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	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		<i>Year</i>	<i>Measure</i>	<i>Year</i>	<i>Objective</i>
8.	The percent of births resulting from unintended pregnancy.	2004	42.4	2004	-
		2005	41.3	2005	-
		2006	43.2	2006	42.1
		2007	44.6	2007	40.9
		2008	44.6	2008	40.5
				2009	40.1
				2010	39.7
				2011	39.3
				2012	39.3
				2013	*
9.	The percent of 9 th grade students who are not within the Healthy Fitness Zone for Body Composition.	2004	32.9	2004	-
		2005	33.1	2005	-
		2006	32.0	2006	32.8
		2007	31.3	2007	32.9
		2008	31.3	2008	32.7
				2009	32.5
				2010	32.3
				2011	32.1
				2012	31.9
				2013	*
10.	The percent of women 18 years or older reporting intimate partner physical, sexual, or psychological abuse in the past 12 months.	2004	9.7	2004	-
		2005	8.5	2005	-
		2006	7.6	2006	9.6
		2007	8.4	2007	8.4
		2008	8.4	2008	8.3
				2009	8.2
				2010	8.1
				2011	8.0
				2012	7.9
				2013	*

* In development at the time of report

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	5.2	2008	5.1	
					2009	5.0
					2010	5.0
					2011	5.0
					2012	4.9
			2013	*		
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	2.5	2008	2.5	
					2009	2.4
					2010	2.4
					2011	2.4
					2012	2.3
			2013	*		
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	3.5	2008	3.4	
					2009	3.4
					2010	3.4
					2011	3.4
					2012	3.3
			2013	*		

* 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
					2010	1.6
					2011	1.6
					2012	1.5
			2013	*		
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	5.4	2008	5.4	
					2009	5.3
					2010	5.3
					2011	5.3
					2012	5.2
			2013	*		
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	15.1	2008	17.0	
					2009	17.0
					2010	16.8
					2011	16.8
					2012	15.9
			2013	*		

* In development at the time of report

California Title V *State Outcome Measures*

State Outcome Measure		<i>Year</i>	<i>Measure</i>	<i>Year</i>	<i>Objective</i>	
1	The maternal mortality rate per 100,000 live births.	2000	11.1	2000	8.0	
		2001	10.2	2001	7.3	
		2002	10.6	2002	7.8	
		2003	15.2	2003	10.4	
		2004	13.6	2004	10.3	
		2005	19.3	2005	11.6	
		2006	19.2	2006	13.3	
		2007	14.1	2007	13.0	
		2008	14.1	2008	12.7	
					2009	12.4
					2010	12.1
					2011	12.1
					2012	12.1
					2013	*

* In development at the time of report

Health System Capacity and Health Status Indicators

Health System Capacity Indicators		<i>Year</i>	<i>Indicator</i>
1	The rate per 10,000 for asthma hospitalizations among children less than five years old. <i>Note: 2000-2006 data had previously been re-calculated using new Dept. of Finance population projection estimates.</i>	2000 2001 2002 2003 2004 2005 2006 2007 2008	35.1 32.8 33.6 31.6 29.6 23.9 24.3 22.8 22.8
2	The percent of Medicaid enrollees whose age is less than one year during the reporting year that received at least one initial periodic screen.	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 82.5
3	The percent of Children's Health Insurance Program (CHIP) enrollees whose age is less than one year during the reporting year that received at least one periodic screen.		NA
4	The percent of women (15 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.	2000 2001 2002 2003 2004 2005 2006 2007 2008	76.3 76.6 77.8 78.7 78.5 78.4 78.7 78.6 78.6
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 2006 2006 2007 2007 2007	6.8(Medic) 6.9(N-Med) 6.9(All) 6.8(Medic) 6.9(N-Med) 6.9(All)

Health System Capacity Indicators (continued)			<i>Year</i>	<i>Indicator</i>	
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)	
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)	
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)	
Health System Capacity Indicator 6: Medicaid and CHIP Eligibility Levels			<i>Year</i>	<i>Indicator</i>	
6A	The percent of poverty for eligibility in the State's Medicaid and CHIP programs for infants.	(Age 0-1)	2007	<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) (Ages 6-18)	2007	133	250
			2007	100	250
6C	The percent of poverty for eligibility in the State's Medicaid and CHIP programs for pregnant women		2007	200	300

Health System Capacity Indicators (continued)		<i>Year</i>	<i>Indicator</i>
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	42.9 ^a
2008	42.9 ^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		

Health Status Indicators		<i>Year</i>	<i>Indicator</i>
1A	The percent of live births weighing less than 2,500 grams	2000 2001 2002 2003 2004 2005 2006 2007 2008	6.2 6.3 6.4 6.6 6.7 6.9 6.9 6.9 6.9
1B	The percent of live singleton births weighing less than 2,500 grams	2000 2001 2002 2003 2004 2005 2006 2007 2008	4.9 4.9 5.0 5.1 5.2 5.2 5.2 5.3 5.3
2A	The percent of very low birth weight births.	2000 2001 2002 2003 2004 2005 2006 2007 2008	1.1 1.1 1.2 1.2 1.2 1.2 1.2 1.2 1.2
2B	The percent of very low birth weight singleton births.	2000 2001 2002 2003 2004 2005 2006 2007 2008	0.9 0.9 0.9 0.9 0.9 0.9 0.9 0.9 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	6.9
		2001	6.2
		2002	5.8
		2003	6.0
		2004	5.6
		2005	6.2
		2006	5.5
		2007	5.3
		2008	5.3
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	2.6
		2001	2.7
		2002	2.6
		2003	3.2
		2004	2.7
		2005	2.8
		2006	2.4
		2007	2.3
		2008	2.3
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	14.2
		2001	18.7
		2002	21.0
		2003	20.8
		2004	19.7
		2005	19.7
		2006	19.8
		2007	18.2
		2008	18.2
4A	The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.	2000	284.9
		2001	273.4
		2002	266.2
		2003	257.3
		2004	250.7
		2005	229.2
		2006	210.9
		2007	198.0
		2008	198.0

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 2001 2002 2003 2004 2005 2006 2007 2008	39.6 35.9 36.4 35.9 35.4 29.6 26.5 23.0 23.0
4C	The rate per 100,000 of nonfatal injuries due to vehicle crashes among youth aged 15 through 24 years.	2000 2001 2002 2003 2004 2005 2006 2007 2008	147.7 152.0 162.4 164.2 164.5 156.0 146.7 135.4 135.4
5A	The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia	2000 2001 2002 2003 2004 2005 2006 2007 2008	21.8 21.9 22.3 22.2 22.3 22.8 22.8 23.1 23.1
5B	The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.	2000 2001 2002 2003 2004 2005 2006 2007 2008	7.1 7.6 8.2 8.4 8.6 9.1 9.7 10.1 10.1