

California Title V Block Grant Program

DRAFT 2014 Report/ 2016 Application

Maternal, Child and Adolescent Health Program, California Department of Public Health
Systems of Care Division, California Department of Healthcare Services

5/18/2015 version

Contents

I-E. Executive Summary	1
Needs Assessment	1
Accomplishments and Priority Needs by Population Domain	1
II-A. State Overview	6
II. B. Needs Assessment Summary	14
MCAH Population Needs	15
Current State Collaboration and Coordination	27
Mechanism for Multiculturalism	29
II-C. State Selected Priorities	31
Domain: Women/ Maternal Health	31
Domain: Perinatal/ Infant Health	31
Domain: Child Health.....	31
Domain: Children with Special Healthcare Needs.....	31
Domain: Adolescent Health.....	31
II-D. Linkage of Priorities, National Performance Measures and National Outcome Measures ..	35
II-E. Linkage of Priorities, State Performance and Outcome Measures	44
II-F. Five-Year State Action Plan	44
State Action Plan Tables by MCH Population Domain	44
a. Domain: Women/ Maternal Health.....	44
b. Domain: Perinatal/ Infant Health	46
c. Domain: Child Health	47
d. Domain: Children with Special Healthcare Needs.....	50
e. Domain: Adolescent Health	58
f. Domain: Cross-cutting/ Life Course	59
1. State Action Plan and Strategies by MCH Population Domain.....	64
Introduction.....	64
a. Domain: Women/ Maternal Health.....	65
b. Domain: Perinatal/ Infant Health	69
c. Domain: Child Health	71
d. Domain: Children with Special Healthcare Needs.....	75
e. Domain: Adolescent Health	79

f. Domain: Cross-cutting/ Life Course	79
g. Other Programmatic Activities	88
2. MCH Workforce Development.....	89
3. Family/ Consumer Partnership.....	92
4. Healthcare Reform	94
5. Emerging Issues	97
6. Technical Assistance	101

I-E. Executive Summary

Needs Assessment

Planning the statewide needs assessment started in March 2013. All 61 local health jurisdictions (LHJs) conducted a local needs assessment. California's Title V harnessed the power of local data to provide a shared understanding of the various strengths and needs at the local level. To further support local assessments, Maternal, Child, & Adolescent Health Division (MCAH) provided a set of priority problems to focus on in six domains; developed sample logic models, problem analyses and action plans; conducted training webinars; and, hosted regular listening sessions to provide technical assistance. Surveys were developed to identify efforts and opportunities at the local level with regards to the status of implementing the Affordable Care Act (ACA) provisions and better understanding of local health delivery to children with special healthcare needs (CSHCN) and the American Indian population. Collaboration among local MCAH Directors, county leaders, local organizations, tribal communities and residents to identify and prioritize the local needs and in developing a local action plan was encouraged. For the CSHCN population, identification of problem needs was augmented by more in-depth needs assessment of CSHCN enrolled in the California Children's Services (CCS) Program.

Accomplishments and Priority Needs by Population Domain

A summary of accomplishments in 2014 by population domain is presented below. California's priority needs from 2016 to 2020 are a continuance of priority needs identified for the 2011 to 2015 reporting period. For 2016-2020, the California Title V Program selected eight priority needs. Listed below are the priority needs by population domain and their related objectives.

Domain: Women/ Maternal Health

MCAH continued efforts to prevent and reduce tobacco among women, with emphasis on preventing smoking relapse. LHJs, the Black Infant Health Program (BIH), the Adolescent Family Life Program (AFLP) and other teen programs, and the Preconception Health Council of California (PHCC) promoted smoking cessation. LHJs and the Fetal Alcohol Spectrum Disorder (FASD) Task Force continued its efforts on preconception health education and promotion. MCAH continued ongoing quality improvement and education efforts to learn about emerging best practices for reducing binge drinking.

MCAH expanded its interconception and reproductive life planning initiatives and updated its messages about birth spacing and overall preconception/ interconception health. MCAH publicized its Interconception Care Project of California (ICPC) guidelines and continued to share national resources, including the preconception campaign materials developed by the Centers for Disease Control (CDC) and Preconception Peer Educators materials provided by the federal Office of Minority Health.

Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age.

To address Priority 1, objectives in the next five years include:

1. Adopt policies on assessing clients for intimate partner violence including reproductive and sexual coercion.
2. Reduce the prevalence of mistimed or unwanted pregnancy among Black and Latina women with live births to 43.4% and 37.1%, respectively.
3. Create a strategy to measure and monitor chronic disease conditions and associated risk factors among women of reproductive age.
4. Reduce the prevalence of chronic disease among women at labor and delivery

Domain: Perinatal/ Infant Health

LHJs monitor access to early prenatal care, conduct outreach to women, provide linkages and streamline processes to increase access to early prenatal care. These are complemented by AFLP and BIH by providing case management services and linkages to prenatal or medical care to their clients. The Regional Perinatal Programs of California (RPPC) and the California Perinatal Transport System (CPeTS) continue their work with hospitals in regional health planning, care coordination and providing birth data quality improvement trainings. In addition, RPPC, the California Perinatal Quality Care Collaborative (CPQCC) and the California Maternal Quality Care Collaborative (CMQCC) continue to provide assistance to hospitals in implementing maternal quality improvement toolkits including the Elimination on Non-Medically Indicated Deliveries < 39 Weeks Gestation Toolkit. MCAH continues to work closely with the Medi-Cal Managed Care Division (MMCD) to improve the timeliness and quality of obstetric services for Medi-Cal-eligible pregnant women. The Systems of Care Division (SCD) and CPQCC continue to analyze data and address outliers and concerns about quality of care.

California received an “A” grade in the March of Dimes (MOD) 2013 Prematurity Birth Report Card and garnered the 2014 Franklin Delano Roosevelt Prematurity Campaign Leadership Award. California also received MOD’s 2015 Virginia Apgar Prematurity Campaign Leadership Award.

Priority 2: Reduce infant morbidity and mortality.

To address Priority 2, objectives in the next five years include:

1. Participate in collaborative efforts to reduce preterm birth and infant mortality.
2. Increase the percentage of women who report exclusive breastfeeding at 3 months to 68.4% and reduce racial/ethnic disparities.
3. Reduce the number of Sudden Unexpected Infant Deaths (SUID) by 5%

Domain: Child Health

Immunization, proper nutrition, injury prevention and oral health promotion efforts include community education and outreach. MCAH completed the adolescent Nutrition and Physical Activity guidelines to help integrate efforts to increase community physical activity in the upcoming five-year action plan.

Priority 3: Improve the cognitive, physical, and emotional development of all children.

To address Priority 3, objectives in the next five years include the following:

1. Develop and disseminate a policy recommendation to incorporate evidence-based interventions proven to prevent unintentional injuries in children ages 0-14 into existing activities.
2. Publish a white paper detailing best practices for reducing child abuse and neglect
3. Increase early identification of children with special health care needs (CSHCN) and linkage to appropriate services by increasing social/emotional and developmental monitoring and screening for children ages 0 months to 5 years.
4. implement a service coordination protocol for Children with Special Health Care Needs (CSHCN) with requirements for referrals and timely care

Domain: Children with Special Healthcare Needs

Trainings for program development, implementation, evaluation, and quality improvement to LHJs were provided as they implement activities and programs to identify and serve CSHCN. LHJs provided education and awareness on the use of developmental screening tools to detect early signs of developmental delays for children. A survey was conducted to examine the status of current local programs and services for CSHCN.

Priority 4: Provide a whole-child approach to services.

To address Priority 4, objectives in the next five years include:

1. Increase the percentage of CCS children who receive their primary and specialty care within one system of care
2. Determine the extent to which CCS children receiving primary and specialty care within one system of care report that the care they receive is coordinated.
3. Increase the number of CCS clients with a patient-centered medical home.
4. Increase the number of counties that have created and made available medical home binders.
5. Increase the number of CCS provider / provider organizations that meet the National Committee for Quality Assurance or National Consensus on medical homes framework standards.
6. Increase the number of counties that have a family advisory council.
7. Implement at least two strategies to increase family involvement at all levels.
8. Implement a CCS best practice guideline at the local CCS county
9. Develop standards for individualized California Children’s Services plans (ICCSPs).
10. Increase the number of medical home providers who are able to create an ICCSP.
11. Increase the number of clients with an ICCSP.
12. Improve coordination by medical home between specialty care centers (SCCs), primary care providers (PCPs), etc.
13. Explore the creation of an active online network for resource and service information access.
14. Establish medical home collaborative(s) for at least 50% of CCS programs.
15. Develop a recommended core set of evidence based transition materials, process and protocols.
16. Establish a baseline of CCS transition age clients that have completed a transition readiness checklist.
17. Explore methods to increase CCS clients, ages 19 and 20 years, who receive at least one visit with an adult subspecialist.

18. Increase the number of Specialty Care Centers (SCCs) who have incorporated transition into a plan of care template for all patients.
19. Implement transition readiness questionnaire to identify CCS children who will transition to adult services in the next two years.
20. Develop tools/curriculum to provide training on transition services.
21. Identify and promote a transition toolkit.
22. Develop and adopt standards to care for young adults with complex medical conditions.

Priority 5: Improve access to healthcare.

To address Priority 5, objectives in the next five years include:

1. Increase the number of CCS paneled medical providers.
2. Develop methods to establish a baseline for the number of E-appointments made with paneled specialty care providers and increase access to E-consultation process at SCCs.
3. Increase the availability of telehealth services by CCS clients living in rural areas or far from SCCs.
4. Review and revise the CCS standards and procedures for facilities, providers, and county CCS programs.
5. Explore methods to demonstrate reductions in variation among County CCS programs and across SCCs.
6. Explore methods to decrease the wait time from referral to service for CCS clients who require SCC services that are authorized to SCC by county for select diagnoses.

Domain: Adolescent Health

MCAH provides the infrastructure to support program implementation across all local adolescent health programs and continues to monitor grantees in 30 LHJs with the highest teen births. MCAH worked to complete the evaluation and revise the standardized intervention that is based on positive youth development (PYD) principles integrated with life planning.

Priority 6: Increase conditions in adolescents that lead to improved adolescent health.

To address Priority 6, objectives in the next five years include following:

1. Decrease by 10%, racial and ethnic disparities in birth rates among adolescents aged 15-19
2. Incorporate the PYD/Resiliency framework in all Title V programs.

Domain: Cross-cutting/Life Course

Substance use prevention, obesity prevention, breastfeeding promotion, oral health promotion and mental health promotion activities were conducted through partnerships and collaboration and through services provided by LHJs, BIH, and AFLP. MCAH promoted the California perinatal clinical oral health guidelines and assisted LHJs develop oral health activities to increase community access and outreach. California conducted outreach and education to encourage and facilitate enrollment in Covered California, Medi-Cal and other health insurance. RPPC and CPeTS continued their work in regional planning and coordination, matching the transport of high-risk patients with the appropriate level of care and assisting hospitals with data collection and quality improvement surrounding patient transfer.

Priority 7: Increase access and utilization of health and social services

To address Priority 7, objectives in the next five years include:

1. Increase by 5% the number of eligible women and children individuals enrolled into Medi-Cal insurance, which includes Denti-Cal benefits.
2. Increase the number of women of reproductive age with appropriate preventive care including the rate of preventive visits to 65.3%; .the rate of first trimester prenatal care initiation to 92.4% and the rate of post-partum visits to 92.9%
3. Increase the number of children and adolescents (ages 0-17) attending one or more preventive visits in the last 12 months to 82.6%.
4. Increase the number of women with pre-pregnancy health insurance to 79.5% and the number of children and adolescents (age 0-17) with health insurance to 78.2%.
5. Decrease the number of postpartum women without health insurance to 16.2%.
6. Provide grief/bereavement support services to parents and caregivers of all infants who die suddenly and unexpectedly.
7. Increase the number of institutions that screen, refer, and address mental health and substance use disorders.

Priority 8: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy weight.

To address Priority 8, objectives in the next five years include the following:

1. Reduce obesity among reproductive age women to 20.9% and reduce racial/ethnic disparities.
2. Increase the percent of women with recommended weight gain during pregnancy to 43%.
3. Reduce overweight/ obesity among low-income children, ages 2 to 5 to 31.1.
4. Increase the percentage of women who took a multivitamin every day of the week during the month before pregnancy to 35.9%.
5. Increase the rate of children, adolescents and adult women of reproductive age meeting the age-specific guidelines for physical activity to 31.5%, 16.9% and 25.2% for children ages 6-11, adolescents ages 12-17, and women ages 18-44 respectively.

II-A. State Overview

California is the most populous state and, in terms of total land area, the third largest state in the nation. Covering over 163,696 square miles California is home to numerous mountain ranges, valleys and deserts. [1] It is located in the West Coast of the United States, bordered by Oregon to the north, Mexico to the south, Nevada and Arizona to the east, and the Pacific Ocean to the west. There are 58 counties in the state with a land area ranging from 47 square miles in San Francisco to 20,053 square miles in San Bernardino. Most counties cover an area greater than 1,000 square miles. The regions with the largest land area include Inyo, Kern, Riverside, and San Bernardino Counties. Each of these counties covers an area greater than 7,000 square miles. The smallest regions, those with less than 600 square miles of land area, include Santa Cruz, San Mateo, San Francisco, and Amador Counties. [1]

➤ Population

Based on the 2010 Census, California's population was at 37.3 million people, a population greater than the total population of 13 other western states combined [2]. In 2013, California's population was estimated at 38 million people.[3] California's population will cross the 40 million mark in 2019 and grow to nearly 52.7 million by 2060. By 2020, California will have 10 counties (Alameda, Contra Costa, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego and Santa Clara) with a population of more than one million each. [4]

The 2010 California population's median age is 35 and will rise to 37.2 by 2020 but still remain as one of the younger states in the Union for the next twenty years. This may be partially due to California's role as the primary gateway state for immigration. The White population is older and is not replenished by high levels of immigrants or birth rates. The Asian population structure is older than the Hispanic population and has a lower fertility rate. However, due to higher rates of immigration from Asia than from European or other countries with a predominately White population, it is anticipated that the Asian population will grow in numbers but its proportion to the total population will not change.

California is the most diverse state shaped by the multitude of racial and ethnic sub-groups across the state. For example, California's Asian population, the largest in the nation, demonstrates substantial diversity. The largest Asian sub-groups in California are Chinese, Filipino and Vietnamese. Within each Asian group is variation in language and culture. While the largest numbers of Asians reside in the large population centers of Southern California in Los Angeles (L.A.), Orange, and San Diego counties, counties with the largest percentage of Asian residents are in the Bay Area counties of San Francisco, Santa Clara, Alameda and San Mateo. [5] Hispanic groups in California are predominantly Mexican, followed by other Hispanic or Latino groups from Central and South America. Due to shifts in immigration patterns, an increasing number of indigenous Mexicans have settled in California. [6] While Southern California has the largest numbers of Hispanic residents, Imperial County, at 81%, has by far the largest proportion of Hispanics in 2014. In addition, more than 50% of the population in the agricultural counties of Central California is Hispanic. [4]

Trends in the racial/ethnic composition of California's population through 2020 predict a continuing decline in the proportion of White and Black population and an increase in the Hispanic population, which will comprise 41% of the population and become the largest

racial/ethnic group in California. The proportion of other racial and ethnic groups in California will remain relatively stable through 2020.[7]

California is a majority-minority state, i.e., over 50% of the population is minority. [U. S. Census] In 2014, White and Hispanic each comprise 39% of the population, 13% Asian, 6% Black, 3% multiple race, 0.4% American Indian/Alaska Native, and 0.4% Native Hawaiian/Pacific Islander. It ranks first in the U.S. in terms of its population size for Hispanics, Whites, and Asian/Pacific Islanders [2] The population size of African-Americans and American Indians/Native Americans ranks fourth and fifth, respectively. In fact, one-third of all Asian/Pacific Islanders in the U.S. live in California, and the number of Hispanics is more than the entire population in 46 states. [8]

➤ Economy

California, with 12% of the U.S. population, accounts for 13% of the nation's output. If it were a country, it would be the 9th largest economy in the world. [9]

➤ Age Distribution

The child population is growing slower as compared to the overall state population. The population of children 0-17 years of age has increased by less than one percent between the 2000 and 2010 Census, and is projected to increase by 5% between 2010 and 2025. In 2014, the population of children who are Hispanic is 52%, compared to 27% White, 11% Asian, and 5% Black. The proportion of population identified as multiple race increased from 4% in 2005 to 5% in 2014. The proportion of children that are Hispanic will continue to increase while the proportion of White children will decrease. Children of other racial/ethnic groups will remain relatively stable.

Children 0-5 years of age are in a particularly sensitive developmental period, and experiences during this time have great influence over subsequent life course health trajectories. The population of children 0-5 years of age has increased, and is projected to reach 3.8 million by 2020. As with the overall population, proportion of Hispanic children ages 0-5 is expected to continue to increase through 2020, while the proportion that is White is expected to continue to decline. Other racial/ethnic groups are projected to remain fairly stable through 2020. [5] In 2013, there were 7.6 million women of reproductive age (ages 15-44) in California. The largest group was Hispanic women (44%), followed by White (33%), Asian (14%) and African American (6%). The percentage of Hispanic women is expected to continue to increase among this age group through 2020 to 46%, and the percentage of White women are expected to decline to 31%. Other groups are expected to remain somewhat stable. Of particular interest are the youngest women of reproductive age, who demonstrate increased risks and poorer birth outcomes compared to their older counterparts. [10] [11]

➤ Immigration

In 2013, California was home to 10.3 million immigrants or nearly 27% of its population, the largest number and percentage of foreign born residents in the U.S. More than one third of the population in Santa Clara, San Francisco, Los Angeles, San Mateo and Imperial counties were foreign-born. International immigration has accounted for 40% of California's population growth since 2000. Further, since 44.5% of California births are to women born outside the U.S., [9] the well-being of this population has a strong influence on overall MCAH status in

California. Most of California's immigrants are from Latin America (56%) or Asia (34%). The leading countries of origin for immigrants are Mexico (4.4 million), the Philippines (750,000) and China (659,000). [12] Immigration status is related to poverty among children in California, which in turn is a strong predictor of health outcomes. Overall, 48% of California's children have immigrant parents; 34% have at least one legal immigrant parent and an estimated 14% have at least one undocumented immigrant parent. Among these children, 24% of children with legal immigrant parents are poor and 38% of children with undocumented immigrant parents are poor. [13] California has the largest number and proportion of undocumented immigrants of any state. [14] Many undocumented immigrants in California experience difficulty in meeting basic needs and accessing services, while facing additional health risks related to low wage jobs that lack protections and benefits. In 2008, approximately 2.7 million undocumented immigrants lived in California, an increase from 1.5 million in 1990. [14] In 2004, approximately 41% of California's undocumented immigrants resided in L.A. County. [13]

➤ Languages Spoken

Limited English proficiency (being able to speak English less than 'very well') poses challenges for educational achievement, employment, and accessing services, and results in lower quality care for immigrant communities--each of which influences MCAH outcomes. Among California's population over 5 years of age in 2013, 15.7million spoke a language other than English at home and 6.8 million had limited English proficiency. More than half of residents in Los Angeles, Merced, Santa Clara, Monterey and Tulare over 5 years of age spoke a language other than English at home and also had the highest proportion of the population who had limited English proficiency. [15] California's linguistic diversity requires the MCAH system to develop linguistic competence in multiple languages. Among youth in California's public schools, one in four is an English Language Learner who is not proficient in English.[16]

➤ Education

California's public education system is extensive. In 2011-12, there were 9895 schools distributed in 962 school districts with 6.2 million children enrolled in the K-12 system. There were 112 community colleges in 72 districts serving 1.2 million full-time equivalent (FTE) students. The California State University has 23 campuses serving 340,000 FTE students while the University of California system has 10 campuses, 5 medical centers and 3 national laboratories serving 214,000 FTE students.

In the K-12 schools, about half are from low-income families, a quarter of students are English language learners and a tenth are in special education classes, most commonly for learning disabilities. The primary source of revenue for schools is the State (61%), followed by local funds (27%) and federal funds (12%). Programmatic funding per pupil has declined in recent years from \$8414 per pupil in 2008-09 to \$7598 in 2011-12. Compared to 2007, school staffing, which include teachers, pupil support personnel, administrators and operational support personnel have shrank. Statewide K-12 enrollment is projected to grow by 1.1 percent from 2011-12 through 2020-21. [9]

In 2013, 18.3% of California residents over the age of 25 had not completed high school and 10.1% had not completed 9th grade. More than a quarter of residents 25 years of age and older in Tulare, Merced, Imperial, Kings, Monterey, Fresno and Kern counties did not graduate high school.

➤ Poverty

According to the 2011-2013 American Community Survey, over 6 million Californians, 16.8% of the population, had incomes below 100 percent of the federal poverty level (FPL). More than a quarter of all residents in Tulare, Fresno and Merced counties were living below the poverty level. The 100 percent FPL in 2013 was \$23,550 for a family of four.

Only examining the official federal poverty level, which has been determined using the same general framework since the mid-1960's, obscures the struggles faced by many families in California because of the high cost of living in this state. The supplemental poverty measure, which produces state level poverty rates differ considerably from the official poverty measures. In California, the supplemental poverty rate was 23.4%, the highest in the nation. [17] The major financial stressors for households with children are housing and child care; many of these families struggle to meet the most basic needs, cannot afford quality child care, and have limited financial resources to address crises. [15] It is also worthwhile to note that rates of poverty and low income are higher during pregnancy than when measured among children. This means that many more infants are born into financial hardship than statistics on children indicate. [18]

Research suggests that poverty in the first few years of life may undermine brain development, adversely affect overall health status and lead to both diminished success in early elementary school grades and lower chance of ever completing high school. Among children under age 18 the official poverty rate is higher: 23.3% of the population is in poverty, or approximately 2.1 million children. The California poverty measure which is more comprehensive, detailed and up-to-date than the official poverty statistics and more California-relevant than the Supplemental Poverty measure, estimates child poverty in the state at 24.3%. [19] Latino (31.2%) and African American children (33.4%) have higher poverty rates than other groups. Poverty rates are higher for children living with single mothers (45.7%) than married-couple families (15.5%) or with a single father (30%). California child poverty varies tremendously by region. It is lower in the Bay Area counties and higher in the Central Valley counties. Nearly 30% of poor children in California live in Los Angeles County.

➤ Housing

California's high housing costs create a burden for families, resulting in less income available for other resources needed to maintain health. [20] Lack of affordable housing also forces families to live in conditions that negatively impact MCAH outcomes: overcrowded or substandard housing or living in close proximity to industrial areas increases exposure to toxins such as mold and lead, as well as increased stress, violence, and respiratory infections. [20] It also exposes families to urban deserts, i.e., neighborhoods lacking sidewalks, grocery stores and parks. Even for working families, the high cost of fair market rent is out of reach. In California, on average, one wage earner working at minimum wage would have to work 120 hours per week, 52 weeks per year in order to afford a two-bedroom apartment at fair market rent.

The median single-family home sales price in California declined by \$250,000 when the "housing bubble" burst in 2007. Many homeowners were stuck with an outstanding mortgage greater than the market value of their home with thousands going through foreclosures.[9] The foreclosure crisis had greatly impacted California home-owner families. In 2010, there were about 170,000 foreclosures. [21] In 2011, California had 155,000 foreclosures, the second

highest rate of foreclosures in the country. [22] Foreclosure can force families into lower quality homes and neighborhoods, lead to great financial and emotional stress, and disrupt social relationships and educational continuity. Inability to access affordable housing leads to homelessness for some families. More than 292,000 children are homeless each year in California, which is ranked 48th in the percent of child homelessness in the United States, with only Texas and Louisiana having worse rates among children. [20] Homelessness in children has been linked to behavioral health problems, [20]and negatively impacts educational progress. [20]

➤ Health Insurance and Healthcare Reform

Health insurance coverage is the gateway to accessing the healthcare system and provides financial protection from health care expenses. Insurance coverage makes a stable connection to health care access. Lacking that stable connection may mean missing out on essential preventive services which include up-to-date recommended health screenings and mammograms [23]. In 2013, it was estimated that 17.2% of California residents were uninsured with more than 20% of the county population uninsured residing in Monterey, Los Angeles, Humboldt and Imperial.

In early 2014, Californians experienced a fundamental transformation in their health insurance system. The major health coverage provisions of the Patient Protection and Affordable Care Act (ACA) went into effect in January of that year, providing new options for people who did not have insurance and sweeping new protections for those who buy health plans on their own. California was the first state to pass legislation to create a health benefit exchange called Covered California, a quasi-governmental body that follows the "active purchaser" model of benefits exchanges. [24] It also allowed California to expand its Medi-Cal program to people up to 138% of the federal poverty level. Starting October 2013, Covered California qualified low-income individuals and families for free health insurance through Medi-Cal and moderate-income families to premium subsidies to make private health coverage affordable. It provides consumer protections set forth by the ACA including the ten Essential Health Benefits. Several provisions of ACA strengthen coordination and integration of care among health care providers by establishing Accountable Care Organizations, adoption of the Patient-centered Medical Home model of care and community-based collaborative demonstration projects.

A case study of five local health jurisdictions (LHJs) suggests that great strides were made at the county level toward creating integrated delivery systems for the medically underserved. These counties have the partnerships and shared commitment to create seamless systems of care. The presence of safety net collaboratives and/or Medi-Cal managed care organizations and clinic consortia afford counties the ability to secure resources and implement integration initiatives individual stakeholders might not otherwise undertake. The analysis of the 30 safety net integration "best practices" points to several common factors for success, including leadership support at the top, shared leadership among organizations, perseverance of effort, open communications, and buy-in at all levels. [25]

Medi-Cal and Covered California created an online "one-stop shop" for health coverage. By March 2014, Covered California had nearly 1.4 million enrollees and with Medi-Cal expansion, an additional 1.5million new Medi-Cal enrollees. Counties with the largest proportion of enrollees in Covered California include Los Angeles (28.7%), Orange (9.4%) and Sand Diego

(8.7%). By imputed race/ ethnicity, the total enrollment in Covered California health insurance plans is comprised of 40% White, 29% Latino, 21% Asian, 4 % Black, 3% multiracial and 2% other race. [26]

The State Health Access Data Assistance Center developed a framework to evaluate the impact of the ACA in California. Measures on health insurance coverage, affordability and comprehensiveness of coverage, and access to care will be used to track progress on three of the major aims of ACA. [27]

ACA presented a significant opportunity for MCAH and its partners to improve the health care delivery system overall, promote health and assure that women, children and families have access to quality health care.

The uninsured rate dropped to 11 percent for the quarter that ended in June, down from 22 percent from the quarter that ended in September 2013, according to a survey by the Commonwealth Fund. [28]

➤ Health and Human Services

California's Executive Branch of government is organized into many departments, most of which are grouped into Cabinet-level agencies. Of the seven Cabinet-level agencies in California, major health programs are administered at the state level by several different departments under the California Health and Human Services Agency. Most health programs are administered at the state level by one of the following five departments: (1) Department of Healthcare Services (DHCS), (2) California Department of Public Health (CDPH), (3) Managed Risk Medical Insurance Board (MRMIB), (4) Department of Developmental Services (DDS) and (5) Department of State Hospitals (DSH). Some departments administer more than one health program. For example, DHCS administers Medi-Cal, California's version of the federal Medicaid Program, as well as the California Children's Services Program and other programs. The California Department of Public Health perform various public health functions. The actual delivery of many health services often takes place at the local level and is carried out by LHJs, and by private entities, such as commercial health plans. Exceptions to the local health delivery model includes DSH operating five state hospitals for the mentally ill and DDS operating four Developmental Centers (DCs) that provide developmentally disabled individuals with 24-hour care. Both the state hospitals and the DCs are staffed with state employees who directly provide services to the residents of these state institutions. [29]

On May 3, 2012, Governor Jerry Brown issued Executive Order B-19-12 establishing the Let's Get Healthy California Task Force to develop a 10-year plan for improving the health of Californians, controlling health care costs, promoting personal responsibility for individual health, and advancing health equity. A public-private partnership brought together 23 California leaders in health and health care, supported by 19 Expert Advisors. To develop a statewide culture of health, a report was developed to provide a framework for assessing Californians' health across the lifespan with a focus on healthy beginnings, living well and end-of-life. Health equity and reduction of health disparities was an underlying principle guiding the establishment of ten-year health targets. [30].

➤ Public Health System

Working together with local health departments and other State agencies such as the Environmental Protection Agency and the Consumer Services Agency, CDPH is the lead state entity in California providing core public health functions and essential services. All of these operate in conjunction with federal efforts to keep communities healthy by educating them about physical and mental health and operating diverse programs that include enforcement of safety and sanitary codes and mandating reporting of certain diseases to prevent disease, injury and disability. CDPH delegates most of this authority to local health departments. [31] CDPH is organized around categorically funded programs which provide detection, treatment, prevention and surveillance of public health and environmental issues and its role include providing funding, oversight an overall strategic leadership for improving public health.

MCAH, the lead entity that administers the Title V Block Grant and the California Home Visiting Program (CHVP), funded by the Affordable Care Act, is housed under the Center for Family Health (CFH). CFH also oversees provision of supplemental food to women, infants and children, prenatal and newborn screening genetic disease detection and programs directed at addressing teen pregnancy, maternal and child health. The other Centers within CDPH include the Center for Chronic Disease Prevention and Health Promotion which provides surveillance, early detection and prevention education related to cancer, cardiovascular diseases, diabetes, tobacco cessation, injury and obesity; the Center for Environmental Health which is responsible for identifying and preventing foodborne illnesses and regulates the generation, handling and disposal of medical waste; the Center for Health Care Quality which licenses and inspects healthcare facilities to ensure quality of care, inspects laboratory facilities and licenses personnel; and the Center for Infectious Diseases which provides surveillance, health education, prevention and control of communicable diseases.

➤ MCAH Local Health Jurisdictions

Legal authority for local public health agencies is established in the California Health and Safety Code, Chapter 2, Sections 101100 – 101115, and the California Code of Regulations, Title 17, Section 1253. Local health departments are on the front line in promoting public health and responding to health emergencies. The Health and Human Services agency, together with its health and human services departments is responsible determining the importance and, magnitude of health issues and prioritizing competing factors which impact health services delivery. While CDPH is responsible for most policy-making and regulatory activities, the day-to-day job of protecting the public rests with the local health agencies. [32] .

California is divided into counties which are legal subdivisions of the state. (Constitution of California, Article 11, Section 1). There are 482 cities in 58 counties. California has 61 LHJs representing 58 counties and three incorporated cities. While there is widespread variation in providing core public health functions, all 61 LHJs provide MCH services [33] More than half of California counties have populations of 200,000 or less, presenting unique challenges in implementing a local MCAH program. Smaller counties generally face staffing challenges within their MCAH program and representation in the broader community. A single staff might implement several categorical programs whereas a highly populated county would assign the responsibility for a particular program to an entire unit of staff within its health department. For smaller counties, it is also hard to maintain an adequate corps of well-trained MCAH professionals. Some counties have dealt with these by pooling their resources regionally. In addition to providing the basic framework to protect the health of the community through

prevention programs, LHJs provide health care for the uninsured, which may include mental health and substance abuse treatment services. Given the diversity of these LHJs in size, demographics, income and culture, tremendous diversity also exists in how LHJs organize, fund and administer health programs.

MCAH allocates Title V funds to all 61 LHJs to enable them to perform the core public health functions to improve the health of their MCAH populations, to help create a health infrastructure where barriers to improvement are identified and lowered, where evidence-based practices and best strategies are replicated and improved and where the public and policy makers are confident to invest additional resources. All LHJs must have an MCAH Director to oversee the local program. LHJs must also conduct a community needs assessment and identify local priorities every five years. LHJs address one or more local priorities in their annual MCAH Scope of Work. LHJs must also operate a toll-free telephone number and conduct other outreach activities to link the MCAH population to needed care and services with emphasis on children and mothers eligible for Medi-Cal. Other LHJ activities include assessment of health status indicators for the MCAH population, and community health education and promotion programs. Specific MCAH categorical programs administered by LHJs include AFLP, BIH, CPSP, the Sudden Infant Death Syndrome (SIDS) education and support services, and Fetal and Infant Mortality Review. Recent cuts in state funding for MCAH programs and the decrease in Title V Block Grant funding to the State forced some LHJs to dismantle some of their MCH public health infrastructure further compounding the challenge for local MCH programs with little requisite capacity and resources. It is the persistent resolve of local MCAH leadership and a supportive local board of supervisors that local MCAH programs are being revitalized.

➤ **Local Healthcare and Hospital Districts**

To give rural, low-income areas without ready access to hospital facilities a source of tax dollars that can be used to construct and operate community hospitals and healthcare institutions and in medically underserved areas, to recruit and retain physicians and support their practices, the California Legislature enacted the Local Hospital District Law [34] in 1945. These districts are independent from city and county governments and support a wide range of community-based health and wellness facilities and activities. There are 73 health care districts with 43 operating hospitals in 40 counties [35] have been formed and operate 52 public hospitals or health facilities that provide a significant portion of medical care to minority populations and the uninsured in medically underserved communities. A few districts provide health-related services such as providing grants to healthcare organizations that serve specific needs of the community. The services place great emphasis on community health and wellness programs designed to prevent or postpone acute hospital care. [36]

II. B. Needs Assessment Summary

MCAH and SCD conducted a statewide needs assessment that resulted in eight priorities and a comprehensive 5-Year Action Plan. MCAH developed these priorities and Action Plan based on an analysis of data, feedback from our stakeholders and partners, including all 61 local health jurisdictions (LHJs), identified emerging issues and our current and future capacity to address priority health topics and implement activities to improve the health and well-being of women, infants, children and youth, including Children with Special Health Care Needs (CSHCN), and their families. This was augmented by a California Children's Services (CCS) assessment of CCS parents whose children receive CCS services and stakeholders providing services for CCS eligible and enrolled children.

The following goals guided the 2016-2020 Title V Needs Assessment Process.

Goal 1: Improve, expand, and strengthen new and existing stakeholder and community partnerships at the state and local level to improve the collective impact of both DHCS/SCD and CDPH/MCAH Programs across the state

Goal 2: Facilitate data-driven planning to inform development of 5-Year Action Plans that will address a specific list of priority health problems using standardized objectives while also allowing for local flexibility

Goal 3: Enhance data surveillance and program evaluation activities

The assessment was guided by several frameworks including the life course perspective, social determinants of health, the socio-ecological model and BARHII, a public health framework to address health inequities; and national and state health initiatives that include the National Prevention Strategy, ACA, MCH Transformation 3.0, a *Health in All Policies* approach, *Let's Get Healthy California*, and the *California Wellness Plan*.

The 2016-2020 MCAH needs assessment drew upon the expertise of over 2,700 stakeholders and partners statewide. LHJs comprise the largest body of partners and provided MCAH with qualitative and quantitative data via two approaches. First, LHJs responded to a survey designed to inform MCAH efforts with regards to the American Indian and CSHCN populations, and implementation of the ACA. Next, all 61 LHJ's completed a comprehensive local needs assessment. Each LHJ needs assessment included a review of local data, stakeholder engagement, a health status assessment process, capacity assessment, and identification of local priority needs and preliminary strategies to address identified needs. Bi-weekly technical assistance was provided to the LHJs by the MCAH Program to assure that questions and concerns were quickly addressed throughout the process. LHJs are now developing 5-Year Action Plans to address locally identified priority areas.

The State priority selection process included external and internal data collection efforts. The local needs assessment process generated a comprehensive set of health topics relevant for women of reproductive age, pregnant women, infants, children, CSHCN, and adolescents. A review of academic literature, including national and statewide surveys supported the topic's level of importance to the MCAH population. The Field Poll, for example, funded by the

California Endowment, has monitored health risks for California's children for over 10 yearsⁱ; these data were examined to support the local findings.

The data were then used to build a matrix with 26 topics and 17 health drivers (LHJ need, capacity, NPM, state law, etc.). Each health driver was then weighted based upon recommendations from topical experts at MCAH. For example, *local need* was weighted higher than *capacity*, as LHJs are implementers and are closely connected with the MCAH population. Once ranked, MCAH staff reviewed the top rankings in relationship to the qualitative needs assessment data provided by LHJs. The qualitative data assisted in adding detail to the topics to assure that data were captured accurately. Once the priorities were identified, individuals representing MCAH local programs were invited to provide feedback to finalize the priorities.

The 2016-2020 CCS-focused CSHCN needs assessment included key informant interviews, focus groups, and a survey that was completed by 2065 respondents. Stakeholders were gathered and subcommittees were convened to provide input on the various needs assessment tools, including key informant interviews, surveys, and focus groups. Participants selected to complete the 16 key informant interview represented county CCS programs, Medical Therapy Programs (MTPs), Regional Centers, specialty care physicians, primary care physicians, children's hospitals, university-based researchers, professional organizations and family advocates. Stakeholders contributed to survey development including web-based and telephone options, surveys for administrators and physicians, and questions for families and providers. Topics covered in the online surveys included: access to medical care and durable medical equipment (DME); barriers to physician and DME providers participating in CCS; strategies to address the barriers, case management and the coordination of services; county variations in CCS services; conditions covered by CCS; transitioning of youth who age out of CCS; telehealth and palliative services; and, access to and overall satisfaction with the CCS program. A final qualitative data source was drawn from focus groups. The development and refinement of the focus group discussion guides created for each group category was informed by findings from the key informant interviews and with input from the stakeholder subcommittees. SCD also gathered both primary and secondary data from the National Survey of Children with Special Healthcare Needs (NSCHCN), and CMS Net, the case management data system and provider tracking system of CCS.

MCAH Population Needs

Prevention wellness visits and access to care are the first steps in addressing the health needs of the MCAH population. Starting October 2013, California's ACA state-run health insurance market, *Covered California*, is providing qualified low-income individuals and families with free health insurance, insurance premium subsidies to qualifying individuals, and assisting consumers in determining if they are eligible for low-cost or no-cost Medi-Cal. To ensure that Californians are aware of health insurance options, MCAH and LHJs collaborate with their respective partners to support eligible residents in accessing healthcare made available through ACA. Data reflecting the still-nascent ACA may not reflect health outcomes for the newly insured populations.

Life course theory addresses the importance of early life experiences, including social and physical experiences that affect health and influence health disparities. The Life course perspective is found within the six population health domains in the three levels of MCAH: direct services, enabling services, and public health services and systems. Despite MCAH's significant existing infrastructure for life course investments in health, there are areas in need of great improvement in California. Many of these areas are beyond the immediate influence of MCAH, but form the foundation upon which our programs and initiatives are anchored. With this understanding, we form partnerships and collaborations to address the social determinants of health from a life course approach to address the needs of California's MCAH population. Below is an overview of each population health domain with data describing California's successes, challenges, and gaps. This report outlines how successful MCAH programmatic approaches can align with areas in need of intervention and support.

1. Women's/Maternal Health

MCAH efforts are supported by data that is of particular concern because of the disparities in key health indicators among women based upon race/ethnicity, geography, socioeconomic status, and other characteristics. Glaring examples exist in the areas of chronic conditions, pre-term births, and other morbidities that may impact mothers and their babies. MCAH and LHJs participate in collaboratives and partnerships to optimize preconception health to support all women particularly those affected by health disparities. One significant programmatic approach is the funding of CMQCC which seeks to prevent maternal death and injury by developing resources and techniques for maternal care providers.

To respond to its needs assessment findings that indicates the state's limitations when addressing disparities within Women's and Maternal Health, MCAH developed *Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age*. Studies indicate that whether women have had a well-woman visit in the past year gives some indication of their attention to pre-pregnancy or inter-pregnancy health status.ⁱⁱ MCAH is poised to address NPM 1: *the percent of women with a past year preventive medical visit*, as most LHJs have established a process to refer people to health care. According to the Title V Needs Assessment Strategic Question Survey administered to all LHJs in September/ October 2013, 27 LHJs were involved with activities to increase public awareness of the increased coverage for women's preventive services, including outreach and education to clients, providers, community partners, and internal staff. Overall, in California, over three quarters of women ages 15-44 were insured, 23%-24% each year from 2008 to 2012 (FIGURE 1).

However, having a health care plan did not directly correlate with having a routine checkup. By race/ethnicity, reproductive-aged Black women were far more likely to report having a routine checkup in the past year (74.6%) compared to Hispanics (61.1%) and Whites (58.9%) in 2013 (FIGURE 2).

In 2013, 68.7 percent of non-pregnant women aged 18-44 reported having one or more persons they think of as their personal doctor or health care provider. This represents a slight improvement from the (66.1%) that had a usual source of care in 2012. In 2013, the percent of non-pregnant women aged 18-44 reporting a usual source of care increased as the reported

income increased. While only 54.8% of women below 100% FPL had a health care plan, 59.1% reported having a routine checkup, whereas for women with incomes over 200% of FPL, 84.8% had a health care plan, but only 65.3% had a routine visit. Women with income more than 200% above poverty level were the most likely to report a usual source of care (84.8%). The least likely were women with income at below poverty level (54.8%). (FIGURE 3) African Americans had the greatest disparity. The prevalence of mistimed or unwanted pregnancy also differed widely by income level.

In 2012, almost all women had prenatal health insurance (98.3%) and almost all infants had health insurance (97.6%) (FIGURE 4). There were few disparities by race/ethnicity and income (FIGURE 5). In 2012, 75.3% of women had insurance before pregnancy and 83.3% had health insurance after pregnancy. Hispanic women had a lower prevalence of health insurance before (68.2%) and after (75.0%) pregnancy compared with all other race/ethnic groups (FIGURE 6).

Addressing the burden of chronic conditions is a goal of preconception health efforts. In 2000, 5.6% of women had an ICD9-CM code for hypertension at the time of labor and delivery. Since then, the number of women with hypertension has steadily increased to (7.6%) in 2012. Gestational or pre-existing diabetes at delivery has doubled, from (5.0%) in 2000 to (10.0%) in 2012. Additionally, in 2000 1.0% of women had a diagnosis code for asthma at the time of labor and delivery. Since then, asthma has steadily increased to 3.2% in 2012 (FIGURE 7).

Asthma and hypertension were most common among Black women (7.9% and 12.6%) followed by White women (4.2% and 7.7%), compared with lower rates among Hispanic women (2.4% and 7.4%) and Asian/ Pacific Islander (PI) women (2.2% and 5.8%). In contrast, diabetes was more common among Asian/PI women (14.7%) and Hispanic women (10.6%), as compared with Black women (7.6%) and White (7.5%) women.

Maternal Morbidity: In 2000, the rate of severe maternal morbidity was 97.8 per 10,000 delivery hospitalizations but by 2012, had increased to 175.5, a nearly 80 percent increase. The number of deliveries with severe maternal morbidity increased across all racial/ethnic sub-groups from 5,026 in 2000 to 8,508 in 2012. In 2012, Black women were more likely than all other race/ethnic groups to have at least one severe maternal complication (281.3 per 10,000). Hispanic women were the next most likely to have a severe morbidity at delivery, (182.3 per 10,000), followed by Asian/Pacific Islanders (169.5 per 10,000) and Whites (148.4 per 10,000). In 2012, severe maternal morbidity was more likely among deliveries with Medi-Cal as the expected source of payment (185.4 per 10,000) as compared to deliveries with other expected sources of payment (166.7 per 10,000). Nationally, in the period 2008–2009, for every 10,000 delivery hospitalizations, there were 129 delivery hospitalizations with at least one severe complication, an increase of 75% compared with 1998–1999.

In addition, in 2012, 42.4% of women were overweight/obese prior to pregnancy. Hispanics (52.1%) and Blacks (50.3%) had the highest prevalence of pre-pregnancy overweight or obesity, followed by Whites (35.6%) and Asian/Pacific Islanders (23.2%) (FIGURE 9).

Maternal Mortality: The Healthy People 2020 objective is to reduce the number of maternal deaths to 11.4 per 100,000 live births.ⁱⁱⁱ In California, the maternal mortality rate peaked to 14.0 during the years 2006-2008, and has since been on the decline to 7.6 per 100,000 live births for the years 2010-2012 (FIGURE 11). Despite the reduction in overall maternal

mortality rates, significant racial disparities persist with African-American women having almost three times higher occurrence of mortality than White women, 15.1 per 100,000 and 5.1 per 100,000 respectively for the year 2012 (Figure 12) .

2. Perinatal/Infant Health

California has done extensive work to reduce infant morbidity and mortality and will continue the work on this concern through *Priority 2, Reduce infant morbidity and mortality*. The disparity within this population domain is most egregious in the African American community. To address this disparity, Title V dollars support the Black Infant Health (BIH) program in communities experiencing the most significant number of African American births and disparities. BIH aims to improve health among African American mothers and babies and to reduce the Black: White disparities by empowering pregnant and mothering African American women to make healthy choices for themselves, their families, and their communities. The HP 2020 objective is to reduce the rate of infant deaths to 6.0 per 1,000 live births, the rate of neonatal deaths (among infants < 28 days) to 4.1, and the rate of post-neonatal deaths (among infants 28 days to 1 year) to 2.0.^{iv} California has met all of these objectives. From 2000 to 2012, the infant mortality rate decreased from 5.4 per 1,000 live births to 4.5, the neonatal mortality rate decreased from 3.7 to 3.1, and the post neonatal mortality rate decreased from 1.7 to 1.3 (FIGURE 13).

Infant Morbidity Rate: MCAH addresses National Performance Measure 3 through its emphasis on LBW and preterm births which are strong predictors of infant mortality. The HP 2020 objective is to reduce the proportion of LBW births to no more than 7.8%. California has met this objective. However, the percent of LBW births increased from 6.2% in 2000 to 6.7% in 2012, and remained relatively unchanged from 2005 through 2012 on (FIGURE 14). Due to the size of the birthing population in California, the burden of LBW is large. There were nearly 33,657 LBW births in 2012 and nearly half were among Hispanic women. The percent of LBW births among Black women (12.0%) is nearly double the percent among Hispanics (6.1%). At 7.9%, Asian women also have higher rates of LBW compared with Hispanics.

Infant Mortality In 2012, infant mortality rates were lowest among Asian women (2.9) and highest among Black women (9.8) (FIGURES 17 & 18). Although the disparity in the infant mortality rate primarily affects Black women and infants, the burden in California is largely experienced by Hispanics because of the size of the Hispanic birthing population.

Between 2000 and 2011, the perinatal mortality rate decreased from 5.9 to 5.4 per 1,000 live births plus fetal deaths. This rate is lower than the HP 2020 objective of 5.9. In 2011, the perinatal mortality rate was lowest among Asian women (3.9) and highest among Black women (11.1) (FIGURES 19 & 20).

Breastfeeding: MCAH has consistently worked on NPM 4 through addressing breastfeeding using internal and external stakeholders. Newer focus areas include promoting lactation accommodation for the low wage worker and developing breastfeeding friendly clinics. The HP 2020 objective is to increase to 46% the proportion of mothers who breastfeed exclusively through 3 months.^v California's rate of any breastfeeding increased from 90.8% to 92.9%, while exclusive breastfeeding rates increased from 56.6% to 64.6% (FIGURE 21). Although improvements were seen across all racial/ethnic groups during this time period, disparities in

infant feeding practices persist. In 2013, Black women had the lowest in-hospital breastfeeding initiation rates (84.0%) and less than a third of Black women breastfed exclusively. Although 92.7% of Hispanic women breastfed their infants in the hospital, over one third gave their infants formula during the hospital stay, while only 15 percent of breastfeeding White women supplemented with formula (FIGURE 22).

3. Child Health

The first few years of life is a particularly critical period in the life course; therefore, MCAH includes *Priority 3, improve the cognitive, physical, and emotional development of all children*. To achieve measures associated with *Priority 3*, State MCAH works with Local MCAH that provide direct services to the child population. In addition, State MCAH partners across governmental agencies to address unintentional injuries, child abuse/neglect, and developmental screening. Enabling services, including promotion and implementation of evidence-based practices such as Nurse Family Partnership and Healthy Families America are closely monitored by state MCAH. While funding for these two home visiting programs is distinct from Title V, state and local MCAH Title V programs work closely with these programs. Another example of braided funding includes California's Project LAUNCH and ECCS, which informs public health services and systems that support a more cohesive response to California's children. For example, developing a solid infrastructure for developmental screening has been an emphasis for both programs, in collaboration with Title V, local, and state MCAH.

As with all MCAH populations, the effect of ACA on the health status of California's children is yet to be realized. Local MCAH programs, as described above, link families to health insurance, a critical component to public health, as evident in the wellness disparity. Children ages 0-5 had the highest percentage of adequate health insurance (78.7%) compared with 73.9% of children ages 6-11.^{vi} Nationwide, 54.4% of children aged 0-17 receive coordinated, ongoing, comprehensive care within a medical home.^{vii} In California, this percentage is lower at 44.7%. White children had the highest percent who received care within a medical home (63.9%), compared with 50.6% of Black children and 46.5% of "Other" have a medical home. Only 34.1% of Hispanic children had a medical home (FIGURE 23).

The local needs assessment process emphasized that mental health continues to be a health concern across all MCAH populations, particularly children. MCAH plans on addressing this need under *Priority 7, Increase access and utilization of health and social services*. HP 2020 set a goal of 75.8% of children with mental health problems to receive treatment.^{viii} Nationwide in 2012, 43.4% of children ages 2-5 years, and 62.6% of children ages 6-11 years with a mental/behavioral condition received treatment.^{ix} A similar percentage of California children with a mental/behavioral condition received treatment during this same time (40.4% and 65.2%, respectively). The percentage of children and adolescents (ages 2-17) with a mental/behavioral condition who received treatment varies across income levels, with the lowest percentage not receiving treatment in households with income at or below 199% of the federal poverty level (45.4%) (FIGURE 24). The percentage of children aged 2-17 receiving treatment also varies by race/ethnicity, with only 15.7% of Black children with a mental/behavioral condition receiving treatment compared to 59.2% of Hispanic children, 66.4% of White children, and 87.4% of children from "Other" race/ethnicity groups (FIGURE 25). The percentage of children with private insurance receiving treatment (73.4%) was higher than those children with public insurance (44.5%). A large increase in the percentage of children ages 6-11 with a

mental/behavioral condition who received treatment occurred between 2003 (45.5%) and 2012 (65.2%). For adolescents aged 12-17 there has been little change in the percentage of those with a mental/behavioral condition receiving treatment from 2003 (64.3%) to 2012 (64.9%).

Immunizations: HP 2020 set a goal of increasing the percentage of children aged 19-35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine combined series of vaccines) from a baseline of 44.3% to a target of 80.0%.^x Of California's children aged 19-35 months, 66.8% received the combined series of vaccines in 2012, a very close to the national percentage of 68.4%.^{xi} The percentage of children who have received the combined series of vaccines has fluctuated slightly during the 2000 to 2012 time period while overall decreasing slightly (FIGURE 26).

Nutrition and Physical Activity):

In 2011-12, 32.6% of children ages 2-11 were physically active for at least one hour every day in the past week, excluding school and 52.6% ate five or more servings of fruit and vegetables daily. Black children were much more likely to participate in daily physical activity and to consume fruits and vegetables than children of all other races/ethnicities (FIGURE 27).

Child Morbidity and Mortality:

One of the 2016-2020 priorities is to intervene early by addressing healthy weights in the MCAH population. The disparity is substantial. In 2011-2012, 13.6% of California children ages 2-11 were overweight. White (8.7%) and Asian/PI (4.5%) children were less likely to be overweight than Black (19.9%) and Hispanic (17.5%) children (FIGURE 28).

Unintentional injuries are consistently among the top reasons for hospitalization among California children/ adolescents. Healthy People 2020 set a target goal of 555.8 non-fatal injuries per 100,000. MCAH is planning on addressing *NPM 7* in collaboration with other state agencies responsible for injury control. In 2012, the rate of non-fatal intentional and unintentional injuries among children ages 0 – 9 years was 201.6 per 100,000(FIGURES 29 & 30).

4. CSHCN

Although MCAH has worked with several partnerships and collaborations to address *NPM 6*, developmental screening; overall screening rates in California have remained low over recent years, while the percent of children with a developmental disorder has increased. In 2012, 28.5% of California children were screened in the previous 12 months for being at risk for developmental, behavioral or social delays using a parent-reported standardized screening tool during a health care visit. The 2012 rate of 28.5% is more than double that of children screened in 2007 (14.0%), showing a substantial improvement in screening rates.^{xiii} The percent of children who received a developmental screening using a parent-completed screening tool was similar across income levels but varied across race/ethnicity groups, with Black children having lower screening rates (FIGURE 33).

There are an estimated 1,000,000 Children and Youth with Special Healthcare Needs (CYSHCN) in California. CCS is the ‘insurance entity’ for approximately 180,000 clients. CMS Net 2013 data from the statewide CCS case management system was analyzed to provide

descriptive information on the diagnoses of CCS clients by body system and by major clinical condition. The average number of separate diagnoses per child is 1.66. It is notable that the number of clients enrolled has remained relatively unchanged, despite large changes in the health care delivery system in CA, including spread of managed care; managed care now covers the non-CCS health needs of approximately 75% of all CCS clients; the initiation of Covered California, the state's health insurance exchange, and the incorporation of Healthy Families into Medi-Cal.

Overall, families expressed a high degree of satisfaction with CCS, with 82% of respondents to the family survey giving CCS an 8 or above on a scale of 0-10. There was also a fairly high level of satisfaction with case management services (66% of those families that know they have a CCS case manager are very satisfied, 25% are satisfied, 5% have no opinion and only 4% are dissatisfied). Coordination of care is an area suggested where improvement is needed; 62% of families report that their children's services were always or usually coordinated in a way that makes them easy to use.

CCS administrative processing times of service authorization requests (SAR) to providers have shown improvement since the last needs assessment, with 79% of requests for services authorized within 2 weeks (vs. 61% in 2009).

Gaps in the program exist related to care coordination, including communication. Family focus groups identified issues related to communication with families in the area of covered services, and eligible diagnoses. Family survey results also indicate family perceptions of inadequate county support for transportation to and from appointments and at hospital discharge.

Although 94% of respondents to the family survey indicated that their child has a primary care provider (PCP), these PCPs are not providing all the services and supports, including care coordination and robust communications with the other entities also serving the child (i.e. special care centers, regional centers, medical therapists, mental health providers, schools), to be considered true medical homes. Physician survey and focus group respondents indicated that more resources, including enhanced reimbursement, are needed to be able to provide medical homes for CCS clients.

Seventy percent of respondents to the CCS Administrators Survey and 69% of respondents to the physician survey indicate that fragmentation of services could be reduced by having one program cover the whole child instead of just the child's CCS eligible medical condition. Administrators reported in focus groups and surveys that coordinating systems of care between CCS providers and Medi-Cal managed care plans is a challenge.

Under one approach to increase access to CCS paneled specialists, telehealth was expanded in 2013 with state legislation designed to remove barriers to telehealth. Use of the method remains limited, however. Administrators and medical consultants agree that it would be very helpful to expand telehealth options for CCS children, particularly in rural areas (42%).

There are some successes including county-based transition fairs and county CCS parent liaisons that work with families to identify community resources. In addition, some counties have implemented transition case management. Despite these positive developments, California ranks

45th in the nation for transition to adulthood, based on the NCSHN transition item. Families, physicians and CCS administrators all indicated that when a child grows up and ages out of CCS, there are significant challenges finding adult primary and specialty care providers. Over 80% of physician respondents to the survey believed that children would benefit by CCS helping to find adult providers. Of the respondents to the family survey with a child age 14 or older, 15% reported CCS helping them to find adult providers, and 80% of those helped report success. Families reported not enough education and information available to clients, families, and providers as to how to go about transitioning CCS clients to adult care. Providers report ‘There are no places that want to receive these kids.’

In summation, these data elicited from the needs assessment yielded two major priorities: Priority 4 provides a whole-child approach to serve Children with Special Health Care Needs and Priority 5, to improving access: ensuring the right patient to the Right Place. (See Table 1).

Approximately 62% of respondents to the CCS family survey indicate their services are usually or always organized in a way that makes them easy to use, while 64.8% of CSHCN in the state (data from the NSCSHCN 2009/2010) report that their services are organized so they are easy to use. Some CCS county administrators report delays in authorizing services as local CCS and the health plans covering the child’s non-eligible CCS condition determine which entity is responsible for covering various services (42% report always or frequently delays and 36% report occasionally experiencing delays. As a result, the Priority 4 is the promotion of caring for the Whole Child, rather than just serving a child’s CCS-eligible medical condition:. Included in the whole-child approach is increasing the percentage of CCS clients whose care is coordinated in a family centered health home that includes the promotion of transition to adult health services, California ranks 44th in the nation for health homes and 45th in the nation for CSHCN transition to adulthood, based on the NCSHCN. For CCS clients, family survey data indicate that only 28% of respondents with a child 14 or older report providers talking to them about how their child’s health care needs will be met when he/she turns 21 and that only 15% of CCS case managers assisted families with youth over age 14 with finding an adult provider.

Although CCS has an effective regionalized system of care, there are areas which can be improved (see Table 1.) Four such areas needing improvement are:

1. Access to specialty providers for clients who reside long distances from specialty clinics through tele-health or other modalities;
2. Access to a primary care provider with the necessary skills to coordinate care for a special needs child;
3. Access to necessary durable medical equipment (DME), pharmacy and home health services, and;
4. Access to consistent high quality specialty care from county to county one region to another.

4. Adolescent Health

Promoting and advancing adolescent health is a consistent interest at both the local and state level. *Priority 6, promote and enhance adolescent strengths, skills, and supports to improve adolescent health* is supported by State MCAH and Local MCAH in a number of current and proposed efforts. Although funding has always been a concern, the ACA is expected to benefit

the adolescent population. Because of the ACA's recent rollout, it is too early to assess the rates health care coverage among adolescents; however, currently, 71% of adolescents between the ages of 12-17 were adequately insured.^{xiii}

Well-Visit: HP 2020 set a goal of increasing the proportion of adolescents who have had a wellness check up in the past twelve months from the baseline of 68.7% to the target of 75.6%.^{xiv} In California, this percentage is slightly lower than the HP 2020 goal with 75.1% of adolescents ages 12-17 having one or more preventive visits in the last 12 months. There was an overall increase in the percentage of adolescents who have had a preventive services visit since 2003 (63.6%). Percentages of children and adolescents (ages 0-17) with a preventive service visit vary across income levels. The higher the income level, the higher the percentage of children and adolescents who have had a preventive care visit in the last 12 months. Percentages of children and adolescents (ages 0-17) who have had a preventive services visit are similar across Hispanic (80.2%), White (80.0%), Black (88.3%), and "Other" (83.1%) racial groups (FIGURE 34). Similar percentages of children and adolescents (ages 0-17) with public and private insurance had a preventive services visit in the past 12 months (80.8% vs. 84.7% respectively) (FIGURE 35). However, far fewer children and adolescents without insurance had a preventive services visit (48.5%). Immunizations are another measure of whether routine preventive care is being received. Nationwide, 53.8% of adolescents aged 13-17 have at least 1 dose of the HPV vaccine^{xv}. California's percentage is higher, with 65.0% of adolescents having received at least 1 dose of the HPV vaccine.

Nutrition and Physical Activity: As with the Child health domain, MCAH will continue to support nutrition and physical activity through *Priority 8: increase the proportion of children, adolescents and women of reproductive age who maintain a healthy weight*. Only 16.1% of adolescents age 12-17 reported physical activity lasting at least one hour per day in a typical week. Hispanics (15.1%) were less likely to report daily physical activity compared with Blacks (23.1%) and Whites (18.3%) (FIGURE 36). In 2011-2012, 15.8% of 12-17 year olds were obese (BMI \geq 95 percentile for age and gender) and 32.4% were overweight or obese. Significant racial and ethnic disparities have developed since 2001 with an obesity rate of 28.6% for Black, 19.7% for Hispanic, and 9.4% for white children 12-17 (FIGURE 41).

Mental Health: As in the child health population, California is challenged to meet the mental health needs of the adolescent health population. HP 2020 set a goal of increasing the proportion of children with mental health problems who receive treatment from the baseline of 68.9% to the target of 75.0%.^{xvi} Nationwide, in 2011/2012, 64.1% of adolescents, ages 12-17 years of age with a mental/behavioral condition received treatment^{xvii}.

Sexual and Reproductive Health: The adolescent birth rate in California was slightly lower than the national rate at 25.7 per 1,000 females ages 15-19. Adolescent birth rates vary greatly by race/ethnicity. Disparities exist particularly with the Hispanic females who have the highest adolescent birth rate at 38.9 births per 1,000. (FIGURE 37). Across all races and ethnicities, the adolescent birth rate has overall decreased over time as shown in FIGURE 38. In 2000, it was 46.7 births per 1,000 females. In 2005, it dropped to 38.6 births per 1,000 females. In 2007, the teen birth rate increased slightly to 40.1 but dropped again in 2008 (40.2) and has continued to decline, to the current (2012) rate of 25.7 per 1,000 females.

In 2012, CA female adolescents ages 15-19 had a Chlamydia rate of 2,355 per 100,000 while CA male adolescents had a Chlamydia rate of only 562.7 per 100,000 (FIGURE 39).^{xviii} Black adolescents had the highest Chlamydia rate, 4075.3 per 100,000 adolescents. This is approximately four times higher than the next highest group, American Indian/Alaska Native, at 1068.8 per 100,000 adolescents. Asian/Pacific Islander adolescents had the lowest incidence rate of Chlamydia in 2012, 292.7 per 100,000 15-19 year olds (FIGURE 40). Rates of Chlamydia have slightly increased since 2000; however, 2012 rates were lower than 2011 for both male and female adolescents.

6. Cross-cutting Issues

Life Course: A strong predictor of health status across the life course is socioeconomic status, the combination of one's social, economic, and physical environment. The health differences across socioeconomic statuses reflect social disparities of health. MCAH monitors social disparities of health under three categories: economic experiences, family well-being, and community well-being as well cross-cutting issues such as obesity and health care access.

Economic Experiences

Poverty Rate Among Women: The population of women of reproductive ages 15-44 with incomes below the poverty level is 20 percent, or about 1.5 million. Examining the poverty rate by race/ethnicity reveals that black (27.9%) and American Indian/Alaska Native (27.1%) women are twice as likely to be in poverty as are white women (13.5%) (FIGURE 46): Percentage of reproductive age women 15-44 in California that are below 100 percent of Federal Poverty Level by race/ethnicity

In 2011, 43.8% of mothers in California with a recent live birth had incomes \leq 100% of the federal poverty level (FPL). FIGURE 47 shows that compared to the state average, many more Black women (61.4%) and Hispanic women (62.9%) incomes \leq 100% of the FPL, than White women (22.4%) and Asian/PI women (13.3%).

Poverty Rate Among Children: An estimated 23% of California children under age 18 lived below the Federal Poverty Level (FPL). For example, FIGURE 48 shows that 33% of Black, 31% of Hispanic, and 27% of American Indian/Alaska Native children lived below the FPL, compared to 13% of Asian and 11% of white children.

Housing Cost Burden: In 2012, about half of California children ages 0-17 (51%) were living in households with a high housing cost burden (FIGURE 49).

Early Reading on Health: In California in 2012, 39.1% of children ages 0-5 are read with every day, down from 44.6% in 2003 but up from 36.5% in 2007. The percentages of children read to every day vary by race/ethnicity group in 2012, with a greater percentage of White children (62.9%) being read to than Multi-racial/ethnic (43.4%), Black (40.4%) and Hispanic (28.3%) children (FIGURE 50). A greater percentage of children with private insurance (50.6%) were read to every day compared to children who were uninsured (38.7%) or had public insurance (26.9%).

Community Well-Being

A growing body of literature shows discrimination raises the risk of many emotional and physical problems (FIGURE 51).^{xix}

In 2011, 5.3% of mothers with a recent live birth reported that they had neither practical nor emotional support. The lack of support differed by race/ethnicity: more Hispanic (7.4%) and Asian/PI women (6.7%) lacked support compared with Black (3.1%) and White women (1.2%) (FIGURE 52).

Among 504,000 live births, 33.1% (167,000) occurred to residents living in areas of concentrated poverty.^{xx} Blacks and Hispanics had the largest proportions of live births in poverty areas (48.4 percent and 46.0 percent, respectively) (FIGURE 53).

Only 60% of Latino children live in a neighborhood that have amenities that include parks, sidewalks, recreation centers and libraries, lower than Whites (73%), Blacks (87%) and “Other” Race (71%). There was a stepwise increase in availability of all four amenities in the neighborhood as income increased.

Family Well-Being

A number of factors affect the well-being of families. Physical health, including oral health, as well as tobacco use impacts short- and long-term health outcomes.

Oral health: Dental care is the most prevalent unmet health care need of children; the condition of children’s teeth in California was ranked the third worst in the country.^{xxi} In 2012, the percent of children with a preventive dental visit in the last year was 54.3% for ages 1-5, 87.6% for ages 6 – 11 and 81.3% for ages 12 – 17.

In 2013, the percent of non-pregnant women aged 18-44 who had a dental visit in the past year was 64.5%, with variation by household income levels, race/ethnicity, and health insurance provider type (FIGURE 54).

- By income (%FPL): 0-99% (49.7%); 100-199% (52.9%); 200% or greater (78.9%).
- By race/ethnicity: White (73.6%); Hispanic (56.8%); Blacks (55.1%)
- By insurance type: Medi-Cal (47.9%); other insurance providers (68.1%)^{xxii}

In 2012, 42.1% of all women with a live birth reported receiving dental care during pregnancy, a 25% increase since 2002 (33.8%) (FIGURE 55). Visiting the dentist was similar for Medi-Cal (30.5%) and uninsured women (31.7%). White (55.7%) and Asian/PI women (51.3%) had a higher percent compared with Black (43.9%) and Hispanic (39.3%) women.

Tobacco: During 2008-2010, the percentage of 11th graders who reported any cigarette use in the past month was 13.2%, higher than both 9th (9.1%) and 7th (5.1%) graders. American Indian/Alaska Natives had the highest and Asian students reported the lowest rate of cigarette use in the past month (FIGURE 56).

In 2012, the prevalence of smoking during the 3rd trimester of pregnancy was higher among Black (9.1%) and White (4.4%) women, compared with Hispanic (1.2%) and Asian/PI (0.7%) women (FIGURE 57). Smoking was also more common among women with incomes \leq 100% of the FPL (4.9%) compared with women with incomes $>$ 400% of the FPL (0.2%). The prevalence of third trimester smoking decreased from 4.8% in 2000 to 2.6% in 2012, however, the prevalence has not changed since 2007, when it was also 2.6% (FIGURE 58)

Organizational Structure

The Governor oversees the Health and Human Services Agency which is responsible for CDPH and DHCS; MCAH Title V Block Grant resides under CDPH; and SCD which oversees CSHCN in the CCS program, resides under DHCS. The Acting Chief of the MCAH is the California Title V Director and is responsible for the administration of Title V programs. Attachment 1 provides the Title V Organization Chart. Attachment 2 describes Title V programs.

Agency Capacity

MCAH Public Health Nurses (PHNs) oversee the work of LHJs which is the umbrella program for Title V programs. Each MCAH LHJ has an MCAH Director, who has the general responsibility and authority to plan, implement, evaluate, coordinate, and manage all MCAH services within the LHJ. Depending on the size of the county, the MCAH Director is a PHN or physician. There are 61 LHJs funded by Title V, local funds, and Title XIX matching.

MCAH PHNS and other MCAH public health professionals monitor the LHJ work in the delivery of services to the six population health domains. To optimize public health influence, MCAH integrates evidence-informed and evidence-based interventions to address the population health domains. For example, one program that addresses the infant population across local MCAH is the Sudden Infant Death Syndrome's (SIDS) Safe to Sleep Campaign; promotion of the campaign exists in Local MCAH, AFLP, and BIH programs.

CCS provides a statewide organized, regionalized system of care for children with special health care needs. This includes standards for hospitals and other special care centers that include multidisciplinary care teams and access to appropriate specialists. While CCS only covers children who meet specific diagnostic and financial criteria, the standards and regionalized systems of care created to serve CCS benefit the broader group of CSHCN receiving services in this regionalized system of care. Twenty-six out of 28 pediatric intensive care units in the state are reviewed and approved by CCS including 100% of facilities providing the highest acuity services. CCS has approved 126 out of 128 NICUs.

Local CCS programs provide case management and care coordination services to help families navigate the system. Family and consumer partnerships are another area of strength for the CCS program. Local (county) CCS programs maintain parent liaisons through Family Voices of CA Member Agencies. These liaisons train CCS staff on family perspectives, help families' access services and provide conflict resolution assistance for CCS staff and family members. Families have participated in NICU quality workgroups and hospital length of stay work groups in

collaboration with CPQCC. CCS has been working on family representation on technical advisory groups but is seeking a way to offer legal protection to advisory group members.

See the Attachment 3 that depicts MCAH's approach to the six population health domains.

The MCAH Director ensures the performance of the core public health functions of assessment, policy development, assurance, and evaluation. Annual reports and regular contact with MCAH staff from the Program Standards Branch assure that activities are completed and that outcome measures respond to MCAH program goals that are included in the MCAH SOW. MCAH SOW in Attachment 4 provides a detailed description of LHJ activities that respond to the following goals.

Goal 1: Improve Outreach and Access to quality health and human services (All populations)

Goal 2: Improve Maternal and Women's Health

Goal 3: Improve Infant Health

Goal 4: Improve Nutrition and Physical Activity (among maternal, child and adolescent populations)

Goal 5: Improve Child Health

Goal 6: Improve Adolescent Health

Current State Collaboration and Coordination

MCAH and CSHCN programs have taken several steps to ensure a statewide system of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care. Examples of MCAH collaborating with other state agencies include the following:

- Data linkage with WIC on public health research projects to examine the association between WIC and MCAH outcomes such as pre-term birth.
- The SCD and IZ Branches collaborate with the Vaccines for program by providing vaccination coverage and modifications through the Child Health and Disability Prevention (CHDP) program, including: tetanus, diphtheria and acellular pertussis vaccine; FluMist; meningococcal conjugate; measles, mumps, rubella, and varicella; hepatitis A, hepatitis B, Haemophilus influenzae type B vaccine, rotavirus, influenza, human papillomavirus, and meningitis vaccines.
- California Nutrition, Physical Activity and Obesity Prevention Program/ Champions for Change, MCAH, and CMS collaborate with the California Nutrition, Physical Activity and Obesity Prevention on conference presentations.
- MCAH collaborates with the Safe and Active Communities (SAC) on injury prevention activities, including local training programs, SIDS and the Child Death Review Team (CDRT), SAFE-KIDS California Advisory Committee, and the Strategic Coalition on Traffic Safety. MCAH Title V support data collection and prevention work of the local CDRTs. MCAH and SAC are also working together to address Electronic Death Recording System data issues related to Shaken Baby Syndrome and SIDS.

MCAH and SCD support communities in a number of ways. For example, local MCAH programs coordinate the facilitation of enrollment into medical assistance programs, such as those available through Covered California and California Children's Services (EPSDT). Additionally, local programs integrate health education into their outreach and referral efforts for high-risk MCAH clients such as health fairs, forums, toll-free telephone line, and referrals

regarding prenatal and child health issues including childhood safety and injury prevention. Additionally, many urban, suburban and rural MCAH Programs provide transportation for MCAH population to access prenatal care and other medical and dental services.

More intensive interventions are also available for high-risk populations through case management provided by PHNs and community outreach workers. Case managers conduct assessments; monitor infant and child development; provide health education; and provide referrals to medical, dental, nutrition, behavioral health, and social services.

LHJs provide extensive outreach and education activities in the community as described above, and as required in the local scope of work. Capacity needs related to enabling services were identified by 80% of LHJs in the areas of linking clients to health and community services and in informing and educating the public about MCH issues. Examples related to capacity needed to link clients to services include improved collaboration across agencies to overcome barriers, respond to the needs of changing populations, and increase cultural competence in outreach approaches. Examples of health education capacity needs include improved breastfeeding education, increased cultural competence of health education materials and approaches, parent education related to preventive care, and collaboration with businesses to increase penetration of health education messages into the community. A comprehensive list of collaborators is shown in [Attachment 5](#).

MCH Workforce Development and Capacity

MCAH programs boast a cadre of highly qualified public health professionals. These professionals total a full-time equivalent of 791 staff positions from throughout the California funded by Title V, Title XIX, California State General Funds, and local agencies funds that include public and private sources. See Attachment 6 for detailed descriptions of staff requirements for Local MCAH programs.

MCAH is led by the Acting Title V Director, supported by four managers responsible for the policy, program, evaluation, and fiscal administration of Title V activities:

Addie Aguirre, Acting Title V Director, is the lead administrative staff in state and federal public health initiatives.

Laurel A Cima Coates, MPA, Chief, Prevention, Policy and Program Standards Branch, has 20 years in administering state and federal public health policy and programs, including CDC Prevention Funding, Title V, MIECHV, SAMHSA Project LAUNCH, Early Comprehensive Childhood Systems, Office of Adolescent Health/ Positive Youth Development

Shabbir Ahmad, PhD, Chief, Epidemiology, Assessment and Program Development Branch, has over 10 years in managing and leading a team of public health professionals, researchers and analysts for MCAH surveillance and program assessments.

Jo Miglas, Chief, Financial Management and Contract Operations Branch assumes the contract monitoring functions for MCAH, including fiscal forecasting, budget-related work, management of over 200 contracts, and working with Department of Finance and other control agencies.

At the MCAH Division, located in Sacramento, California, these key positions oversee 118 Title V funded positions and 47 contract staff funded by multiple federal funding sources.

DHCS/SCD Workforce Development and Capacity

The primary use of Title V funds is for administrative case management. This work is shared between the state and county professionals. These professionals total approximately 1400 full-time equivalent staff positions from throughout California funded by Title V, Title XIX, California State General Fund, and local agency funds that include public and private sources.

The Systems of Care Division is led by the Division Chief, supported by 7 managers, and 58 counties responsible for the administrative case management, policy, program, evaluation, and fiscal administration of Title V activities:

Louis Rico, Chief of SCD is the lead on the CSHCN Block Grant and ultimately responsible for service provided by staff in the Division.

Dr. Robert Dimand, Chief Medical Officer is responsible for all medical aspects of SCD programs.

Mechanism for Multiculturalism

MCAH's mechanisms to assure multiculturalism across Title V programs include 1) staff development; 2) the analysis of the national and state MCAH population health indicators, including preconception health indicators and life course metrics by self-identified race and cultural designations; 3) development and implementation of policies and programs reflective of the data.

Local programs funded with Title V dollars have scopes of work that include multicultural objectives. MCAH has led and collaborated with organizations and agencies to reduce the health disparities and ensure appropriate delivery of health services, information and health care using culturally sensitive engagement techniques.

MCAH data analyses result in the development of strategic policies and programs. For example, the disproportionate rates of infant mortality in the Black community drove MCAH to develop an intervention that is governed by Black cultural competence as one of its core values.

Another example is the MCAH adolescent health programs that are developed and implemented to address the unique cultural nuances in the Latino community which represents the majority of California's adolescents. All youth programs are tailored to support the cultural and linguistic needs of the Spanish-speaking youth.

Partnerships, Collaboration, and Coordination

The Title V Five-year Needs Assessment findings emphasize the importance in continuing current collaborations and coordination with other entities that share MCAH Title V population outcomes.

MCAH has addressed the child health domain through its leadership role in the development of a coordinated and comprehensive early childhood system in California and has worked to strengthen partnerships with key early childhood initiatives and agencies. One example is the implementation of California's Early Childhood Comprehensive Systems (ECCS) grant. The ECCS Leadership Team represents early childhood system stakeholders that include First 5 California, First 5 Association, California Departments of Social Services (Office of Child Abuse Prevention) and Education (Race-to-the-Top), and the California Head Start Association. MCAH participates in the State Interagency Team which is a multi-state agency group for Children, Youth and Families that consists of high-ranking state level partners. Most recently, and in response to unmet needs, new partnerships have been forged between MCAH, California Maternal, Infant, and Early Childhood Home Visiting program (MIECHV), and the California Department of Health Care Services (DHCS) to identify mental health services and Medi-Cal reimbursement mechanisms for home visiting families. All of California's MIECHV are under the oversight of the Local MCAH director.

The California Adolescent Sexual Health Work Group which is comprised of representatives from CDPH/Office of AIDS, CDPH/Sexually Transmitted Disease Branch, CDE, universities and non-governmental organizations to address sexual and reproductive health issues of California adolescents. ASHWG develops adolescent health competencies, coordinated data tables, and content expertise on adolescent health constructs such as positive youth development.

The formation of the Preconception Health Council of California (PHCC) was founded in May 2006 by MCAH and the California Chapter of the March of Dimes. Through PHCC, MCAH partners with organizations and stakeholders across the state to provide direction for the integration of preconception care into public health and clinical practice and promote preconception health messaging for women of reproductive age. In partnership with the American Congress of Obstetricians and Gynecologists (ACOG) and MOD, the Council developed the Interconception Care Project of California which provides clinical guidance to providers on critical health issues to address in the postpartum visit for women with maternal morbidities.

Local CCS programs maintain parent liaisons through Family Voices of CA Member Agencies. These liaisons train CCS staff on family perspectives, help families access services and provide conflict resolution assistance for CCS staff and family members. Families have participated in NICU quality workgroups and hospital length of stay work groups in collaboration with CPQCC. CCS has been working on family representation on technical advisory groups but is seeking a way to offer legal protection to advisory group members.

II-C. State Selected Priorities

For 2016-2020, the California Title V Program selected the following priority needs and related goals by population domain:

Domain: Women/ Maternal Health

Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age

- Goal 1: Decrease intimate partner violence
- Goal 2: Decrease unintended pregnancy
- Goal 3: Decrease the burden of chronic disease

Domain: Perinatal/ Infant Health

Priority 2: Reduce infant morbidity and mortality

- Goal 1: Reduce pre-term births and infant mortality
- Goal 2: Increase exclusive breastfeeding initiation and duration
- Goal 3: Increase safe sleep practices

Domain: Child Health

Priority 3: Improve the cognitive, physical, and emotional development of all children

- Goal 1: Reduce unintentional injuries
- Goal 2: Reduce child abuse and neglect
- Goal 3: Provide developmental screening for all children

Domain: Children with Special Healthcare Needs

Priority 4: Provide a whole-child approach to services to Children with Special Health Care Needs

- Goal 1: Increase systems that support children with special health care needs
- Goal 2: Increase access to Medical Homes for children with special health care needs
- Goal 3: Improve transition services to children with special health care needs

Priority 5: Improve access: ensuring the right patient to the Right Place

- Goal 1: To increase access to high quality care
- Goal 2: Maintain and support regionalization of care
- Goal 3: Improve consistency of services across the state

Domain: Adolescent Health

Priority 6: Increase conditions in adolescents that lead to improved adolescent health

- Goal 1: Decrease teen pregnancies
- Goal 2: Reduce teen dating violence, bullying and harassment

Domain: Cross-cutting/Life Course

Priority 7: Increase access and utilization of health and social services

Goal 1: Increase access to oral health services

Goal 2: Increase utilization of preventive health services

Goal 3: Increase screening and referral for mental health and substance use services

Priority 8: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy weight.

Goal 1: Increase consumption of a healthy diet

Goal 2: Increase physical activity

California’s priority needs from 2016 to 2020 is a continuance of priority needs identified for the 2011 to 2015 reporting period. Unlike in the 2011-2015 period, strategies to address each priority need was not included in the 2016-2020 priority statements and instead, goals for each priority statement were identified and specific objectives and strategies to address each goal were stated in the action plan.

A cross-walk between the 2011-2015 and 2016-2020 priority statements is shown in the table below and an explanation on why these are considered a continuation of the 2011-2015 priority statements.

2016-2020 PRIORITY NEEDS	Closely related 2011-2015 PRIORITY NEEDS	New(N), Replaced (R) or Continued (C) for 2016-20
Priority 1. Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age	2011 Priority 4. Improve maternal health by optimizing the health and well-being of girls and women across the life course.	C- Closely related to the 2011-2015 priority statements 4, 6 and 7; the current priority is on improving women’s health in general with emphasis on primary prevention particularly for women of reproductive age
	2011 Priority 6. Reduce maternal morbidity and mortality and the increasing disparity in maternal health outcomes.	
	2011 Priority 7. Reduce infant mortality and address disparities by promoting preconception health and health care and by preventing causes such as birth defects, low birth weight/prematurity, SIDS, and maternal complications in pregnancy	
Priority 2. Reduce infant morbidity and mortality	2011 Priority 7. Reduce infant mortality and address disparities by promoting preconception health and health care and by preventing causes such as birth defects, low birth weight/prematurity, SIDS, and maternal complications in pregnancy	C- Closely related to the 2011-2015 priority statement 7; priority need for infant health has been expanded to include strategies to address infant morbidities
Priority 3. Improve the	2011 Priority 8. Support the physical,	C- Closely related to the 2011-

cognitive, physical, and emotional development of all children	socio-emotional, and cognitive development of children, including the prevention of injuries, through the implementation of prevention, early identification and intervention strategies	2015 priority statement 8; priority need and strategies to address this priority is carried forward for 2016-2020
Priority 4. Provide a whole-child approach to services to Children with Special Health Care Needs	2011 Priority 1. Modify the California Children’s Services (CCS) program, with appropriate funding, to cover the whole child.	C- Closely related to the 2011-2015 priority statements 1 and 3;
	2011 Priority 3. CCS will work with appropriate partners to define and create and implement standards for Medical Homes for CCS children.	
Priority 5. Improve access: ensuring the right patient to the Right Place	2011 Priority 2. Expand the number of qualified providers of all types in the CCS program.	C- Closely related to the 2011-2015 priority statements 2 and 3; problem need is to address access to care for CSHCN
	2011 Priority 3. CCS will work with appropriate partners to define and create and implement standards for Medical Homes for CCS children.	
Priority 6. Increase conditions in adolescents that lead to improved adolescent health	2011 Priority 9. Promote positive youth development strategies to support the physical, mental, sexual and reproductive health of adolescents.	C- Closely related to the 2011-2015 priority statements 9; problem need to address adolescent physical, mental and sexual health is carried forward for 2016-20
Priority 7. Increase access and utilization of health and social services	2011 Priority 10. Link the MCAH population to needed medical, mental, social, dental, and community services to promote equity in access to quality services.	C- Closely related to the 2011-2015 priority statement 10; strategies developed in 2011-2015 will continue through 2016-2020
Priority 8. Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy weight.	2011 Priority 5. Promote healthy nutrition and physical activity among MCAH populations throughout the lifespan beginning with exclusive breastfeeding of infants to six months of age	C- s Closely related to the 2011-2015 priority statement 5; strategies developed in 2011-2015 will continue through 2016-2020

Local needs assessments were conducted in all 61 LHJs where input from 3126 community stakeholders and representatives were obtained. A list of the 25 most commonly reported health issues identified in the local needs assessment was created and criteria for prioritization of these health issues were developed. The health issues were ranked and common themes were identified to define a problem need for each population domain. Ranking of the 25 health issues was done using the following criteria:

- 1) Relevance as it relates to state and national priority needs
 - Is the health issue reflective of the Title V national performance measure priority areas?
 - Is this a health issues with sub-optimal performance for California in the America Health Rankings?
 - Is this problem need identified in the California Governor's Let's Get Healthy California Strategic Plan?
 - Does the California Health and Safety code mandate state health programs to address this health issue?
 - Is the health issue a focus area in the CDPH California Wellness Plan?
 - Is the health issues identified as a quality assurance focus area in the DHCS Baseline Assessment of Quality Improvement Activities?
 - Are there significant racial or socioeconomic disparities related to this health issue

- 2) Ability to be addressed by existing resources and opportunities
 - Did the LHJs identify strategies/ activities in their community to address this health issue?
 - Does California's Title V programs have existing activities or strategies that will address the upstream risk factors that affect this health issue?
 - Is there Title V resources earmarked to address this health issue?
 - Is there expertise in the Title V funded workforce that can implement and monitor evidence based interventions to address this health issue?

- 3) Ease in monitoring progress in addressing the health issue
 - Are there existing indicators or measures collected at the local and state level to monitor progress toward addressing this health issue?
 - Compared to national statistics, is California performing worse with regard to the health issue?
 - Is the overall trend for this health issue worsening in California?

- 4) Impact on the population
 - Based on current statistics, are there a lot of individuals affected by this health issue?
 - Based on scientific literature does this health issue have a profound impact on downstream health issues?
 - Based on surveys conducted, did stakeholders or the general public identify or perceive this as an emerging or unmet health issue that needs to be prioritized?

The highest ranking health issues specific to a population domain were identified and translated into goal statements for a given population domain. Given the goals identified by population domain, an overarching problem needs statement was stated for each population domain.

For the CSCHN Population Domain, identification of problem needs was augmented by a more in-depth needs assessment of CSCHN enrolled in CCS. A contractor was hired by SCD to conduct the CCS-focused CSHCN needs assessment. The stakeholder process began with an initial meeting at which the concepts of the needs assessment were introduced, and stakeholder subcommittees were convened to provide input on the various needs assessment tools, including key informant interviews, surveys, and focus groups. Sixteen key informant

interviews were conducted representing county CCS programs, Medical Therapy Programs (MTPs), Regional Centers, specialty care physicians, primary care physicians, children's hospitals, university-based researchers, professional organizations and family advocates.

Family satisfaction, administrator, physician and provider surveys were conducted which include topics related to access to medical care and durable medical equipment (DME), barriers to physician and DME providers participating in CCS and strategies to address the barriers, case management and the coordination of services, county variations in CCS services, conditions covered by CCS, transitioning of youth who age out of CCS, tele health and palliative services, and access to and overall satisfaction with the CCS program. A final qualitative data source was focus groups. The focus group process was guided by a combination of subcommittee input, stakeholder coordination, and assessment of feasibility. The development and refinement of the focus group discussion guides created for each group category was informed by the findings from the key informant interviews and with input from the stakeholder subcommittees. Also primary and secondary data from NSCHCN, and CMS Net, the case management data system and provider tracking system of CCS was analyzed. Priority needs and goals were developed to address weaknesses specific to the CCS program that were identified in the needs assessment.

II-D. Linkage of Priorities, National Performance Measures and National Outcome Measures

The Guidance recommends that grantees select national performance measures where there is anticipated improvement in the baseline rate. The selection of eight of the fifteen national performance measures (NPMs) for programmatic focus was informed by the programmatic objectives and strategies identified for each of the 2016-2020 priority needs. Each of the six population domains have one corresponding NPM selected.

For the Maternal/ Women's Health domain, the priority need is to decrease risk factors for adverse pregnancy outcome among women of reproductive age, and a related objective is to decrease the burden of chronic disease in this population. NPM 14A, the percent of women who smoke during pregnancy was selected since smoking is linked with adverse pregnancy outcomes that include miscarriages, problems with the placenta, premature birth, Sudden Infant Death Syndrome (SIDS) and birth defects. Smoking also increases the risk for chronic conditions such as heart disease and cancer.

For the Perinatal/ Infant Health domain, the priority need was to reduce infant morbidity and mortality and a related objective is to improve access to enhanced perinatal services. To address this priority need, strategies were identified in the action plan related to improving access to NICU services. With very low birthweight (VLBW) infants accounting for 53% of all infant deaths, NPM 3, the percent of VLBW infants born in a hospital with a Level III+ NICU was selected as a performance measure since VLBW infants are less likely to die if they are born/cared for in a sub-specialty facility that is appropriately staffed and equipped and with a high volume of high-risk admissions.

For the Child Health domain, the priority need is to improve the cognitive, physical, and emotional development of all children, including children with special health care needs, with provision of developmental screening for all children as a related objective. Developmental screening is designed to identify problems or delays during normal childhood development. When properly applied, screening tests for developmental or behavioral problems in preschool children allow improved outcomes due to early implementation of treatment. NPM 6, the percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool was thus selected as a performance measure.

For the Children with Special Healthcare Needs domain, the priority needs are to provide a who child approach to CSHCN services and to improve access: ensuring the right patient to the right place. The two CSCHN-specific NPMs were both selected as they pertain to goals of ensuring CSCHN have a medical home and as they mature, are provided transition services. The two NPMS selected include NPM 11, the percent of children with and without special health care needs having a medical home, and NPM 12, the percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care.

For the Adolescent Health domain, the priority need is to improve adolescent sexual health with a related objective of reducing teen dating violence, bullying and harassment. Healthy relationships consist of trust, honesty, respect, equality, and compromise. Any violence in the form of bullying, harassment or dating violence in adolescence can negatively influence the development of healthy sexuality, intimacy and identity as a youth grows into adulthood and can increase the risk of physical injury, poor academic performance, binge drinking, suicide attempts, unhealthy sexual behaviors, substance use, negative body image and self-esteem and violence in future relationships. NPM 9, the percent of adolescents, ages 12 through 17 years, who are bullied or bully others was selected as a performance measure.

For the Cross-cutting/ Lifecourse domain, the priority needs are to increase access and utilization of health and social services and increase the proportion of children, adolescents and women of reproductive age who maintain a healthy weight. NPM 1, the percent of women with a past year preventive medical visit was selected because having an annual preventive medical visit is distal to efforts and strategies to expand healthcare access. Since preventive screening for chronic disease conditions and intimate partner violence are performed as part of preventive medical visits, it acts as a health marker for the mothers/ women population domain. NPM4, the percent of infants ever breastfed and the percent of infants breastfeeding exclusively at six months of age was selected as they are indicative of the success of implementing strategies to make breastfeeding as the normal feeding method in the first year of life.

The table below cross-references the 2016-2020 goals for each priority statement by population domain, their related 2016-2020 national performance measures and the rationale for selection of the eight of the fifteen national performance measures. The eight selected national performance measures are italicized and bolded in the table.

The specificity of the performance measure definition as it applies to the specific objectives and strategies for each priority need were given primary consideration in the selection of the eight NPMs as these are most amenable to change. Less consideration was given to the data source

for the NPMs and their inherent limitations such as the precision and accuracy of the estimates generated, frequency of the data collection and reporting, its proxy power to say something important about a particular health issue, its ability to speak to a broad and diverse audience about a result the Maternal Child Health Bureau (MCHB) want to collectively achieve and its ability to motivate the MCAH community to action. It is assumed that these other criteria were vetted out when MCHB pared down the list to 15 NPMs which grantees were to select from.

2016- 2020 State Priority Needs	Related Goals	Closely Related NPM (2016-20)	NPM Selection Rationale
(Domain Mother/ Women' s Health) Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age	2: Decrease unintended pregnancy		
	1: Decrease intimate partner violence	NPM #1 <i>Well-woman visit (Percent of women with a past year preventive medical visit)</i>	NPM 1 plays a role as a sentinel health marker in the mothers/women's health domain for receipt of preventive screening for chronic disease and intimate partner violence, risk factors for adverse life course events among women of reproductive age
	3: Decrease burden of chronic disease		
(Domain: Perinatal/ Infant Health) Priority 2: Reduce infant morbidity and mortality	1: Reduce pre-term births and infant mortality	NPM #2 Percent of cesarean deliveries among low-risk first births	
		NPM # 3 <i>Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)</i>	VLBW infants account for 53% of all infant deaths. NPM 3 was selected as a measure since VLBW infants are less likely to die if they are born/cared for in a sub-specialty facility that is appropriately staffed and equipped facility with a high volume of high-risk admissions
	3: Increase breastfeeding initiation and duration	NPM #4A <i>Percent of infants who are ever breastfed</i> NPM #4B <i>Percent of infants breastfed exclusively through 6 months</i>	Improvements in this performance measure is indicative of success in implementing strategies to achieve California's statewide goal to make breastfeeding the normal method of infant feeding for at least the first year of life.

	3: Increase safe sleep practices	NPM # 5 Percent of infants placed to sleep on their backs	
--	----------------------------------	--	--

2015 State Priority	Related Goals	Closely Related NPM (2016-20)	NPM # and Selection Rationale
(Domain: Child Health) Priority 3: Improve the cognitive, physical, and emotional development of all children, including children with special health care needs	1: Reduce unintentional injuries	NPM # 7 Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19	Bruises, burns, fractures, head and abdominal injuries are common to physical abuse. Nationally, hospitalization for abuse-related injuries have risen since 1997 even if reported child abuse cases have decreased. Shifts in how child abuse is counted is more likely to account for the differences and highlight the challenge of using a single source of data to track a complex problem such as child abuse
	2: Reduce child abuse and neglect		
	3: Provide developmental screening for all children	<i>NPM #6 Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool</i>	

2015 State Priority	Objectives	Closely Related NPM (2016-20)	NPM Selection Rationale
(Domain: CSHCN) Priority 4: Provide a whole-child approach to services to Children with Special Health Care Needs	1: Increase systems that support children with special health care needs		
	2: Increase access to medical homes	<i>NPM #11</i> <i>Percent of children with and without special health care needs having a medical home</i>	NPM 11 was selected since one of the goals specific to CSCHN is to increase access to medical homes.
	3: Improve transition services	<i>NPM # 12</i> <i>Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care</i>	NPM 12 was selected because strategies to increase systems that support CSHCN include enhanced service delivery of transition services
Priority 5: Improve access: ensuring the right patient to the Right Place	1: Increase access to high quality care		
	2: Maintain and support regionalization of care		
	3: Improve consistency of services across the state		

2015 State Priority	Objectives	Closely Related NPM (2016-20)	NPM Selection Rationale
(Domain: Adolescent Health) Priority 6: Increase conditions in adolescents that lead to improved adolescent health	1: To decrease teen pregnancies		
	2: To reduce teen dating violence, bullying and harassment	<i>NPM #9</i> <i>Percent of adolescents, ages 12 through 17 years, who are bullied or bully others</i>	<ul style="list-style-type: none"> • Healthy relationships consist of trust, honesty, respect, equality, and compromise. Any violence in the form of bullying, harassment or dating violence in adolescence can negatively influence the development of healthy sexuality, intimacy and identity as a youth grows into adulthood and can increase the risk of physical injury, poor academic performance, binge drinking, suicide attempts, unhealthy sexual behaviors, substance use, negative body image and self-esteem and violence in future relationships.

2015 State Priority	Objectives	Closely Related NPM (2016-20)	NPM # and Selection Rationale
(Domain: Cross-cutting/ Life Course) Priority 7 Increase access and utilization of health and social services	1: Increase access to oral health services	NPM #13A Percent of women who had a dental visit during pregnancy NPM # 13B Percent of infants and children, ages 1 through 17 years, who had a preventive dental visit in the last year	
	2: Increase access to preventive health services	NPM #10 Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year	
		NPM #15 Percent of children 0 through 17 years who are adequately insured	Having health insurance coverage is intricately linked to having access to a regular source of care and timely and less costly medical services. From a lifecourse perspective, having health insurance for children is an important investment in improving the quality of life. Maximizing a child's potential is possible if it is not hindered by an underlying medical condition or impaired by a medical emergency.
	3: Increase screening and referral for mental health and substance use services	NPM 14A. Percent of women who smoke during pregnancy	
		NPM # 14B Percent of children who live in households where someone smokes	
Priority 8: Increase the proportion of children, adolescents and women of reproductive age who	1: Increase consumption of a healthy diet		
	2: Increase physical activity	NPM # 8 Percent of children ages 6 through 11 years and adolescents ages 12 through 17 years who are physically active at least 60 minutes per day	

maintain a healthy weight.			
----------------------------	--	--	--

II-E. Linkage of Priorities, State Performance and Outcome Measures

California will identify and establish three to five state performance measures and their performance objectives as part of the FY 2017 Application/ 2015 Annual Report and will begin submission of state performance data starting with the FY 2018 Application/ FY2016 Annual Report. Although not required, California may consider including one or more state outcome measures based on the MCH priorities established.

II-F. Five-Year State Action Plan

State Action Plan Tables by MCH Population Domain

a. Domain: Women/ Maternal Health

State Priority Needs	SMART Objectives	Key Strategies
Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age	1. By June 30, 2020, all Title V funded programs will adopt policies on assessing clients for intimate partner violence including reproductive and sexual coercion.	i. Develop a collaboration of internal and external partners to help Title V programs identify and respond to IPV and reproductive and sexual coercion using the confidentiality, universal education, and ongoing support (CUES) framework.
		ii. Partner with Office of Health Equity, Health in all Policies Taskforce to develop policies and initiatives to address community risk factors for intimate partner violence (e.g. poverty, overcrowding, low social capital, mass incarceration and recidivism)
		iii. Partner with Safe and Active Communities to offer Domestic Violence Training and Education Program to Title V program staff which provides technical assistance and funding to community-based organizations to teach young people to engage in healthy, respectful relationships
		iv. Provide primary prevention training to Title V funded programs to assist them in providing knowledge, skills and tools to support clients—especially clients with risk factors for future violence perpetration or victimization--in making safe choices that prevent violence and injuries.
		v.. Disseminate or develop quality improvement tools, resources, and ongoing training (including provider support for working with trauma victims) and technical assistance.
	2. By June 30, 2020, California will reduce the prevalence of mistimed or	i. Broadly disseminate the concept of a Reproductive Life Plan by developing or disseminating culturally and linguistically

	unwanted pregnancy among Black and Latina women with live births to 43.4% and 37.1% respectively.	appropriate tools for integrating into existing MCAH programs and Public Health Departments
		ii. Integrate One Key Question (OKQ) into Title V Program Toolkits and partner programs to promote appropriate contraception counseling to match pregnancy desire and timing
		iii. Standardize the content of the Postpartum Visit with the Interconception Care Project of California and the Before, Between and Beyond Pregnancy Clinical guidance
		iv. Partner with CPSP, LHJs, WIC, Text 4 Baby, Medi-Cal Managed Care and hospital partners to promote the Postpartum Visit during prenatal care and labor/delivery
	3. By June 30, 2020, MCAH will create a strategy to measure (hypertension, diabetes, cardiovascular disease and mental illness) surveillance and associated risk factors (smoking and obesity) among women of reproductive age.	i. Partner with Chronic Disease Branch to identify ways to use existing registries and mechanisms to measure the burden of chronic disease among women ages 15-44
		ii. In partnership with CDIC, develop an ongoing population-based surveillance mechanism for chronic disease among non-pregnant women ages 15-44
		iii. Use Office of Statewide Health Planning and Development Hospital Discharge Data to provide ongoing surveillance of prevalence and trends in chronic disease that is present on admission during childbirth hospitalization.
	4. By June 30, 2020, MCAH will work with partners to reduce prevalence of chronic disease among women at labor and delivery from (5% reduction from 2009 data).	i. Partner with disease specific organizations to target prevention outreach to women of reproductive age for Cardiovascular Disease, Hypertension, Diabetes, and Chronic Mental Health to ensure prevention strategies are culturally, linguistically, and age appropriate and match literacy level.
		ii. Partner with Office of Health Equity, Health in all Policies Taskforce to develop policies and initiatives to address community risk factors for chronic disease (e.g. healthy food availability, built environment, community safety, education quality) and ensure applicability to women of reproductive age.
		iii. Disseminate standard of care tools to standardize screening and follow up practice to ensure women with risk factors receive appropriate postpartum care
		iv. Ensure that existing MCAH tobacco prevention and data collection for smoking as a risk factor for chronic disease include

		appropriate references to e-cigarettes
		v. Increase the number of non-pregnant women of reproductive age who access routine preventive health services

b. Domain: Perinatal/ Infant Health

State Priority Needs	SMART Objectives	Key Strategies
Priority 2: Reduce infant morbidity and mortality	1. By June 30, 2020, CDPH/MCAH will officially participate in federal and state collaborative efforts to reduce preterm birth and infant mortality	i. Define new and existing partnerships with state and local agencies, community-based organizations, academia, provider networks and hospitals to maximize resource capacity in addressing preterm birth reduction
		ii. Develop a plan to ensure coordination of existing perinatal program efforts and avoid duplication of services
		iii. Establish a defined collaborative relationship between local MCAH and RPPC
		iv. Integrate prematurity prevention evidence-based practices in relevant MCAH program curricula and activities
		v. Assist local agencies/partners in developing policies to educate pregnant women/women of reproductive age on the signs and symptoms of preterm labor
		vi. Provide training and evidence-based materials on prematurity prevention to local MCAH, relevant health department programs, providers and community partners
		vii. Collaborate with relevant community agencies, health plans, academic institutions and state agencies regarding evidence-based practices that decrease the risk factors for pre-term birth
	2. By June 30, 2020, increase the percentage of women who report exclusive breastfeeding at 3 months to 68.4% and reduce racial –ethnic disparities.	Surveillance: Conduct research, surveillance and evaluation on breastfeeding outcomes, trends and quality of maternity care related to breastfeeding.
		ii. Mothers and Their Families: Encourage the utilization of culturally congruent approaches to promote breastfeeding to mothers, fathers and grandmothers (e.g. breastfeeding support within MCAH programs, AFLP, BIH, California Diabetes and Pregnancy Program (CDAPP), CPSP, WIC, LHJ Breastfeeding Coordinators, etc.)
		iii. Communities: Maintain collaborations to provide mother-to-mother and peer counseling

		and minimizing the impact of formula marketing. Collaborate with National, State and local stakeholders to promote breastfeeding support and duration.
		Provide technical support to develop breastfeeding-friendly health care system that promotes continuity of care between hospitals/clinics and community services (i.e. training and technical). Provide guidance and technical assistance for implementation of enhanced breastfeeding support within Medi-Cal, including provisions in the Affordable Care Act (e.g. lactation support visits and equipment when needed).
		v. Laws, Policies and Regulations: Provide guidance and support on California laws, policies and regulations that promote and protect breastfeeding.
	3. By June 30, 2020, reduce the number of Sudden Unexpected Infant Deaths (SUID) by 5%.	i. Provide latest American Academy of Pediatrics (AAP) guidelines on infant safe sleep practices/SIDS risk reduction through 2 SIDS trainings each year, the Annual SIDS Conference for SIDS coordinators, public health professionals, and emergency personnel
		ii. Update the curriculum on infant safe sleep/SIDS risk reduction for hospital staff, health professionals and childcare provider training sessions.
		iii. Promote up-to-date safe sleep/SIDS risk reduction health education materials/messages in Title V programs and on the State CDPH/MCAH and California SIDS Program websites

c. Domain: Child Health

State Priority Needs	SMART Objectives	Key Strategies
Priority 3: Improve the cognitive, physical, and emotional development of all children	1. By June 30, 2020, partner with relevant State and Local Agencies to develop a policy recommendation to disseminate to Title V programs that incorporates evidence-based	i. Increase cross-system collaboration and coordination with traditional and non-traditional partners such as Safe and Active Communities (SAC) Branch, Women, Infants and Children (WIC), Department of Social Services (DSS), DDS, California Highway Patrol (CHP), California Department of Education (CDE) to develop shared policies or protocols

	interventions proven to prevent unintentional injuries in children ages 0-14 into existing activities.	
		ii.. Promote workforce development and training to improve knowledge of unintentional injury prevention strategies
		iii. Identify best-practices, promising practices and culturally and linguistically appropriate resources and materials and share with local health jurisdictions (LHJs), partners, and stakeholders
		iv. Provide technical assistance (TA) to LHJs to integrate best-practices, promising practices and culturally and linguistically appropriate prevention strategies in local MCAH programs and activities; provide support to increase awareness of unintentional injuries among children, such as motor vehicle injuries, drowning, car seat use, texting while driving, into MCAH programs and activities
		v. Identify a Quality Assurance (QA) process to measure progress
2. By June 30, 2020, collaborate with appropriate state agencies to publish a white paper detailing best practices for reducing child abuse and neglect in local Title V funded programs.		i. Increase cross-system collaboration and coordination with traditional and non-traditional partners such as SAC Branch, Women, Infants and Children (WIC), DSS, DDS, CHP, CDE to identify and implement a multi-prong approach to reduce child abuse and neglect, especially for at-risk sub-populations
		ii. Identify and provide best-practices, promising practices and culturally and linguistically appropriate materials to share with local LHJs, partners, and stakeholders
3. By June 30, 2020, increase early identification of children with special health care needs (CSHCN) and linkage to appropriate services by increasing social/emotional and developmental monitoring and screening for children ages 0 months to 5 years by 5%.		i. Identify and establish collaborations such as other program branches within CDPH, DHCS Systems of Care Division (SCD, California First Five & Commissions, AAP, child health advocates, consumers, Regional Center representatives and early interventionists, Help Me Grow, Family Resource Centers and other state agencies existing partners, stakeholders and other community groups to improve social/emotional and developmental monitoring and screening and linkage to needed services for all children, especially for at-risk sub-populations
		ii. Develop shared policies with state partners such as SCD, CCS, CHDP, CDE, DSS, DDS, First 5 California, and other state departments to increase alignment among systems and practices to increase rates of culturally and linguistically

		appropriate social/emotional and developmental screening, referral, and linkage
		<p>iii. Promote the use of Birth to 5: Watch Me Thrive! materials and support LHJs to develop protocols and pathways to refer children needing services to local evidence-based screening and referral systems to ensure CSHCN are identified early and connected to needed services</p> <p>Birth to 5: Watch Me Thrive! http://www.acf.hhs.gov/programs/ecd/child-health-development/watch-me-thrive</p>
		iv. Promote social/emotional and developmental monitoring and screening for all children, especially at-risk children using a parent completed screening tool.
		v. Support LHJs to establish networks and connections among MCAH programs, primary care providers, Federally Qualified Health Centers, Rural Health Clinics, CCS, CHDP, community clinics, and other pediatric providers to support developmental screening at or in close connection with healthcare providers
	4. By June 30, 2020, MCAH will implement a service coordination protocol for Children with Special Health Care Needs (CSHCN) with requirements for referrals and timely care.	i. Develop effective organizational approach to coordination/collaboration between systems including DHCS, CDE, DDS, CCS, health plans, and CDPH/MCAH
		ii. Workforce development through promotion of the California Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health
		iii. Work with state partners to develop policies and promising practices to connect CSHCN identified through screening to treatment options and medical necessity
		iv. Work with state partners to identify solutions to lack of qualified treatment providers
		v. Support state and local efforts by providing TA, information, education, and resources related to CSHCN, for example creating a resource directory and identifying advocacy contacts
		vi. Identify and participate in existing collaboratives, councils and advisory boards related to CSHCN

d. Domain: Children with Special Healthcare Needs

State Priority Needs	SMART Objectives	Key Strategies
<p>Priority 4: To provide a whole-child approach to services to Children with Special Health Care Needs</p>	<ol style="list-style-type: none"> 1. By June 30, 2020, increase the percentage of CCS children who receive their primary and specialty care within one system of care consistent with the DHCS Quality Strategy structure. 2. By June 30, 2020, determine the extent to which CCS children receiving primary and specialty care within one system of care report that the care they receive is coordinated. This should be consistent with the DHCS on-going effort to improve the CCS delivery system. 	<ol style="list-style-type: none"> i. Following up with the work of the CCS Redesign stakeholder process review recommendations for providing a whole child approach to services for CSHCN. i. Select approach(s) consistent with DHCS Quality Strategy. i. Develop a timeline for implementing approaches. v. Review methods (algorithms) to identify CCS clients with complex needs. v. Develop ability to track in CMSNet or other system, if clients are receiving primary and specialty care within one system of care i. Develop a survey of CCS families to assess satisfaction with organization of services
	<ol style="list-style-type: none"> 3. By June 30, 2020, increase the number of CCS clients with a patient-centered medical home and commit to exploring the use of ACA Section 2703 “health homes” concept to align CCS with the rest of the Department, as appropriate. 4. By June 30, 2020, increase the number of counties that have created and made available medical home binders. 5. By June 30, 2020, commit to increasing 	<ol style="list-style-type: none"> i. Create statewide implementation workgroup charged with the following types of actions: <ul style="list-style-type: none"> · Build upon the CCS redesign and collaborate with any on-going CCS stakeholder processes and agencies utilizing the medical home concept (i.e. Health Plans, AAP, Children’s hospitals – their CCS liaisons, Family Voices, local CCS county programs) to share existing models and resources that support the medical homes concept. · Review existing national, state and local models and tools including MH System Standards. · Partner with other agencies in the state that are working on/ certifying medical home models. · Identify effective ways to share information on medical homes with providers and families · Work with Family Voices and other stakeholders to investigate how families are educated about medical homes and how to choose a primary provider and make improvements as needed. · Commit to exploring the dissemination of informing materials and provide consultation/training to PCPs, Health Plans and Specialty Care Centers.

State Priority Needs	SMART Objectives	Key Strategies
	the number of CCS provider / provider organizations that meet NCQA or National Consensus with regard to medical homes Framework standards	<ul style="list-style-type: none"> · Strengthen reporting medical homes in CMSNet or other tracking system. · Develop method of assessing if practices meet medical home expectations. · Ensure that this process aligns with the on-going DHCS CCS improvement efforts and the 1115 Waiver. · Partner efforts with the on-going CCS stakeholder engagement process and consideration of recommendations from the CCS redesign.
	<p>6. By June 30, 2020, commit to increasing the number of counties that have a family advisory council.</p>	<ul style="list-style-type: none"> i. Determine how many counties currently have a CCS family advisory council. i. Partner with Family Voices, Family Resource Centers and other family advocacy organizations and county CCS programs to develop a recommendations / guidelines for creating local family advisory councils i. Explore options for increasing family input in small and/or rural counties v. Develop method for linking CCS family advisory councils across the state webinars, conference calls and other venues.
	<p>7. By June 30, 2020 at least two strategies will be implemented to increase family involvement at all levels.</p>	<ul style="list-style-type: none"> i. The family centered care action plan workgroup will commit to exploring methods for including family input into program policy decisions that affect their care. i. Explore strategies to increase the number of counties with Family Health Liaisons. i. Explore strategies to create a statewide family advisory council. v. Explore meeting options for a statewide family advisory council (could be anchored at Family Resource Centers, Family Voices Chapter, or at County CCS). v. Investigate how many counties have Family Centered Care Committees, how they function, their roles, and if CCS should work to increase the number of these committees.
	<p>8. By June 30, 2020, implement a CCS best practice guideline at the local CCS county level to welcome and orient new families to CCS.</p>	<ul style="list-style-type: none"> i. Work with local CCS programs and family advocacy organizations to identify best practices for outreach to families newly enrolled in CCS (i.e. welcome packet, welcome phone call, welcome meeting at MTU, etc.). i. Establish best practice guidelines for welcoming and orienting new families to CCS

State Priority Needs	SMART Objectives	Key Strategies
	<p>9. By June 30, 2020 at least two strategies will be implemented to increase family involvement at all levels.</p>	<ul style="list-style-type: none"> i. Explore strategies to increase the number of counties with Family Health Liaisons. i. Explore strategies to create a statewide family advisory council i. Explore meeting options for a statewide family advisory council (could be anchored at Family Resource Centers, Family Voices Chapter, or at County CCS). v. Investigate how many counties have Family Centered Care Committees, how they function, their roles, and if CCS should work to increase the number of these committees
	<p>a.</p> <p>10. By June 30, 2020 develop standards for ICCSPs</p> <p>11. By June 30, 2020, increase the number of medical home providers who are able to create an ICCSP.</p> <p>12. By June 30, 2020 increase the number of clients with a ICCSP</p>	<ul style="list-style-type: none"> i. Review care plans now used in the CCS program/ Special Care Centers for plan structure and content and implementation (could include survey, interviews). i. Review identified care plan resources including: LPFCH – Achieving a Shared Plan of Care Implementation Guide and medical home Learning Collaborative - Comprehensive Care Planning. i. Draft and disseminate a minimum set of standards for care plans to specialty care centers/stakeholders for feed-back. v. Consider methods (algorithms) to identify CCS clients with complex needs. v. Utilize final standards to adopt a Care Plan policy and create a number letter/information notice. i. Provide materials and education to medical home providers.
	<p>13. Improve coordination by medical home between SCCs, PCPs, etc.</p> <p>14. By June 30, 2020, commit to exploring the creation of an active on –line network for access to information on available resources and services for each county and region and made available to medical home providers.</p> <p>15. By June 30, 2020 at least 50% of CCS</p>	<ul style="list-style-type: none"> i. Explore and identify strategies to facilitate communication between CCS and families, Special Care Centers, PCPs, MCOs, Education, DME providers, pharmacy, home health, Regional Centers and others. i. Maintain stakeholder engagement with the on-going efforts to improve the CCS delivery system including whole child approach.

State Priority Needs	SMART Objectives	Key Strategies
	<p>programs will establish medical home collaborative(s) that include CCS family groups, local PCP provider groups and other service providers.</p>	
	<p>16. By June 30, 2020, commit to working with county CCS programs to develop a recommended core set of evidence based transition materials, process and protocols to share with SCCs, PCPs, MCPs and others.</p> <p>17. By June 30, 2020, establish a baseline of the number of CCS transition age clients with Cerebral Palsy, Cystic Fibrosis, Sickle Cell Disease, Hemophilia and Diabetes that have completed a transition readiness checklist. Establish county level target for improvement.</p> <p>18. By June 30, 2020, commit to exploring methods to increase the number of 19 / 20 years old clients with Cerebral Palsy, Cystic Fibrosis, Sickle Cell Disease, Hemophilia and Diabetes, who receive at least one visit with an adult subspecialist.</p>	<p>i. Create a statewide transition workgroup to provide assistance and input on the development and implementation of a transition action plan:</p> <ul style="list-style-type: none"> a. Create rural and MTP sub- workgroup to explore rural county issues. <p>i. Review county use of 2010 CCS transition materials, other county transition practices including transition specialists, fairs, family navigators, transition checklists(to improve parent/youth communication), transition binders; SCC practices and protocols, consensus guidelines and toolkits including Got Transition.</p> <p>i. Identify a core set of set of evidence based transition materials and protocols for use by county CCS programs with transition age clients.</p> <p>v. Develop/identify transition care plan template, including medical summary, emergency care plan, transition goals and action steps to add to CCP.</p> <p>v. Explore best practices used by hospitals/special care centers for disease specific transition (i.e. Cystic Fibrosis), and if appropriate identify disease specific elements to add to transition plan.</p> <p>i. Develop assessment tool to measure transition readiness.</p>

State Priority Needs	SMART Objectives	Key Strategies
	<p>19. By June 30, 2020, increase the number of SCCs who have incorporated transition into a plan of care template for all patients (ref. GotTransition)</p>	<ul style="list-style-type: none"> i. Develop guideline for the establishment of local transition planning committees (to meet monthly or quarterly based on size of county CCS population). ii. Develop methods to encourage Medi-Cal managed care plans to authorize access to an adult provider at least once while still under care of pediatric MD.
	<p>20. By June 30, 2020 implement transition readiness questionnaire to identify CCS children who will transition to adult services in the next two years.</p>	<ul style="list-style-type: none"> i. Review and select tools to assess readiness to transition high risk CCS clients with chronic and complex conditions and consider any of the recommendations of the CCS redesign stakeholder process. ii. Make available selected transition readiness questionnaire(s)
	<p>21. By June 30, 2020, identify or develop tools/curriculum to provide training on transition for CCS staff, Special Care Centers and other pediatric practices with CCS clients</p>	<ul style="list-style-type: none"> i. Identify or develop tools/curriculum to provide training on transition for Special Care Centers and other pediatric practices with many CCS clients. Work with DHCS CCS stakeholder process established to implement redesign recommendations.
	<p>22. By June 30, 2020 identify a transition tool kit and work with partners (i.e. AAP, MMCD, CA AMA, and others) to promote its distribution and use.</p>	<ul style="list-style-type: none"> 1. Work with partners to identify evidence-based transition toolkit(s) and have it disseminated to CCS providers and other clinicians caring for CYSHCN 2. Include in toolkit resources to assist with Conservatorships – establishing resources/guidelines

State Priority Needs	SMART Objectives	Key Strategies
	<p>23. By June, 2020, develop and adopt standards to share with MCOs for providers to care for young adults with complex medical conditions.</p>	<ol style="list-style-type: none"> 3. Develop process to share CCS client medical records with Medi-Cal managed care plans upon transition into that health plan Share CCS provider standards with Medi-Cal managed care plans. 4. Support the collaboration between LA County CCS, specialty care providers, and Medi-Cal managed care plans in developing stratification algorithms to identify high risk clients and share strategies for enhanced case management with CCS/Special Care Centers/Hospitals. 5. Commit to exploring methods to incent residents to train as pediatric subspecialists/specialists. 6. Identify consumer and provider resources and models to share with managed care plans, to support coordination of health care needs of at risk children. 7. Establish relationship between specialty care providers in an area doing post graduate education for providers in the area to learn about issues that impact CCS clients/families and facilitate working with hospitals and special care centers.

State Priority Needs	SMART Objectives	Key Strategy
<p>Priority 5: To improve access: ensuring the right patient to the Right Place</p>	<ol style="list-style-type: none"> 1. By June 30, 2020, increase the number of CCS paneled primary and specialty care medical providers. 2. By June 30, 2020, increase the number of CCS paneled specialty care medical providers in the field experiencing the greatest shortages (i.e. audiology, endocrinology). 	<ol style="list-style-type: none"> i. Use the CCS RSAB Provider Access and Network workgroup to discuss strategies to increase provider access, including a focus on access issues and strategies in rural areas. i. Review the recommendations from the CCS Redesign and align this action plan as needed i. Explore and implement strategies to increase the number of CCS paneled providers, including DME, pharmacy, and mental health such as: <ul style="list-style-type: none"> · Expanding who can get CCS paneled – creating a role for nurse practitioners. · Making sure CCS paneling is working smoothly. · Review and explore the qualification for providers to be paneled with the goal of increasing the number of paneled providers while maintaining adequate quality standards. · Explore methods to reduce reliance on paper driven processes. · Work to simplify the process of becoming an approved Medi-Cal provider (this is a precondition of becoming a CCS paneled provider). · · Explore methods of graphic displays of areas experiencing provider shortages. · Review and potentially modify annual survey done on DME Access
	<ol style="list-style-type: none"> 1. By June 30, 2020, Commit to exploring methods to develop a baseline for the number of E-appointments made with paneled specialty care providers and strive to increase access to E-consultation process at Special Care Centers 1. By June 30, 2020, increase the availability of telehealth services by CCS clients living in rural areas or far from Special Care Centers (SCC) 	<ol style="list-style-type: none"> i. Work with stakeholders to review strategies and make recommendations to implement an E-consultation process for standardized referral to subspecialist who will review and provide guidance ii. Identify strategies to increase coordination of subspecialty visits so that multiple appointments can be scheduled in one day for CCS clients in rural counties i. Use the RSAB Provider Access and Network Workgroup to identify effective strategies for implementing and utilizing telehealth that could be used to expand access to health care services (including behavioral health), in rural areas i. Work with stakeholders to expand access to telehealth.

State Priority Needs	SMART Objectives	Key Strategy
	<p>1. By June 2020, review and revise as needed the CCS standards and procedures for facilities, providers, and county CCS programs to ensure CCS clients have access to high quality providers in a timely fashion.</p>	<ul style="list-style-type: none"> i. Review and consider any of the work and recommendations of the CCS redesign and any ongoing CCS stakeholder engagement process. ii. Review and revise, as needed, CCS standards for facilities. iii. Review and revise, as needed, requirements for CCS paneled clinicians to maintain certification. iv. Review and revise as needed county CCS procedures consistent with the Department’s Quality Strategy for ensuring that CCS clients get to the right level of care in a timely fashion
	<p>1. By June 30, 2020 Commit to exploring methods to demonstrate reductions in variation among County CCS programs and across Special Care Centers as assessed by surveying CCS providers, and health plans, and reviewing administrative data.</p> <p><i>(Note, with the CCS Redesign, if different regions or counties are implementing different models, then it will be helpful to measure improvements in consistency among counties/regions implementing the same models)</i></p>	<ul style="list-style-type: none"> i. Review outcomes of the CCS redesign and future CCS ii. Stakeholder engagement process. Develop standardized virtual system of care across county CCS programs by – sharing and using common tools (i.e. referral forms, same medical record) that align with the DHCS Quality Strategy structure. iii. Work with CCS stakeholders, county organizations, and others to identify and implement strategies to improve consistency across county CCS programs. iv. Work with CCS programs and organizations to create guidance to assure consistency across counties. v. vi. Explore methods to measure consistency across county CCS programs using CMSNet, or other appropriate support system
	<p>1. Commit to exploring methods to decrease the wait time from referral to service for CCS clients who require SCC services that are authorized to SCC by county (for the following diagnoses: Acute Lymphoid Leukemia (ALL) and other Blood Cancers requiring expedited referral, Brain Cancer, Cleft Lip & Palate, Congenital Heart Disease, Cystic Fibrosis, Hearing Loss, Hemophilia)</p>	<ul style="list-style-type: none"> i. Use one of the CCS RSAB workgroups to explore reducing the average waiting time from referral to services.

e. Domain: Adolescent Health

State Priority Needs	SMART Objectives	Key Strategies
Priority 6: To promote and enhance adolescent strengths, skills and supports to improve adolescent health	1. By June 30, 2020, racial and ethnic disparities in adolescent birth rates (ages 15-19) in California will decrease by 10%	i. Target all MCAH adolescent sexual health (ASH) program to high need and/or historically underserved populations.
		ii. Implement evidence-based, community-informed interventions aimed at educating adolescents on preventing pregnancy and sexually transmitted infections (STIs) including the human immunodeficiency virus (HIV).
		iii. Educate adolescents regarding the use of long-acting reversible contraceptives (LARCs), condoms and other birth control methods.
		iv. Link youth to reproductive health services that are affordable, accessible, confidential, and youth-friendly.
		v. Identify gaps in the availability of youth-friendly reproductive health services.
		vi. Develop and implement youth-informed programs to empower parents and caregivers with skills and knowledge to strengthen effective communication with adolescents regarding sexual health.
		vii. Develop tools and standards to incorporate PYD principles, resiliency framework and training on healthy coping skills in program implementation and materials.
	2. By June 30, 2020, all Title V programs serving adolescents will incorporate the Positive Youth Development (PYD)/Resiliency framework.	ii. Train state and local staff on the principles of Positive Youth Development, resiliency and healthy coping skills for adolescents.
		iii. Develop surveillance strategies to measure resiliency in adolescents.
		iv. Streamline PYD messaging across state and local partners.

f. Domain: Cross-cutting/ Life Course

State Priority Needs	SMART Objectives	Key Strategies
<p>Priority 7: Increase access and utilization of health and social services</p>	<p>1. By June 30, 2020, increase by 5% the number of eligible women and children individuals enrolled into Medi-Cal insurance, which includes Denti-Cal benefits.</p>	<p>i. Collaborate with LHJs to provide appropriate client outreach materials and resources to promote Medi-Cal enrollment for eligible families establish baseline number of families/clients to be assisted.</p> <p>ii. Ensure that LHJ staff inform all eligible and enrolled clients of current available dental benefits offered by Medi-Cal.</p> <p>iii. Ensure that LHJ staff assists enrolled clients to find Medi-Cal dental homes by using the Medi-Cal warm transfer service through 1-800 customer service phone number or other referral services.</p>
	<p>2. By June 30, 2020, increase the number of women of reproductive age with appropriate preventive care, including:</p> <p>1) Increase the rate of preventive visits to 65.3%.</p> <p>2) Increase the rate of first trimester prenatal care initiation to 92.4%.</p> <p>3) Increase the rate of postpartum visits to 92.9%.</p>	<p>i. Develop an oversight protocol for LHJs to ensure all persons referred for insurance enrollment complete an appointment</p> <p>ii. Partner with Department of Health Care Services and Health Benefit Exchange to explain and market no-cost preventive services to newly enrolled women of reproductive age, , including early entry into prenatal care.</p> <p>iii. Provide technical assistance to LHJs regarding development of adequate community referral resource networks to help perinatal providers address barriers to early entry into prenatal care</p> <p>iv. Finalize development and pilot test the (IRIS (Internal, Reproductive, Integrative, Skin) designation for preventive care visits for young women’s health care (a clinician training program to increase utilization of preventive health services by young women, especially low income).</p> <p>v. Partner with CPSP, LHJs, WIC, Text 4 Baby and hospital partners to schedule and discuss the importance of the Postpartum Visit during prenatal care and/or labor/delivery</p>
	<p>3. By June 30, 2020, MCAH and partners will increase the number of children and adolescents (ages 0-17) attending one or more preventive visits in the last 12 months to 82.6%.</p>	<p>i. Develop an oversight protocol for LHJs to ensure all persons referred for insurance enrollment complete an appointment</p> <p>ii. Integrate preventive care concepts for children and adolescents into MCAH program curricula to educate parents, including importance of administering immunizations</p>

		according to the recommended schedule
4. By June 30, 2020, MCAH and partners will increase the number of women of with pre-pregnancy health insurance to 79.5% and the number of children and adolescents (age 0-17) with health insurance to 78.2%		i. Develop an oversight protocol for LHJs to ensure Title V MCAH program participants are referred to Medi-Cal and receive follow up on enrollment
		ii. Develop a protocol for all MCAH partners to refer for health insurance enrollment in Covered California.
		iii. Develop an oversight protocol for LHJs to ensure eligible Title V MCAH program participants are referred to WIC for ancillary services.
		iv. Partner with the California Health Benefit Exchange Board—an independent public entity within state government—to provide input on regulations that impact insurance enrollment and referral for women of reproductive age and their dependents.
5. By June 30, 2020, MCAH and partners will decrease the number of postpartum women of without health insurance to 16.2%		i. Develop an oversight protocol for LHJs to ensure all Title V MCAH program participants prenatal Medi-Cal enrollment receive counseling on postpartum insurance continuation.
6. By June 30, 2020, provide grief/bereavement support services to parents and caregivers of all infants who die suddenly and unexpectedly, including infants who die in an unsafe sleep environment (causes of death include Unknown, Accidental Suffocation and Strangulation in Bed, and SIDS)		i. Provide training on grief/bereavement support services to public health professionals who respond to sudden unexpected infant deaths to public health professionals and emergency personnel
		ii. LHJs contact families who experienced a sudden unexpected infant death from which a referral was received from the local coroner’s office to provide grief/bereavement support
		iii. Contact local coroner offices to remind and encourage referral of parents of all babies who die suddenly and unexpectedly regardless of circumstances of death
		iv. Make grief/bereavement support materials and peer support organizations available on the State CDPH, MCAH and California SIDS Program websites
7. By June 30, 2020, all Title V funded programs and initiatives will implement policies or protocols to increase the number of institutions that screen, refer, and address mental health and substance use		i. Increase cross-system collaboration and coordination with traditional and non-traditional partners, such as the DOJ, DOE, DOT, DSS, DDS, DHCS, CBHDA, the Mental Health Services Act (MHSA), Covered California, the Office of Statewide Health Planning and Development, , Medi-Cal, ACOG, AAP, First 5, providers, consumers, faith-based organizations, non-

	disorders.	governmental organizations, and persons who have overcome mental health/substance use challenges and their families to provide mental health and substance use consultation support for staff and to facilitate service provision for clients
		ii. Partner with CHVP, Early Childhood Comprehensive Systems (EECS), and the CHVP State Interagency Team (SIT) Workgroup to identify and address service gaps in mental health for families and young children
		iii. Develop culturally and linguistically appropriate policies and protocols to reduce discrimination, disparities, and stigmatization in the workplace, schools, community, and among health and social service providers
		iv. Encourage and support peer-run and peer-led programs and initiatives as an important way to reduce stigma, disparities, and discrimination
		v. Utilize tailored education and materials on mental well-being and substance use to specific population groups, such as infants, children, youth, youth in transition, women, and families
		vi. Promote a strength-based approach to improving mental health and reducing discrimination and disparities.
		vii. Develop and implement policies that require all Title V funded and initiatives to increase awareness and screen participating women and adolescents to determine if they are at risk for mental health and substance use disorders and refer, link, and provide a brief intervention to those who screen positive
		viii. Promote workforce development for clinicians, teachers, caregivers, and MCAH staff on: <ul style="list-style-type: none"> - screening initiatives such as free Screening, Brief intervention, Referral to Treatment (SBIRT), and substance use screening - early childhood mental health (using California Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health) - infant mental health -social and emotional development strategies - trauma-informed practice

<p>Priority 8: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy diet and physically active lifestyle.</p>	<p>1. By June 30, 2020, reduce obesity among reproductive age women to 20.9% and reduce racial-ethnic disparities.</p>	<p>i. Conduct research and evaluation on maternal weight status and dietary intake including assessment of trends and disparities.</p>
		<p>ii. Interface with the Office of Health Equity, Health in all Policies Task Force to support efforts e.g. better food in workplaces and early childhood education centers as well as schools.</p>
		<p>iii. Support clinicians in implementing weight assessments, counseling and referrals for all women and children according to clinical practice guidelines for obesity prevention, including provisions of the Affordable Care Act.</p>
		<p>iv. Develop and disseminate easy-to-understand information and tools to help women meet the Dietary Guidelines for Americans (e.g. MyPlate)</p>
		<p>v. Promote a Systems and Environmental Change approach for increasing optimum nutrition and physical activity within the MCAH population</p>
	<p>2. By June 30, 2020, increase the percent of women with recommended weight gain during pregnancy to 43%.</p>	<p>i. Develop and disseminate culturally responsive approaches to promote IOM guidelines for optimum pre-pregnancy weight and maternal weight gain in MCAH programs (e.g. AFLP, BIH, CDAPP, CPSP, health care clinics, WIC).</p>
		<p>ii. Develop and disseminate resources to promote a healthy weight of a mother before and during her pregnancy –including in adolescence</p>
	<p>3. By June 30, 2020, reduce overweight/ obesity among low-income children (ages 2 to 5) to 31.1%.</p>	<p>i. Collaborate with the California Women, Infants and Children Program (WIC) to develop a consistent measure of overweight and obesity among low-income children.</p>
		<p>ii. Support the development of best practices for child care providers regarding feeding infants and toddlers in emergencies, and provide these standards to the EMS Authority for distribution to child care provider training programs.</p>
		<p>iii. CHDP provides training to providers on pediatric overweight and obesity and use of the Body Mass Index (BMI).</p>
	<p>4. By June 30, 2020, increase the percentage of women who took a vitamin containing folic acid every day of the week during the month before pregnancy to 35.9%.</p>	<p>i. Disseminate folic acid educational materials, messaging and guidelines to MCAH programs and contacts</p>
	<p>5. By June 30, 2020,</p>	<p>i. Conduct research and evaluation on maternal,</p>

	<p>increase the rate of children, adolescents and adult women of reproductive age meeting the age-specific guidelines for physical activity to 31.5%, 16.9% and 25.2% for children ages 6-11, adolescents 12-17, and women ages 18-44 respectively.</p>	<p>child and adolescent physical activity practices, trends, and racial –ethnic disparities.</p>
		<p>ii. Promote implementation of national recommended physical activity guidelines.</p>
		<p>iii. Implement organizational and programmatic physical activity guidelines and policies for MCAH’s programs/initiatives utilizing the life course framework, such as improving cardio metabolic health prior to conception or plyometric after pregnancy.</p>
		<p>iv. Promote the utilization of culturally congruent approaches to promote physical activity within early care organizations, schools, and state and local agencies.</p>
		<p>v. Utilizing community engagement, promote and facilitate access to safe, accessible, and affordable places that support an active lifestyle for maternal, child and adolescents in particular, in underserved areas. (e.g., Systems and Environmental Change Toolkit)</p>
		<p>vi. Maintain and expand collaborations with National, State and local stakeholders to promote physical activity (including CDE, WIC, the Nutrition, Education and Obesity Prevention Branch, Caltrans, and Indian Health Program).</p>

1. State Action Plan and Strategies by MCH Population Domain

Introduction

5-Year Action Plan Development at the State Level

California Department of Public Health/Maternal, Child and Adolescent Health (CDPH/MCAH) Division developed the 2016-2020 5-year Action Plans based on identified MCAH state priority needs and related goals by the required population domains. Our goals and priorities were identified using a variety of weighted indicators, including data reported from all California's 61 LHJ needs assessments on locally identified needs and problem statements.

Select state staff with subject matter expertise that were involved in the development of the State 5-Year Action Plans received training and had experience developing sample 5-Year Action Plans for the LHJs in 2014 as part of the LHJs 5-Year needs assessment process described below. In preparation for writing the State 5-Year Action Plans, state staff reviewed MCAH-related state data, identified priority health needs and emerging issues based on a number of criteria, used a problem analysis approach to determine possible intervention points, and selected strategies and best or promising practice activities to address the needs by population domain. Staff researched and reviewed other states' action or long-term strategic plans, California state department strategic plans, research publications, public health strategic plans, and best-practice strategies recommended from professional organizations such as Association of Maternal & Child Health Programs and the Substance Abuse and Mental Health Services Administration.

The process used to develop the State 5-year Action Plans was as follows: managers identified appropriate staff to create action plan workgroups for each priority; these workgroups reviewed the goals and priorities and developed Specific Measureable, Achievable, Realistic, Time-Related (SMART) objectives for each priority goal and identified promising or evidence-based strategies to address the objectives, and proposed activities to implement the strategies. The core Title V team members then selected appropriate performance process and outcome measures and the CDPH/MCAH and Systems of Care (SCD) leadership finalized the Action Plan proposals. Each priority area was assigned a lead of several team members consisting of program, policy and epidemiological staff. Staff were trained on the needs assessment process, identification of the priority needs, purpose of developing 5-Year Action Plans, relationship of the Action Plans to our current and future efforts and target goals and were also provided technical assistance during the planning and writing of the Action Plans.

MCAH is cognizant of the need to leverage our existing resources, identify and participate in new and established collaboratives, develop capacity by building on current programs, initiatives and strategies, increase professional development and training opportunities, and work with traditional and non-traditional partners to ensure the MCAH population is represented and our priority needs are addressed. For example, to develop the 5-Year Action Plan to increase screening and referral for mental health and substance use services, the workgroup aligned our objectives, strategies, and proposed activities with the California Reducing Disparities Project, Strategic Plan to Reduce Mental Health Disparities of November, 2014. For the Child Health 5-Year Action Plan, the workgroup reviewed best practices strategies to increase developmental screening and strategies and decided to promote the use of Birth to 5 Watch Me Thrive materials

and establish a relationship with the California Statewide Screening Collaborative to improve the ability of the collaborative to achieve identified goals and objectives. State staff also aligned objectives and activities from The California Wellness Plan of November, 2014 into 5-Year Action Plans where applicable.

5-Year Action Plan Development at the Local Level

Due to diversity of California's LHJs, the local needs assessment process was completed over an 18 month period. All LHJs completed Part 1 of their 5-Year Needs Assessment in June 2014 in which they identified their needs and problem statements. LHJs were then required to complete 5-Year Action Plans, Part 2, based on locally identified needs and their capacity to address these needs. The purpose of having the LHJs develop 5-Year Action Plans was to inform development of the annual LHJ Scopes of Work (SOW) in each of the next five years, improve local MCAH planning efforts and ability to quantify and describe outcomes, leverage resources and improve collective impact across the State by supporting a common understanding of problems and strategies, improve continuity of local programming, respond to recommendations from the federal Maternal and Child Health Bureau and serve as an easy-to-use reference document for staff and stakeholders.

The LHJs 5-Year Action Plans were due to the State on May 15, 2015. State Maternal, Child and Adolescent Health (MCAH) staff provided several forums to offer technical assistance to the LHJs as they completed their needs assessment, including training and working webinars, bi-weekly technical assistance conference calls, and one-on-one consultation. Because the development of Action Plans has been a new process and requirement for LHJs as well as State MCAH, extensive planning, training, technical assistance, data analysis and review was conducted. In preparation for the LHJs Needs Assessment, State subject experts developed detailed sample 5-Year Action plans which included suggestions for best practice strategies for the LHJs to use to develop their specific 5-year Action Plans. Please see the materials developed for the LHJs Needs Assessment located on the CDPH/MCAH website at: <http://www.cdph.ca.gov/programs/mcah/Pages/2016-2020TitleVNeedsAssessment.aspx>

a. Domain: Women/ Maternal Health

i. Plan for the Application Year

The relevant goals for this population domain are to decrease unintended pregnancy with an equity focus on Black and Latina women, to decrease the burden of chronic disease among women of reproductive age, and to decrease intimate partner violence (IPV). While maternal smoking, binge drinking and birth spacing are not explicitly stated as SMART objectives, they are relevant intermediate targets for the new priority and goals; MCAH will continue monitoring and reporting on these measures.

For the first year of these new 5-year goals, MCAH will carry out some developmental activities to lay the groundwork for these goals. For the first year MCAH will work with LHJs to identify what protocols are in place to address IPV and select a staff stress management protocol to implement in all LHJs by the end of the period. For a more upstream preventive approach to IPV, MCAH will implement a protocol to screen program clients for known risk

factors for IPV perpetration or victimization through partnerships with the CDPH Safe and Active Communities Program.

Because of the twofold gap in mistimed and unwanted pregnancy among Black and Latina women in California, several activities have been identified to address this health inequity. In the first year, MCAH will review its Reproductive Life Planning tools for cultural and linguistic appropriateness. MCAH will disseminate the approved tools and work to develop additional tools to fill existing gaps. As a more upstream approach, the Preconception Health Council of California (PHCC) will receive training on One Key Question from Oregon Department of Public Health and develop a plan to integrate and evaluate its implementation statewide. As a first step to addressing the disparate rates of postpartum visit attendance, MCAH will work with Medi-Cal Managed Care to identify an evaluation plan for efforts and then meet with identified partners to determine opportunities for coordination of the postpartum visit message. To ensure providers have adequate education regarding interconception health and birth spacing, an online module with continuing medical education credits is being developed for self-paced instruction to coincide with the Interconception Care Project of California. The module will include instructions for developing a follow up plan for women with lifestyle or behavioral issues identified in pregnancy that pose a risk to their health and subsequent pregnancies.

Hypertension, diabetes, and cardiovascular disease are increasing among childbirth hospitalizations; data for mental illness is less reliable, but the prevalence is substantial. Given the burden of chronic disease, MCAH will undertake several activities to address the prevalence and increase the data infrastructure for public health surveillance of chronic disease. In the first year, MCAH will partner with chronic disease to identify and compare population-based methods for measuring chronic disease among pregnant women and non-pregnant women of reproductive age. This will be a first step to developing capacity for ongoing surveillance of both groups. MCAH will also begin exploring the ways it can account for the new onset of e-cigarettes in its outreach materials and surveillance mechanisms). At the legislative level, MCAH will collaborate with the California Tobacco Control Program (CTCP) to monitor their new local laws and ordinances database. MCAH will explore opportunities to examine smoking trends in relationship to changes in local legislation.

MCAH will strengthen its ability to address social determinants of health by partnering with the Office of Health Equity, Health in All Policies Taskforce. This taskforce includes members of diverse non-health related government branches that collaborate on initiatives to promote health. Community risk factors for intimate partner violence are poverty, overcrowding, low social capital, mass incarceration, and recidivism; community risk factors for chronic disease are healthy food availability, built environment, community safety, and education quality. Starting in Year 1, MCAH will attend taskforce meetings to provide insight in project development that will addresses the unique identified needs of the MCAH population.

ii. Annual Report

➤ Maternal Smoking

In 2013, 2.5 percent of women aged 15 years and older who had a recent live birth reported smoking in the last trimester of pregnancy. In 2013, African American and White women had the highest prevalence of smoking in the last trimester of pregnancy (5.5 and 4.4 percent,

respectively) compared to Latina (1.4 percent) women. Less than 1% of Asian/Pacific Islander women reported smoking in the third trimester. Reported smoking declined in each of these groups since 2008, with the exception of Latina women, whose prevalence did not substantially change.

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

PHCC continued to provide information, tools and resources, including the preconception and interconception guidelines, to local communities focusing on the importance of achieving optimal health before pregnancy. Messages emphasize refraining from tobacco use and avoiding relapse triggers.

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

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

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

At the January 2014 Association of Maternal and Child Health Programs Conference, MCHB announced that the Collaborative Improvement and Innovation Network (CoIIN) to reduce infant mortality and improve birth outcomes will be implemented in all regions by the end of 2014. One of the state-identified priorities is increasing smoking cessation among pregnant women; California however decided to choose other priorities because of the low statewide smoking rate. One of those strategies, social determinants of health, will address some of the upstream factors that are community risk factors for smoking and smoke exposure.

➤ Binge Drinking

In 2013, 14.7 percent of mothers with a recent live birth reported binge drinking during the three months prior to pregnancy. In recent years, binge drinking has fluctuated, reaching a high of 15 percent in 2010 and a low of 13.1 percent in 2011. This prevalence differed by racial and ethnic group. White women (20.7%) were most likely to binge drink during the three months prior to pregnancy, followed by Hispanic (14.3%), Black (14.1%) and Asian/Pacific Islander women (5.2%).

LHJs continued to work on developing and strengthening coalitions with public/private agencies and healthcare providers to determine how best to identify women at risk and how to develop appropriate referral sources. LHJs developed and implemented coordinated and integrated systems of care to address perinatal substance use prevention. MCAH participated in the FASD Task Force and continued its efforts on preconception health education and promotion, including augmenting and monitoring its preconception health website.

MCAH continued ongoing quality improvement and education efforts to learn about emerging best practices for reducing binge drinking. Because California has unique alcohol consumption patterns arising from the popularity and cultural significance of locally produced wine, MCAH continued to explore ways to find culturally appropriate strategies to reduce heavy consumption patterns and prevent illegal consumption by minors by engaging the newly acquired Teen Prevention Programs (TPP), Intervention and Education (I&E) and the California Personal Responsibility Education Program (CA PREP), and strengthening their ability to include substance abuse prevention as a teen pregnancy prevention strategy.

➤ Birth Spacing

In 2013, 11.9 percent of women whose live birth occurred less than 24 months after a prior birth, decreased slightly from 12.0% in 2012. Of the four race/ethnic groups with the largest birthing population in 2013, African American women were most likely to have a live birth less than 24 months after a prior birth (13.7%), followed by Hispanics (12.2%), Whites (11.9%) and Asians (9.7%).

MCAH strengthened and expanded its interconception and reproductive life planning initiatives toward the aim of ensuring adequate birth spacing and reducing repeat teen births. Adolescent programs performed continuous quality improvement of their life planning tools to ensure they were sufficient to address repeat births to teens. Programs that target pregnant women provided up-to-date messaging about birth spacing and overall preconception/interconception health.

CHVP continued to promote appropriate pregnancy spacing with contraceptive education, counseling, and referral to clinical services beginning in the final trimester of pregnancy and extending throughout the postpartum period.

The California Family Health Council continued its implementation efforts to expand its reproductive life planning demonstration project to all clients of Title X-funded clinics by 2015.

MCAH will continue to educate at-risk groups about contraception and birth spacing and will explore the best strategies to effectively engage younger and electronically-inclined populations, empowering them to make healthy reproductive decisions. The social media toolkit will be pilot tested and revised for full-scale implementation.

PHCC pursued a pilot project to provide preconception education at the time of a negative pregnancy test and to pilot test an in-store pharmacy promotion in Sonoma County in conjunction with the California Pharmacists Association. Despite a promising development, this project was not selected by First Response and received pushback from provider groups. It was later abandoned due to lack of political will.

MCAH continued to share national resources, including the preconception campaign materials developed by the CDC and Preconception Peer Educators (PPE) materials provided by the federal Office of Minority Health.

MCAH publicized the preconception and the Interconception Care Project of California (ICPC) guidelines as clinical tools available to providers who connect with women of reproductive age, either in their well-women visit or postpartum visit (for women who just had a baby). These clinical visits are critical opportunities to help women prevent or delay pregnancy until they are ready.

b. Domain: Perinatal/ Infant Health

i. Plan for the Application Year

CPSP provides opportunities to local MCAH to build collaborative partnerships with different agencies to educate staff and refer clinical high-risk pregnant women to appropriate resources; staff education on addressing non-compliant diabetics and appropriate clinical referrals to specialty clinics; identify evidence-based tools for screening and interventions shared with providers, or partner agencies, and partnering with non-profit organizations such as faith-based organizations and schools to help identify vulnerable maternal populations needing health care access and services. Local MCAH's partnership with local Medi-Cal Managed Care Health Plans allowed shared activities and goals through a workable and functional Memorandum of Understanding (MOU). DHCS, Medi-Cal Managed Care Division (MMCD), requires local Medical Managed Care Health Plans to enter into an MOU agreement with local MCAH regarding maternal and infant health. This policy helped develop, define and facilitate improved partnerships between local public health and the medical health care system to improve perinatal and infant care. For example, Sonoma and Shasta Counties participate in quality assurance activities with their local health plans. As a result, there is better care coordination and access to organized resources.

MCAH continues to collaborate with MMCD in providing training and resources. For example, MMCD presented at the 2014 PSC annual meeting on how LHJs can partner with the local health plans to impact early prenatal care and timely postpartum visits. MCAH plans to present in the quarterly statewide meeting of local health plans about the different services offered by MCAH and strategize on how to strengthen and make an established MOU functional and effective.

BIH is implementing a standardized curriculum in July 2015. This will facilitate program evaluation and measurement of program outcomes. AFLP will gradually incorporate Positive Youth Development in all AFLP counties. The Regional Perinatal Programs of California (RPPC) continues to work closely with the California Maternal Quality Care Collaborative (CMQCC) and CPQCC to disseminate quality improvement toolkits and resources to improve maternal and neonatal care.

MCAH and SCD continue to collaborate with MOD and (the Association of State Health Officers (ASTHO) on the Healthy Babies Challenge/Prematurity Campaign. The MCAH Scope of Work for LHJs continues to include prematurity prevention specific objectives.

ii. Annual Report

MCAH monitors best practices in the LHJs and shares these statewide to improve performance. LHJs continue to monitor access to early prenatal care, , conduct targeted outreach to women of childbearing age and pregnant women, provide appropriate linkages and streamline processes for presumptive eligibility to increase access to early prenatal care for pregnant women. LHJs continue to offer the toll-free line and web information to MCAH populations.

CPSP, AFLP, and BIH continue to provide case management services and linkages to medical care for their target populations and educate clients regarding the importance of receiving early prenatal care for future pregnancies.

Local CPSP coordinators continue provider recruitment and work with providers to improve pre/interconception education during the preconception and postpartum periods. MCAH and LHJs undertake these activities to ensure the availability and effectiveness of CPSP services and to achieve improvements in first trimester entry into prenatal care. MCAH is working on improving data on beneficiaries, paid claims, birth outcomes, and hospital discharge to develop baseline data on the efficacy of CPSP services. MCAH continues to work closely with MMCD to improve the timeliness and quality of obstetric services for Medi-Cal-eligible pregnant women.

AFLP continues to implement the Positive Youth Development component into existing services. BIH continues to implement the new group intervention, as well as complementary case management, in order to improve the health and social conditions for African-American women and their families.

RPPC and the California Perinatal Transport System (CPeTS) continue their work in regional planning and coordination, matching the transport of high-risk patients with the appropriate level of care and assisting hospitals with data collection and quality improvement surrounding patient transfer.

SCD and CPQCC continue to respond to member questions, analyze data for CCS-approved NICUs, and address outliers and concerns about quality of care. RPPC, with the Office of Vital Record (OVR), continue to present Birth Data Trainings emphasizing collaboration among administration, nurses and birth clerks to obtain and accurately report birth data. RPPC Directors continue to explore opportunities for nursing staff to work with birth clerks on enhanced birth data reporting in continuing efforts to improve data quality.

Los Angeles County (LAC) maintains its Partnership to Eliminate Disparities in Infant Mortality Action Learning Collaborative (ALC) website to provide information on resources and best practices relating to infant mortality and undoing racism. With its multidisciplinary local partners, LAC ALC continues its mission of increasing capacity at the local and state levels to address the

impact of racism on birth outcomes and infant health. The ALC plans to hold more health disparities training workshops for healthcare providers.

RPPC, CMQCC and CPQCC continue to provide technical assistance to hospitals and LHJs who wish to use the Elimination of Non-Medically Indicated (Elective) Deliveries <39 Weeks Gestation Toolkit, as well as the other maternal and neonatal quality improvement toolkits and resources developed by these collaboratives.

MCAH participates in the ASTHO Healthy Babies Challenge, which aims to prevent premature births and reduce infant mortality. In partnership with MOD, ASTHO challenged states to reduce their percent of premature births by 8% by 2014, using 2009 data as baseline. The percent of premature births in California was 10.4% in 2009, decreasing to 9.6% in 2012, thus achieving the target 2014 goal in 2012. This accomplishment earned California the “A” grade in the MOD 2013 Premature Birth Report Card. California received the MOD Franklin Delano Roosevelt Prematurity Campaign Leadership Award for achieving the premature birth rate of 9.6%, which is the MOD 2020 goal, on March 19, 2014. In addition, California was also awarded the MOD Virginia Apgar Prematurity Campaign Leadership Award on March 17, 2015, for achieving the 8% decline in premature birth rates.

c. Domain: Child Health

i. Plan for the Application Year

MCAH will develop shared policies or protocols with relevant State and Local Agencies to incorporate evidence-based interventions proven to prevent unintentional injuries in children ages 0-14 into existing activities. In order to meet this objective, MCAH plans to implement the following strategies for the next five years:

1. Increase cross-system collaboration and coordination with traditional and non-traditional to develop shared policies or protocols
2. Promote workforce development and training to improve knowledge of unintentional injury prevention strategies;
3. Provide technical assistance (TA) to LHJs to integrate best-practices, promising practices and culturally and linguistically appropriate prevention strategies in local MCAH programs and activities;
4. provide support to increase awareness of unintentional injuries among children, such as motor vehicle injuries, drowning, car seat use, texting while driving, into MCAH programs and activities; and
5. Identify a Quality Assurance (QA) process to measure progress. MCAH will continue to engage local MCAH and share effective experiences that can be applied in other local agencies. MCAH will support individualized interventions based on the needs of the population, taking into consideration the community’s strengths, resources and cultural factors.

MCAH strongly supports trauma- informed care, derived from the Adverse Childhood Experiences study. MCAH will develop shared policies or protocols with relevant State and Local Agencies to reduce child abuse and neglect. Proposed strategies for the next 5 years include but are not limited to the following:

- a. Increase cross-system collaboration and coordination with traditional and non-traditional partners to identify and implement a multi-prong approach to reduce child abuse and neglect, especially for at-risk sub-populations;
- b. Identify and provide best-practices, promising practices and culturally and linguistically appropriate materials to share with local LHJs, partners, and stakeholders;
- c. Identify and participate in the implementation of a social marketing or community awareness campaign or encourage LHJs to implement an awareness campaign to improve the well-being of families/caregivers of children in order to reduce child abuse and neglect

MCAH will continue its efforts to communicate with local partners' new state initiatives and community practices performed by other agencies that are found to be effective and perceived to be favorable within the community.

Other updated MCAH activities to promote children's health include the following:

1. Promote and develop a plan to support the MCAH Directors in promoting physical activity;
2. Develop poster and brief on maternal weight and incorporate the effect it has on the life course for offspring;
3. Collaborate with the California Women, Infants and Children Program (WIC) to develop a consistent measure of overweight and obesity among low-income children; and
4. Continue to promote Systems and Environmental Change approaches as noted in the related MCAH online toolkit.

ii. Annual Report

For Fiscal Year, 2013-2014, majority of the local MCAH activities related to children's health included reduction in unintentional injuries, reduction of child abuse and neglect, increase in immunization rates and promotion of physical activity to prevent obesity.

In 2013, the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes was 1.4 per 100,000, showing no change from the rate in 2012. Local MCAH activities addressing injury-related mortality and morbidity in children revolves around public awareness and education on appropriate car seat installation and application. Local MCAH staff performs education via return demonstration with families and provides discounted car seat vouchers following appropriate and safe demonstration and installation of car seats. Other local MCAH have coordinated with local agency partners to perform safe children car seat installation.

There have been numerous active outreach initiatives regarding safe and correct car seat installation. Examples of outreach activities performed include conducting car seat demonstrations in highly publicized child safety seat checkup to promote correct usage at community events, such as parks, shopping centers, car dealers, preschools, or open houses at police or fire departments. San Benito County promoted safe car seat installation through the use of fliers, emails, postings and announcements through their partnership with the Child Injury Prevention Coalition. Other educational topics presented by local MCAH to the community to reduce unintentional injuries included the following: Safe to Sleep, Poisoning/Poison Control, Home Safety, Age appropriate safety education, water/bathing safety, heat stroke/not leaving child in hot car, electrical outlet safety, leaving baby on bed and texting while driving. Other LHJs have integrated injury prevention awareness and education

within the local HVPs using visual toolboxes, pictures and graphics to identify hazards within the child's environment and educate the family on how to minimize and prevent accidents.

Majority of LHJs worked with their community-based organizations to promote outreach and increase community awareness on abuse and neglect. Based on the 2013-2014 LHJ Annual Reports, fifteen LHJs participated in a collaborative that coordinated and promoted activities and community awareness regarding prevention of child abuse and maltreatment. For instance, Yolo County worked with the Child Abuse Prevention Council to align messaging and review patient education materials to increase child abuse awareness. In Ventura County, Public Health Nurses (PHNs) provided comprehensive bio-psychosocial assessments, education and linkage to community resources through home visitation. Covered topics included health and wellness, parenting, child development, pregnancy, and postpartum care.

MCAH supports current local initiatives regarding informing community partners on trauma-informed care, such as Adverse Childhood Experiences and practices and, screening, to recognize, prevent and heal the debilitating effects of violence to the health and quality of life of a family.

The 2013 immunization rates increased from 73.5% in 2012 to 81.9% in 2013. Local MCAH's activities related to increasing immunizations include community education and outreach to child care facilities, immunization clinics, school-based health clinics, and local advisory groups. Engagement with community partners occur during shared participation in different community events such as different immunization months for toddlers, health and dental fairs, flu campaign or designated vaccination week for targeted recipients. For example, Alameda County reached Medi-Cal eligible families through the Family Justice Immunization Clinic. In addition, education was also provided via phone calls that involved approximately 780 calls every year. This activity became an opportunity for Alameda to refer callers to care as appropriate. El Dorado County worked directly with parents and school nurses and educated them on recommended immunization schedule and safety of vaccines. In addition, discussions were also conducted to address barriers to timely immunization. In Sierra County, immunization ads were placed in their biweekly newspaper.

The percent of uninsured children in California was 15.7% in 2000 and has steadily declined since then. In 2012, 10.2% of children were uninsured. The percent of children with no insurance has significantly dropped to a low of 8.0% in 2013. Effective January 1, 2014, ACA expanded dental benefits to new eligible children based on FPL. Children 1-6 years of age from families with 0-133 per cent FPL receive full scope Denti-Cal. Children, 1-6 years of age from undocumented families with FPL 0-133 per cent, receive emergency Denti-Cal coverage. Infants 0-1 year of age from family with 0-200% FPL receive full scope Dent-Cal. Infants 0-1 year of age from undocumented family with FPL 0-200 per cent receive emergency Denti-Cal coverage.

Several LHJs are proactive in promoting community awareness and linking Medi-Cal eligible families, including children to dental care. In addition, partnerships have been created with the school system, Rural Health Care Centers and Federally Qualified Health Centers regarding educating parents on the importance of healthy eating, tooth decay prevention for children, proper gum care for babies until the first tooth arrives, early detection of child hood carries, and

establishing a dental home. San Joaquin County has coordinated round table discussions with providers regarding the importance of dental care. Alameda County continues to implement a dental care service program, where children and families receive anticipatory guidance, screening assessments, fluoride applications and case management assistance to a dental home at selected WIC sites. This dental initiative was also offered at the Native American Health Center. In addition, Alameda County has organized school-based/school-linked dental programs emphasizing prevention (including fluoride varnish, sealants, outreach and case management services, as appropriate, to obtain insurance assistance and access to a dental home) that served low income, (Medi-Cal eligible and/or enrolled) racially and ethnically diverse students. Small rural counties identified the lack of dental providers who serve Medi-Cal clients. In addition, transportation has also been a barrier in accessing dental services.

MCAH provided education on healthy lifestyle, proper diet and nutrition, and reduction of childhood obesity. Obese children and adolescents are defined to be those who are overweight and whose Body Mass Index is at or above the 85th percentile. MCAH provided input into the nutrition curriculum and supportive on-line tools for the Preventive Health and Safety Practices (PHSP) training for licensed childcare facilities. Effective January 2016, those receiving licenses (or their designees) are required to take the training. The training will include the following topics:

1. Healthy nutrition on the developing child and on the overall health of children ages 12 and younger;
2. Basic information about California's Healthy Beverages in Child Care Law (AB 2084);
3. Best practices for feeding infants and toddlers including breast milk, iron fortified formula, and introducing first foods;
4. Age-appropriate healthy foods that are based on current Dietary Guidelines for Americans;
5. How to cut back on foods high in solid fats, added sugars, and salt;
6. Using food labels to assist make healthy choices; and
7. Best Practices for Building Healthy Eating Habits in Children, including the division of responsibility.

In addition to providing input to the nutrition curriculum and on-line tools for the PHSP, MCAH completed the Adolescent Nutrition and Physical Activity guidelines, specifically Body Image, Fruit and Vegetables, and Vegetarian sections. This is an opportunity for the MCAH Directors to integrate efforts to increase community physical activity in the upcoming five-year action plan. Other local initiatives to campaign and increase physical mobility is discussed below.

Modoc County conducted 184 presentations with nutrition messages to preschool and school age children. The content included discussing benefits of each harvest of the month, sampling the harvest of the month, vitamins and minerals in the harvest of the month, discussing the importance of healthy eating, drinking, and exercise, teaching kids where veggies/fruit come from, and reading a book with healthy message. San Bernardino County educated professionals and lay community members (including registered dietitians, First 5 San Bernardino staff, WIC staff, lactation educators, hospital staff, postpartum nurses, pregnant women and women of childbearing age, Preschool Services, Inland Empire Breastfeeding Coalition, Child Health, Disability Prevention Program (CHDP), and CPSP providers and staff at public and private

agencies and community-based organizations regarding exercise that contribute to the reduction of childhood obesity.

d. Domain: Children with Special Healthcare Needs

i. Plan for the Application Year

MCAH is using the information from the LHJ CSHCN Assessment survey and is working with MCAH Directors to develop a list of suggested activities to identify and better serve children and youth with special health care needs. These activities include community-based services, identifying CSHCN by monitoring, screening, assessment, and referrals for all children, providing services for CSHCN and facilitating care coordination, such as youth transitioning to adult services, and interagency coordination and collaboration with CCS. MCAH has incorporated some of these strategies as requirements into the LHJ SOW where LHJs will be able to add activities to address CSHCN health needs.

One of the identified priorities for the next five years for this population is to improve the cognitive, physical, and emotional development of all children, including CSHCN and to improve the systems that support CSHCN. The following strategies are among those proposed:

- 1) identify and establish collaborations with other state partners, stakeholders and other community groups to increase the practice of social-emotional and developmental monitoring and screening and linkages to needed services for all children, especially at-risk populations;
- 2) develop shared policies with state partners to increase alignment among systems and practices to increase rates of culturally and linguistically appropriate social-emotional and developmental screening, referral, and linkages;
- 3) promote the use of Birth to 5: Watch Me Thrive materials, and support LHJs to develop protocols and pathways to refer children needing services to local evidence-based screening and referral systems, including using a parent completed screening tool, to ensure CSHCN are identified early and connected to needed services; and
- 4) support LHJs to establish networks and connections among MCAH programs, primary care providers, Federally Qualified Health Centers, Rural Health Clinics, CCS, Child Health and Disability Prevention Programs, community clinics, and other pediatric providers to support developmental monitoring and screening at or in close connection with healthcare providers.

Other priority efforts involve improving services for youth with special health care needs (YSHCN) as they transition to adult services, including adult health care, work and independence. Proposed strategies include identifying gaps and barriers in existing services for YSHCN transitioning to adult services, partnering with relevant agencies and working with CCS to improve local coordination between CCS and MCAH and assisting to develop processes and resources for YSHCN that ensure continuity of medical care, continued skill building, and access to other community supports.

With regard to the Bridge to Reform Section of the 1115 Waiver to have all care for CCS clients organized within one system, a second demonstration project is expected to be implemented in Fiscal Year (FY) 2015-16 as an Accountable Care Organization Model with Rady Children's Hospital-San Diego (RCHSD). DHCS developed and is currently preparing to administer a family satisfaction phone survey to assess the families' knowledge and satisfaction with the demonstration, knowledge and satisfaction with their care coordinator, access and

satisfaction with providers, satisfaction with the medical services provided, and to establish a baseline of information to compare against future surveys. In addition, DHCS will conduct site visits to the demonstration project (DP) sites to identify “lessons learned and best practices” and explore the successful components as well as the challenges San Mateo County and HPSM encountered in the first year of the demonstration model.

ii. Annual Report

MCAH supports LHJs by providing training for program development, implementation, evaluation, and quality improvement to LHJs as they implement activities and programs to identify and serve CSHCN, particularly those children not served by California Children’s Services (CCS). For example, Contra Costa County provided developmental screening for all infants (n=71) in their Prenatal Care Guidance home visiting program and the 4 infants identified with positive screens were further assessed and referred to treatment. Kern County

MCAH staff participate in the Medically Vulnerable Care Coordination Partnership project. The goal of the project is to utilize coordinated services to measurably improve outcomes for Kern County infants and children, 0–5 years, at risk of costly, lifelong medical and developmental issues. Kern County reported that 91.7% of identified infants discharged from the Neonatal Intensive Care Unit and no longer eligible for CCS were referred to and enrolled in Medi-Cal. San Joaquin County screens all children in families participating in case management for developmental delays and refers children who screen positive for further assessment; 272 children received a comprehensive screen and seven children were referred for additional assessment. In Alpine County, MCAH collaborated with First 5 of CA, Choices for Children, Behavioral Health Services, and Live Violence Free to provide weekly “Nurturing Parenting” discussions and child play groups for young children and their caregivers. The City of Pasadena provided professional development on infant health and teen parent interconception health to a local high school staff serving pregnant and parenting teens. There were 93 attendees and 79% indicated they will incorporate what they learned into their daily work. Several other LHJs are providing information or education, developmental screening and referral services and participating on collaboratives to identify and serve CSHCN, with a focus on non-CCS children and youth with special health care needs.

Additional child health-related initiatives performed by local MCAH included provider education and awareness on the use of developmental screening tools to detect early signs of developmental delays for children. Some local MCAH programs have also partnered with school systems, child care centers and child advocate agencies, “Early Head Start”, and “Help Me Grow” to increase awareness of normal child development, identify gaps, detect developmental concerns, and appropriately refer for treatments or interventions. Several HVPs monitored by the local MCAH Directors are using evidence-based screening tools to screen such as the Ages and Stages Questionnaire (ASQ) and ASQ Social-Emotional .

In an effort to improve outreach, identification of and services for CSHCN, especially non-CCS eligible children, MCAH conducted a survey of MCAH Directors at the 61 LHJs. This was a requirement for the State 2016-2020 Title V Needs Assessment and all of the LHJs participated. The survey examined the status of current programs and services for CSHCN. A summary of the results are below.

For CSHCN, results of September 2013 survey completed by local MCAH indicated that the majority of LHJs link or refer CSCHN to needed services (n=58). Fourteen local MCAH Directors are also the local CCS Director. Of those who do not have this dual role, many local MCAH Directors oversee their local CCS program. Only two LHJs reported not having a local CCS program.

LHJs reported that MCAH partnered with local organizations that provided services to CSHCN. Local partners include the California Children's Services County Office (n=55), Head Start (n=54), Family Resource Centers (n=52), Regional Centers (Department of Developmental Services) (n=50), Local Educational Agencies (n=50), and Early Start (n=47). Other reported partners were Federal Qualified Health Clinics (FQHCs), hospitals, school nurses, First 5 Initiative, and the Nurse Family Partnership Program.

Thirty percent of LHJs (n=14) reported that the local MCAH program provides support for youth with special healthcare needs during transition from CCS to adult services. Fourteen of the LHJs that do not provide transition services explained that this function is performed by the local CCS.

The results suggest that most LHJs have a mechanism in place for two-way communication between health care providers and case managers. Among the LHJs with existing case management programs (CMPs) or home visiting programs (HVPs), the majority (n=35) receive referrals from the local health care providers that screen and identify CSHCN. The majority of LHJs (n=30) also reported that the CMPs and HVPs outreach to inform healthcare providers of available services for CSHCN.

Forty two LHJs identified the need for improved coordination between CCS offices and the MCAH program at the local level. Two functional needs were most commonly identified: a mechanism for the local MCAH Program to better inform local health care providers of its existing services for CSHCN and a referral mechanism whereby providers refer patients to these programs. Although the need for improved coordination was reported frequently, most respondents rated the existing level of coordination as moderate to high.

SCD continues to focus on modifying the CCS program, with appropriate funding, to cover the whole child. This priority was a key factor in developing models for the CSHCN portion of the 1115 Waiver of 2010–2015. One of these demonstrations to implement the CCS Program's portion of the Waiver began April 2013 in San Mateo County with an existing managed care organization: Health Plan of San Mateo. The goal was to have all care for the CCS Program client organized within one system.

➤ CCS Program Redesign

A stakeholder advisory board composed of individuals from various organizations and backgrounds with expertise in both the CCS Program and care for CYSHCN was created. DHCS, together with the stakeholder advisory board, led a stakeholder process. The goals of the process include maintaining a patient and family-centered approach, provide comprehensive treatment for the whole child, improve care coordination through an organized delivery system, improve quality, streamline care delivery, and maintain cost neutrality.

CCS efforts to better organize care also include the Pediatric Palliative Care Waiver (PPCW), which provides intensive care coordination for CCS clients under 21 years of age with life threatening conditions. An independent evaluation of the PPCW found that the program was effective in improving quality of life for clients and families and significantly cost-saving. The Children's Hospice and Palliative Care Coalition which supports pediatric palliative care in California, including PPCW, convenes an annual meeting with CCS participating counties, PPCW providers, referring providers and family members to examine program successes and opportunities for improvement. Services, family satisfaction, claims, adherence to policy including time to services and provider qualifications are monitored by SCD periodically. Pediatric palliative care and CCS Program staff and agencies receive program training from the state PPCW team. The PPCW efforts align with National Performance Measure (NPM) #5, as care coordination allows clients and families in the program to use community-based service systems more easily.

To expand the number of qualified providers of all types in the CCS program, CCS improved the provider paneling process, developing systems to receive and process provider applications electronically.

CCS updated and modernized the facility site review process, which has resulted in an increased number of site visits to Hospitals, Pediatric Intensive Care Units (PICUs), Neonatal Intensive Care Units (NICUs), and Special Care Centers (SCCs) by state CCS staff. Several standards were re-written and are being used in the site visits. Site visits include questions about transition to adulthood. Site visit tools based on CCS Program standards and facility type have also been developed. Currently, there are approximately 12-15 CCS Program site visits conducted per year and since 2012, 51 new facilities (Hospitals, NICUs, PICUs and SCCs) have been approved and 23 facilities (Hospitals, NICUs, PICUs and SCCs) have been recertified. The goal of the visits is to increase access to high quality care by providing constructive guidance to centers to improve the quality of specialty care by following the CCS Program standards.

Improvements in the CCS Program align with National Outcome Measure (NOM) 17.3, Percent of CSHCN receiving care in a well-functioning system.

DHCS is currently submitting to Centers for Medicare and Medicaid Services (CMS) a proposed revised waiver which would increase available services and provider types. To facilitate the expansion including increase in provider participation, the SCD is working with partners to simplify and improve the payment process.

The PPCW Program is scheduled to expand to seven additional counties in FY 2015-16, and continues to work closely with stakeholders.

➤ Telehealth

This Program most closely aligns with NPM #3, medical home and NPM #5, systems organized so that clients can use them easily.

On January 6, 2014 the SCD released CCS Numbered Letter 14-1214, Telehealth Services for CCS and GHPP Programs, which informed local CCS programs and providers of the telehealth advancement act of 2010. Subsequently, an additional release about telehealth code updates of the CCS Program's "This Computes!" #446, Telehealth Codes and Modifiers, was released as well as a series of Frequently Asked Questions about telehealth and CCS and GHPP programs. In addition to these policy updates, SCD staff communicate regularly with stakeholders about telehealth policy and billing issues that affect local CCS programs, providers, and clients

e. Domain: Adolescent Health

i. Plan for the Application Year

Thirteen AFLP sites have been identified to undergo a federal evaluation funded by the Office of Adolescent Health to build evidence for AFLP PYD. MCAH launched the revised PYD intervention with select sites, which was informed by the formative evaluation in fiscal year 2014 described above.

ii. Annual Report

MCAH continue to monitor grantees in 30 California counties with the highest teen births. MCAH provides the infrastructure to support program implementation across all their adolescent health programs including training, technical assistance, and systems development for data collection, monitoring and evaluation.

MCAH continues to fund and monitor AFLP. The number of AFLP sites has declined from the original 41 in 2009, down to 32 in 2013, and now 31 in 2014. MCAH worked to complete the formative evaluation of the AFLP Positive Youth Development (PYD) to revise the standardized intervention that is based on PYD principles integrated with life planning. Intervention tools were translated into Spanish, piloted and evaluated to ensure linguistic, cultural and developmental appropriateness.

f. Domain: Cross-cutting/ Life Course

i. Plan for the Application Year

➤ Mental Health and Substance Abuse:

LHJs will continue to work on developing and strengthening coalitions with public/private agencies and healthcare providers to determine how best to identify women at risk and how to develop appropriate referral sources. LHJs will continue to develop and implement coordinated and integrated systems of care to address perinatal substance use prevention. MCAH will continue to participate in the FASD Task Force and will continue its efforts on preconception health education and promotion, including augmenting and monitoring its preconception health website. The Federal Office of Minority Health established an Advisory Board to Preconception Peer Educators at California Community Colleges and Universities and will partner with LHJs and local organizations to plan campus and community outreach campaigns

and events to promote harm reduction strategies to reduce preconception alcohol exposure and prenatal alcohol exposure. These outreach strategies will include social media.

MCAH will continue ongoing quality improvement and education efforts to learn about emerging best practices for reducing binge drinking. Because California has unique alcohol consumption patterns arising from the popularity and cultural significance of locally produced wine, MCAH will continue to explore ways to find culturally appropriate strategies to reduce heavy consumption patterns and prevent illegal consumption by minors. Among the strategies will be to engage the newly acquired TPPs, I&E and CA PREP, and strengthen their ability to include substance abuse prevention as a teen pregnancy prevention strategy.

➤ **Oral Health:**

MCAH is not renewing its contract with UCSF School of Dentistry for a dental hygienist to serve as the MCAH Oral Health Policy Consultant. However, CDPH will have a new State Dental Director and an oral health epidemiologist to be associated with the Oral Health Unit (OHU). It is anticipated that MCAH will collaborate with OHU and the State Dental Director on oral health issues and future projects. For example, with the assistance of MCAH, A Burden of Oral Disease Report is being prepared by OHU for release in 2015 to identify populations within the state at the greatest risk for preventable dental diseases. This report will raise awareness of specific statewide needs and provide a foundation for a state oral health plan, which will guide efforts to prevent and treat oral diseases.

MCAH is collaborating with DHCS to develop a State Action Plan to address two national Medicaid goals for oral health improvement in children. The first goal is to increase by 10 percentage points the proportion of children enrolled in Medicaid that receive a preventive dental service, over a 5-year period. The second goal is to increase by 10 percentage points the proportion of children ages six to nine enrolled in Medicaid that receive a dental sealant on a permanent molar tooth. Proposed activities include working with local CHDP programs to identify and assist children in need of dental services; increasing the number of school-based programs providing sealants; aiding FQHCs in reporting dental services; encouraging Head Start and WIC programs to bill for fluoride varnish applications; and allowing registered dental hygienists (RDHs) to become Denti-Cal billing providers.

AB 1174 was passed to expand Medi-Cal reimbursements to tele-dentistry services in 2015. The bill emulates the Virtual Dental Home pilot project at the University of the Pacific's School of Dentistry. Under the program, RDHs in alternative practice, RDHs working in public health programs, and registered dental assistants can keep people healthy in underserved community settings by providing education, preventive care, interim therapeutic restorations triage, and case management. Radiographs, dental charts, and pictures are transmitted to collaborating dentists who diagnose and prescribe all treatment. After a consultation, these allied dental professionals perform certain services without a dentist's supervision, such as applying temporary fillings. The law also calls for dental assistants and hygienists wishing to perform these duties to complete approved training programs

In addition to the embedded pediatric dental plans mentioned earlier, the Board of the CA Health Benefit Exchange has decided to offer in 2016 optional stand-alone family dental plans, which includes dental coverage for adults.

➤ **Breastfeeding, Nutrition and Physical Activity:**

The overall emphasis for the breastfeeding, nutrition, and physical activity plans for the next year is to target racial and ethnic disparities. Rather than targeting all women, the goal is to tailor limited resources to address persistent health inequity.

Planned strategies and activities related to breastfeeding promotion include:

- 1) Provide technical assistance for increasing the number of labor and delivery facilities that provide recommended care for lactating mothers and their babies.
- 2) Support RPPC as quality improvement experts for hospital breastfeeding policies.
- 3) Provide technical assistance for increasing the number of community health clinics that provide professional and peer support for breastfeeding.
- 4) Provide technical input for planning the 2016 Breastfeeding Summit.
- 5) Convene a workgroup to collaborate on increasing workplace lactation accommodation for low wage earners
- 6) Advocate for improved lactation accommodation for CDPH employees.
- 7) Revise the current Model Hospital Breastfeeding Policies.
- 8) Continue to encourage and enquire within DHCS to develop guidance on lactation services that support the ACA. If MCAH participates on a DHCS committee to address breastfeeding, MCAH will enquire about involving the Office of the Patient Advocate.
- 9) Promote International Board Certified Lactation Consultant (IBCLC) services to be available when needed within the HVP.
- 10) Complete a set of statewide recommendations and supportive documents that protect, promote, and support breastfeeding and safe infant/child feeding across the preparedness and response continuum.
- 11) Maintain the Local Breastfeeding Coordinators roster and distribute resources to assist them in completing their jobs.
- 12) Maintain the CDPH breastfeeding web page (including the Birth and Beyond California page)
- 13) Develop and distribute an annual letter with breastfeeding initiation data and resources to labor and delivery hospitals.
- 14) Continue to coordinate breastfeeding interventions
- 15) Meet with state WIC, Genetic Disease Screening Program (GDSP), Systems of Care quarterly to coordinate nutrition, breastfeeding and physical activity activities.
- 16) Ensure MCAH Program Breastfeeding guidelines and educational materials, resources and assessment forms exist and are utilized by CDAPP: Sweet Success, CPSP, AFLP, and BIH.
- 17) Support DHCS in including medical nutrition therapy in its benefits packages.

Planned strategies and activities related to nutrition promotion include the following:

- 1) Explore mechanism to monitor fruit and vegetable consumption for MCAH target populations.
- 2) Maintain list serve and provide support and technical assistance to perinatal nutritionists working with MCAH programs.

- 3) Ensure MCAH Program Nutrition and weight gain guidelines and educational materials, resources and assessment forms exist and are utilized by CDAPP: Sweet Success, CPSP, AFLP, and BIH.
- 4) Maintain the MCAH Nutrition and Physical Activity (NUPA) web page
- 5) Develop and disseminate resources to promote a healthy weight of a mother before and during her pregnancy
- 6) Promote a Systems and Environmental Change approach for increasing optimum nutrition and physical activity within the MCAH population.
- 7) Maintain quarterly meetings to coordinate with WIC, GDSP, Systems of Care for consistent MCAH related nutrition messaging (also includes breastfeeding and physical activity)
- 8) Develop and disseminate resources to promote daily preconception intake of 400mcg folic acid.

Planned strategies and activities related to physical activity promotion include the following:

- 1) Promote walking as an easy, low impact, frequently available option for physical activity
- 2) Promote a “Systems and Environmental Change” approach for increasing physical activity
- 3) Provide technical support for LHJs in working on Pedestrian Safety and Walkability
- 4) Coordinate physical activity promotion activities with the CDPH Physical Activity Collaboration Team (PACT)
- 5) Ensure MCAH Program physical activity guidelines and educational materials, resources and assessment forms exist and are utilized by CDAPP: Sweet Success, CPSP, AFLP, and BIH.
- 6) Maintain the MCAH Nutrition and Physical Activity (NUPA) web
- 7) Through collaboration with external partners, promote pedestrian safety and walkability strategies.
- 8) Maintain quarterly meetings to coordinate with WIC, GDSP, Systems of Care for consistent MCAH related nutrition messaging (also includes breastfeeding and physical activity)

➤ Preventive Health Services:

MCAH would like to increase the utilization of preventive health services among women of reproductive age as an opportunity to provide preconception care prior to pregnancy and is an essential clinical component to preventing future morbidity. In the first year, MCAH will analyze the existing efforts to refer or market insurance to women of reproductive age, children and adolescents. The analysis will include identified gaps that can be addressed by programmatic focus, new materials, or direct campaigning. MCAH will partner with the San Francisco Department of Public Health to increase patient-centered care for women through the finalization of the IRIS designation for Excellence in Young Women’s Health Care. IRIS stands for Integrated, Reproductive, Internal and Skin, four areas that are emphasized as points of importance for young women’s health care.

In the next year, two trainings should be planned—for the Adolescent Health Work Group Conference and another statewide or national conference. In preparation to implement additional strategies in the coming years, MCAH will develop a work plan with the California Health Benefit Exchange Board, CPSP, WIC, and Text 4 Baby to develop a plan to promote health insurance enrollment and timely utilization.

ii. Annual Report

Substance Abuse Prevention:

MCAH's efforts related to substance use prevention are conducted through partnerships and collaboration, by activities conducted in the local health jurisdictions and MCAH programs, such as BIH and AFLP.

Many MCAH LHJs have identified substance use, particularly perinatal substance use, prevention as a priority need. Many are working to develop coordinated and integrated systems of care to address issues of perinatal substance use. They have engaged in activities to improve community mobilization and capacity building, and are working with providers to implement screening, referral and linkage to appropriate treatment programs. Community-based prevention programs such as AFLP, BIH and CPSP identify at-risk mothers and refer them for treatment services. LHJs continue to develop and strengthen coalitions with public/private agencies and providers to assess women at risk and develop appropriate referrals to resources including the statewide FASD Taskforce. MCAH works to improve birth outcomes for women at risk for alcohol abuse through screening and referral for treatment services.

MCAH representatives participate in the FASD Task Force, an independent, public-private partnership of parents and professionals from various disciplines committed to improving the lives of Californians affected by FASD and eliminating alcohol use during pregnancy. MCAH also participates in the State Interagency Team FASD workgroup, composed of members from the MCAH, Department of Social Services, California Department of Education, Department of Developmental Services and Arc of California acting as lead. The goal of the workgroup is to identify interagency and systems issues that provides potential opportunities for prevention/intervention of FASD.

MCAH staff collaborated with Centers for Disease Control and Prevention (CDC) to develop 7 proposed Healthy People 2020 measures that combined data from the Pregnancy Risk Assessment Monitoring System and the Maternal Infant Health Assessment Survey (MIHA) to allow tracking of key MCAH indicators, including infant sleep position, substance use and weight gain during pregnancy, postpartum smoking, and preconception/interconception care, many of which are otherwise unavailable from other data sources, and will represent approximately 85% of all births in the United States. MIHA data from 2013 are the first year to reflect these changes.

MCAH staff members participate in and provide expertise to the California Behavioral Risk Factor Surveillance System Workgroup which is composed of many, cross-sectored partners such as the Department of Health Care Services Substance Use Disorders Prevention, Treatment, and Recovery Services Division, CDPH Women, Infants and Children program, CDPH Office of Health Equity, and the CDC.

Mental Health:

MHSA funding is dedicated to statewide suicide prevention programs which are currently being implemented by Cal MHSA. MCAH continued to work with programs in the local jurisdictions, including the CPSP, AFLP, and BIH programs, to identify and refer clients at risk for mental health disorders to appropriate assessment and treatment. MCAH collaborates to maintain and

improve appropriate linkages between other State departments to address systemic barriers and create pathways to service delivery. MCAH promotes provider screening, education, and referral to treatment and services for adolescence at risk of substance abuse, domestic violence, depression, and stress and encourage LHJs to incorporate mental health and behavioral issues into LHJ activities as they work toward improving the health and well-being of adolescents.

DHCS administers grants to local programs under MHSA. Local programs provide direct services.

MCAH programs address mental health needs and access to mental health services as part of a comprehensive approach to health. MCAH acknowledges that there has been a push to screen women for depression, both during pregnancy and the postpartum period. For this reason, our programs deliver enhanced services that include nutrition, psychosocial and health education, in addition to standard obstetrical services. Many of our direct service programs (i.e., CHVP, AFLP & BIH) use the validated Edinburgh Postnatal Depression Scale (EPDS) to identify women with postpartum depression. Although the EPDS is typically used at a single time point to identify women with probable depression, many of our programs are now using the EPDS to routinely screen pregnant and postpartum women. Women with high EPDS scores are referred to a mental health provider for further evaluation.

More specifically, AFLP is a case management-based program that offers services to pregnant and/or parenting youth throughout 30 California counties and 32 local agency sites. The program addresses the mental health needs of its pregnant and/or parenting youth through several screening tools. Upon entering the program, participants complete the Comprehensive Baseline Assessment (CBA). The CBA asks six questions designed to alert case managers to immediate mental health issues. Following the CBA, program participants complete one of the following depression screenings: Patient Health Questionnaire (PHQ-9); PHQ-9 Modified for teens; or the Edinburgh Postnatal Depression Scale screening tool. AFLP also screens for substance use using CRAFFT, a six-question behavioral health screening tool recommended by the American Academy of Pediatrics' Committee on Substance Abuse for use with adolescents. Case managers will refer clients with mental health needs to the appropriate community resources available in the county, based on the results of their screening.

Finally, many local health jurisdictions address perinatal mood and anxiety disorders (PMAD), including screening and linkage to appropriate services as part of their priorities.

Oral Health:

Dental care is the most prevalent unmet health care need of children; the condition of children's teeth in California was ranked the third worst in the country. In 2012, the percent of children with a preventive dental visit in the last year was 54.3% for ages 1-5, 87.6% for ages 6 – 11 and 81.3% for ages 12 – 17. The percent of children, six to nine years of age who are eligible for Early and Periodic Screening, Diagnostic and Treatment for 90 continuous days receiving a dental sealant on a permanent molar tooth dropped from 16.4% in federal fiscal year (FFY) 2012 to 10.9% in FFY 2013.

Preschools and K-12 schools in CA are considering permitting oral health professionals to bring preventive and treatment services on-site. MCAH and OHU collaborated with CA Department

of Education to create a webpage with information and guidance on mobile dental facilities for school administrators when entering into contracts with private dental vendors. The webpage contains links to policy issues, guidelines, laws, insurance enrollment information and additional resources.

During 2013-14, about 45% of LHJs actively provided education, screenings, referrals and limited dental services for children and pregnant women. LHJs also relied on collaboration with local oral health coalitions to bring outreach programs and preventive services to MCAH target populations.

Beginning May 1, 2014, partial dental benefits were restored to Medi-Cal beneficiaries age 21 and older including examinations, radiographs, dental cleanings, complete dentures, restorations, limited crowns and anterior root canals. Then in October, 2014, pregnant beneficiaries, regardless of age, aid code, and/or scope of benefits, will be eligible to receive all dental procedures listed in the Dental-Cal Manual of Criteria that are covered by the Medi-Cal program so long as all procedure requirements and criteria are met.

In 2013, the percent of non-pregnant women aged 18-44 who had a dental visit in the past year was 64.5%. In 2012, 42.1% of all women with a live birth reported receiving dental care during pregnancy, a 25% increase since 2002 (33.8%).

MCAH promotes the California perinatal clinical oral health guidelines to assist health care professionals deliver oral health services to pregnant women and their children. MCAH also dispatches updated information, web links, grant resources and educational materials to local oral health advocates and coordinators. In addition, the oral health policy consultant has encouraged public health nurses within LHJs to promote and apply fluoride applications for children aged 1-5 years. One area of interest is the pediatric dental benefits offered by CA Health Benefit Exchange under the ACA. Dental benefits for children younger than 19 years are embedded into all medical plans offered by Covered CA for 2015.

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

OHU collaborated with MCAH to provide a one-time funding opportunity for oral health activities at the local level. The funding, \$450,000, was provided by the Preventive Health and Health Services Block Grant to OHU and was allocated to 10 counties. Completed oral health activities fall under the following goals: design a comprehensive, integrated approach to meet local oral health needs; strengthen a community fluoridation program; prevention of dental caries through local targeted early intervention; promote perinatal dental care and programs among pregnant women; promote oral health messages among targeted population, such as WIC centers and preschools.

Obesity:

In 2013, the prevalence of obesity in this population was 22.0%, up slightly from 21.6% in 2012. Black (34.1%) and Hispanic (27.4%) women were more likely to be obese than White (16.8%) women.

MCAH will continue to collaborate with state programs and agencies, experts and local MCAH directors to reduce overweight and obesity among women of childbearing age. MCAH programs will offer counseling, such as guidance on dietary intake and physical activity, which is tailored to client circumstances/stage of change.

Per recommendations by the IOM's Committee to Reexamine IOM Pregnancy Weight Guidelines (2009), MCAH will continue to conduct routine surveillance of pre-pregnancy BMI, weight gain during pregnancy and postpartum weight retention and report the results by age, racial/ethnic group, and socioeconomic status to inform local initiatives to promote healthy weight.

MCAH continued to inform women of the importance of conceiving at a normal BMI as part of the preconception initiative, encourage women to limit their weight gain during pregnancy based on the revised IOM guidelines, and make the most current resources on pregnancy weight gain available on the MCAH website.

MCAH helps to maximize use by women of Affordable Care Act provisions for well-woman care and obesity screening/counseling for all adults by partnering with Covered California and Medi-Cal. MCAH publicized resources that support healthy weight to healthcare providers and public health professionals and encourage their use during well-woman and prenatal care. Among these resources are the Interconception Module and the clinical toolkit on the Before, Between and Beyond website.

Breastfeeding:

In 2013, 65.4% of mothers reported that they were still breastfeeding their infants at three months post-partum. African American (48.2%) and Hispanic (60.6%) mothers were less likely than White (74.2%) and Asian/PI (69.8%) mothers to breastfeed their infants at three months of age.

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

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

MCAH attended and supported conferences/meetings such as the Hospital Breastfeeding Summit, and Childhood Obesity Conferences and continues to have a representative on the U.S. Breastfeeding Committee and the Association of State Public Health Nutritionists. MCH

Nutrition Council which address breastfeeding strategies. The MCAH representative participates in the following USBC workgroups: Emergency Preparedness, Media/Public Relations and the Reduce Infant Formula Marketing. MCAH collaborates on promoting breastfeeding within CDPH via a Center for Family Health Nutrition Coordination Workgroup and the Obesity Prevention Group.

LHJs have developed 5-year Action Plans to promote breastfeeding with activities that include developing a lactation accommodation plan that addresses current national and state laws; adopting practices that support the exclusive initiation of breastfeeding within labor and delivery facilities as per state law; adopting practices that support breastfeeding within health centers; expanding breastfeeding support within MCAH programs and including breastfeeding support within emergency preparedness plans

SCD provided specialized assistance in support of the quality improvement project to increase breastfeeding rates among CSHCN.

Insurance:

The percent of uninsured children in California was 15.7% in 2000 and has steadily declined since then. In 2012, 10.2% of children were uninsured. The percent of children with no insurance has significantly dropped to a low of 8.0% in 2013.

California conducted outreach and education to encourage and facilitate enrollment in Covered California, Medi-Cal and other health insurance. Each year Covered California, and state and local partners continue to enroll eligible residents into Covered California health plans or refer to Medi-Cal to complete the enrollment process.

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

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

Appropriate Care Facility Deliveries:

NPM 17, the percent of Very Low Birth Weight < 1500 grams (VLBW) infants delivered at facilities for high-risk deliveries and neonates, was 79.8% in 2013. This was an increase from the 77.5% in 2012, yet still short of the Healthy People 2020 objective of 83.7%. There is some variation by race/ethnicity in the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates. In 2013, American Indians had the lowest percentage of VLBW deliveries at NICU facilities at 72.0. Pacific Islanders had the highest percentage (86.4), followed by Asians (83.4), African Americans (79.9), Hispanic (79.4), and Whites (77.8).

RPPC and CPeTS continued their work in regional planning and coordination, matching the transport of high-risk patients with the appropriate level of care and assisting hospitals with data collection and quality improvement surrounding patient transfer.

SCD and CPQCC responded to member questions, analyzed data for SCD-approved NICUs, and address outliers and concerns about quality of care. RPPC, with OVR, will continue to present Birth Data Trainings emphasizing collaboration among administration, nurses, and birth clerks to obtain and accurately report birth data. RPPC regional leaders continue to explore opportunities for nursing staff to work with birth clerks for enhanced birth data reporting in continuing efforts to improve data quality.

g. Other Programmatic Activities

MCAH is participating in the Infant Mortality CoIIN, a national initiative that emerged as a response to needs identified by the states of the U.S. Health and Human Services (HHS) Regions IV and VI at their Infant Mortality Summit in January of 2012. The CoIIN spread to HHS Region V in 2013 and has since expanded to the rest of the nation. The lead organizations are the Maternal and Child Health Bureau of the Health Resources and Services Administration and the National Institute for Children's Health Quality. Organizations providing support and technical assistance include the Association of State and Territorial Health Officials, Association of Maternal and Child Health Programs, and MOD. On July 21-25, 2014, the National Expansion Infant Mortality Summits for HHS Regions VII-X (California belongs to Region IX) and HHS Regions I-III were held at Arlington, VA.

On June 14, 2012, HHS Secretary Kathleen Sebelius announced the creation of the nation's first ever national strategy to reduce infant mortality. The Infant Mortality CoIIN expansion is a key component of this strategy. This multiyear national initiative ending in September 2016 engages federal, state, and local leaders, public and private agencies, professionals and communities to employ quality improvement, innovation, and collaborative learning to address infant mortality reduction. Participants of CoIIN learn from national experts and one another, share best practices and lessons learned, and track progress toward shared benchmarks. CoIIN has technology-enabled teams that tackle a common problem. The originator of the term describes a CoIIN as a "cyber team of self-motivated people with a collective vision that innovatively collaborate by sharing ideas, information, and work enabled by technology". The IM CoIIN has six topical National Learning Networks, namely, Safe Sleep, Smoking Cessation, Social Determinants of Health (SDOH), Pre/Interconception Care, Preterm/Early Term Births, and Risk Appropriate Perinatal Care. States choose up to 3 topics to address during the 18-month timeline for IM CoIIN efforts. California is addressing Safe Sleep, Risk Appropriate Perinatal Care, and SDOH. MCAH is the CoIIN lead. Members of the state team include MCAH staff, and representatives from partner organizations, including MCAH Action, MOD, CMQCC, CPQCC, and Best Babies Zone.

For Safe Sleep, MCAH has developed an Intervention Protocol that will be implemented in two pilot BIH intervention sites located in counties that have the highest disparities in African American: White Sudden Unexpected Infant Death rates among all LHJs. Implementation of the protocol will coincide with the implementation of the standardized BIH curriculum which will begin in July 2015.

For Risk Appropriate Perinatal Care, MCAH plans to form a task force comprised of representatives from CPQCC, CMQCC, RPPC, CPSP, MOD, SCD, MCAH Action, and other relevant partners/stakeholders to implement an environmental scan of CCS-approved neonatal intensive care units to assess the status of Regional Cooperative Agreements with CCS/SCD. The proposed task force will also work on developing educational materials (e.g. an infographic) on neonatal and maternal levels of care to properly inform healthcare providers and hospital staff.

The SDOH Learning Network has just completed its Learning Session. Participating states are working on developing strategies that will fit the 18-month timeline of CoIIN efforts. CHVP SIT Workgroup’s purpose is to improve the quality, efficiency, and effectiveness of home visiting through interagency collaboration. Focus areas include: program implementation; training and technical assistance; continuous quality improvement; interagency efforts to improve referrals; interagency coordination and data sharing; and collaboration with other early childhood sectors at the state and local levels. In addition to CHVP staff leads, the SIT Workgroup consist of the following stakeholder members:

DSS, Office of Child Abuse and Prevention
CDE, Child Development Division and Special Education Division
DDS, Early Start Program
First Five California
California Head Start Collaboration Office
DHCS, Substance Use Disorder Prevention, Treatment and Recovery Division
DHCS, American Indian Infant Health Initiative
DHCS Sytems of Care Division (representing Child Health Disability Prevention, and California Children’s Services)
CDPH, WIC
CDPH/State and Local Injuries Control
Domestic Violence Leadership Group
MCAH LHJs representing urban and rural counties
American Academy of Pediatrics, California District
California Project LAUNCH
ECCS
Family Resource Center

Most recently, and in response to unmet needs, new partnerships have been forged between MCAH, CHVP, and the DHCS to identify mental health services and Medi-Cal reimbursement mechanisms for home visiting families. It is important to note that local CHVP sites fall under the oversight of the Local MCAH Director.

2. MCH Workforce Development

MCAH Workforce Development activities fall into four broad categories:
Workforce Development for state and local MCAH staff;
Workforce Development for program specific staff;

CDPH Workforce Development activities for CDPH staff; and Develop future public health professionals.

➤ Workforce Development for MCAH staff

Within this category, there are two major activities: (1) MCAH Discussion Group and (2) MCAH Trainings conducted in collaboration with our contractor, the Family Health Outcomes Project (FHOP).

The MCAH Discussion Group provides a forum for discussion regarding current topics and emerging issues in MCAH. These forums increase staff communication across all branches within MCAH, facilitates planning for MCAH Division tasks, and assists staff in executing their job functions more efficiently.

MCAH & FHOP collaborative trainings are intended to provide state and local MCAH staff with webinar based trainings on specific topics identified based on state and local needs. Overall, staff was pleased with the training and health topic, and survey results report that the information was ‘useful’ and ‘very useful’. Some comments included: (1) helped us clarify some of the collaborative efforts in our community; (2) helped identify areas of need; and (3) role of MCAH field nurses with the young California Children’s Services children is invaluable. Webinar topic included:

In addition, from 2013-2015, MCAH & FHOP held twice monthly Title V Needs Assessment Technical Assistance Calls with the local MCAH Directors regarding the Title V Needs Assessment. Feedback was very positive and fostered better collaboration with other agencies.

➤ Workforce Development for program specific staff

BIH provides a group-based intervention with case management services to improve birth outcomes for African-American women in California. The two main areas of workforce developments have been regional trainings that allow for smaller groups of staff to improve specific skills to improve service delivery (e.g. improved critical thinking, enhancing group facilitation skills, etc.). These trainings have received very positive evaluations reporting that they help put theory into practice. The second area of workforce development is the BIH has annual meetings which bring all of the BIH sites together. These meetings focus primarily on standardized program implementation and the use of best practices.

The MCAH adolescent sexual health effort has three primary service areas: (1) AFLP, (2) I&E, and (3) PREP. AFLP provides a range of services to pregnant and parenting adolescents, and their partners. PREP and I&E’s goal is to reduce rates of births and sexually transmitted infections including HIV among high-need youth populations. Central to their workforce development efforts was the Adolescent Sexual Health Conference which brought together experts to inform staff about current issues in adolescent health and best practice strategies. Topics included sexual violence prevention, working with teens that have experienced trauma and meeting the needs of lesbian, gay, bisexual, transgender and questioning youth. The participants provided positive feedback on the selection on workshops and the opportunity to collaborate with other adolescent health programs. The adolescent health programs are also offered opportunities to participate on additional trainings via webinars throughout the year.

CPSP provides a wide range of culturally competent services to Medi-Cal pregnant women, from conception through 60 days postpartum. There are two main workforce development activities. The professional development meeting held annually for the local Perinatal Services Coordinator which focuses on key topic areas critical to their improved performance. Recent topics presented were maternal mental health, perinatal substance use, and adverse childhood events. In addition, to the annual meeting, CPSP Provider Trainings are offered online and in-person to enhance professional skills. The results of the meetings and trainings were positive, and provided an opportunity to collaborate and share best practices with their colleagues in other LHJs.

CDAPP Sweet Success are providers in the community that provide health services to pregnant women who have diabetes. The CDAPP Sweet Success Resource and Training Center supports and trains our CDAPP Sweet Success Affiliates through monthly web-based training and on-line resources.

➤ CDPH Workforce Development activities for CDPH staff

The Needs Assessment and development of a Five-Year Action Plan provided an opportunity to train newly hired MCAH staff in program planning. For example, several of the strategies that have been proposed to address the SMART Objectives for Maternal and Women's Health involve workforce development and capacity. Two of the key strategies to address intimate partner violence involve developing protocols to improve screening which will involve staff training. There is also an emphasis on staff stress management and targeted training on Domestic Violence by Safe and Active Communities to increase the program capacity to preventively teach young people to engage in healthy, respectful relationships.

To address unintended pregnancy, staff will receive training on One Key Question and a postpartum visit protocol to help case managers and providers with appropriate care provision. To create analytic capacity for chronic disease monitoring, partnerships with the Maternal Quality Indicators Work Group, Chronic Disease Branch, and MCAH epidemiology staff will familiarize each other with their skill sets to improve the capacity for surveillance beyond pregnant women, but for non-pregnant women of reproductive age.

Like MCAH, CDPH is also committed to improve the quality of the workforce. Two efforts of note are the Center for Family Health (CFH) Equity Initiative. The Initiative is intended to provide all staff, including administrative staff, with a basic understanding of health equity. Central to that effort was a Health Equity 101 webinar conducted by the CDPH Office of Health Equity. The CFH also held an all-staff meeting to provide a presentation by Paula Braveman, MD, MPH on 'How to integrate health equity into their work'. The response from staff was positive and the initiative will continue using the Dreyfus Model for Skill Acquisition to encourage continued integration of health equity.

CDPH annually convenes a series of webinars on trending issues. This year's four session series is on health insurance and medical care delivery

➤ Developing Public Health Professionals

MCAH has a history of developing future public health professionals through its long-standing relationships with public health schools. These relationships have created opportunities for internships in program, policy and epidemiology.

MCAH is also an active participant of the California MCH Training and Transformation Network, a collaborative of 11 California-based academic institutions funded by MCHB to promote a cross-disciplinary approach that will prepare the next generation of MCH leaders to transform the MCH field into the broader systems and policy context of California's changing healthcare system. The Network aims to foster the knowledge, skills and relationships among trainees and embraces a lifecourse orientation for a comprehensive and networked approach to transforming the health system.

MCAH has provided input and letters of support to training grant applications submitted by the University of California, Berkeley and the University of California, Los Angeles to the National Institute of Health and the Maternal Child Health Bureau. These training grants fund training programs that could serve the ultimate workforce needs and research priorities of the local, state and federal MCH agencies.

3. Family/ Consumer Partnership

California's Title V reaches out to partner with MCHB awardees in the state on an ongoing basis. We have established and maintained working partnerships with other MCHB awardees, Medi-Cal, local and state education and health and human service agencies, community based organizations, professional health organizations, providers, community advocates, community members and other stakeholders that have a vested interest in promoting the health of the MCAH population.

Family and consumer partnerships are integral components of California's Title V MCAH collaborative efforts, programs and services at the state and local level. Family members, former clients, caregivers, and interested lay persons provide valuable input and perspective in the planning, development, implementation, and evaluation of MCAH and SCD's CSCHN programs, services and policies. MCAH and SCD are committed to improving family and consumer involvement and engage community members in discussions related to the allocation and management of resources and community ownership to sustain collaborative efforts. We will continue to promote the value that families and consumers offer to the development and delivery of culturally and linguistically appropriate services and insight on how to address gaps and barriers.

MCAH programs in California's 61 LHJs provide community/population-based and direct services. Many locally developed programs and strategies are informed by feedback received from clients, former clients and families. As part of the 2016-2020 Title V Needs Assessment activities, LHJs were instructed to focus on meeting with stakeholders/community partners, including families and consumers that represented their community's populations and health challenges. We encouraged a wide variety of stakeholder involvement to help LHJs review data, identify and prioritize problems and target populations, review problem analyses to identify intervention strategies and new stakeholders/community partners and promote community support. LHJs were required to report the number of stakeholders involved in their local Needs Assessment, stakeholder/community partner initials, the name of the organization

and sector they represented, such as community clinics, faith-based organizations, First 5, individual youths, individuals or families (community members), schools, and providers. There were a total of 3,216 stakeholders providing input in the needs assessment in 61 LHJs; 26 LHJs reported a total of 398 individuals or families participating; and 8 LHJs reported 47 individual youths participating as stakeholders.

MCAH programs, especially BIH and AFLP, encourage consumers of program services to voice their concerns and provide suggestions on how to improve the quality and effectiveness of MCAH services. Most of the input is received via satisfaction surveys and focus groups. Results of these surveys are reported in the LHJs annual reports which are submitted to MCAH. MCAH invites family and consumer input on an ongoing basis via phone, e-mails or through listservs. The MCAH webpages provides a mechanism for the public to e-mail inquiries and comments directly to MCAH.

There are many examples of family/consumer partnership at the State level. The California Sudden Infant Death Syndrome (SIDS) Advisory Council consists of nine members who are appointed by the CDPH Director. Currently, the advisory council has three members who represent the SIDS parents' groups. About 18 parents/family members attended the 2014 Annual SIDS Conference.

Parents of FASD-affected individuals participate in the FASD Task Force. They attend quarterly meetings and participate in the discussion of agenda items by providing the perspective of the challenges that FASD parents face. They are usually active members of task force member organizations such as Arc of California-Riverside.

SCD seeks to involve families in multiple aspects of policy making and care for CCS Program clients. These efforts are coordinated through multiple organizations. Three entities that are central to this effort include Family Voices of California (FVCA), Children's Regional Integrated Services System (CRISS) and the Los Angeles Partnership for Special Needs Children/ CCS Workgroup.

SCD collaborates with FVCA, which serves parents of CSHCN with and without CCS Program eligible conditions. CCS participates in FVCA webinars and the FVCA annual Health Summit. In 2014, FVCA collaborated with DHCS and other partners on various committees, taskforces, senate hearings, and stakeholder groups related to the 1115 Bridge to Reform Waiver, the CCS Program redesign, and the Title V Needs Assessment, ensuring that parents and community members are involved in these processes. Some FVCA Council Member Agencies continue to renew their Parent Health Liaison contracts with their local CCS programs, continue to train CCS Program staff on family perspectives, and provide conflict resolution assistance for CCS Program staff and family members.

CRISS brings together CCS programs, family support organizations, and pediatric providers and hospitals in a 27-county region of Northern California in a cohesive regional coalition with the goal of creating a regional seamless care for CCS clients. The organization includes over 50 member organizations, including local county CCS programs, FVCA, local family support organizations, children's hospitals, and pediatric provider organizations (AAP and pediatric subspecialists). CRISS has been an active participant in the CCS Program redesign effort, the Title

V Needs Assessment, and the 1115 Bridge to Reform Waiver stakeholder process. The semi-annual CRISS Family-Centered Care newsletter informs groups and constituencies as well as Family Voices about policies and resources that enhance the lives of CSHCN. CRISS has worked actively on supporting medical homes, including disseminating the following materials: medical home index information, parent health notebook, a sample medical home binder from one county's successful medical home project. CRISS has worked on transition issues through both the CRISS Family-Centered Care and MTP workgroups and has collected and disseminated information that focuses on the whole young adult with an emphasis on primary care and specialty needs, vocational needs, and residential and leisure/recreational needs. CRISS is monitoring implementation of Covered California, particularly services available for CSHCN and impact on families of out-of-pocket costs and limits to durable medical equipment and other services embedded in the benchmark plan service package. In addition, rural counties in California recently moved to mandatory enrollment in Medicaid managed care, and CRISS is monitoring the impact on CSHCN. For example, CRISS conducted two surveys six months apart to capture the adequacy of plan networks in those counties for CSHCN (both surveys demonstrated clear problems in network adequacy for CSHCN, and will continue to monitor the situation).

The Los Angeles Partnership for Special Needs Children is the oversight entity for the CCS Workgroup in Los Angeles County. The Workgroup's goal is to improve the system of care for CSHCN. Members include health plans, hospitals, regional centers, providers and parents, including participant members from family resource centers and the Family Centered Care Committee.

4. Healthcare Reform

Covered California is California's marketplace for the ACA. Covered California is overseen by a five-member board, appointed by the Governor and the Legislature (<https://www.coveredca.com/PDFs/CC-health-plans-booklet-rev4.pdf>). Covered California helps individuals compare health insurance plans and choose the plan that works best for their health needs and budget. Additionally, individuals can learn if they qualify for federal financial assistance that can lower the cost of health insurance and also find out if they are eligible for health programs like Medi-Cal. Most Medi-Cal recipients are enrolled in a Medi-Cal Managed Care Health Plans (MMCHP) located in one of the 58 counties.

Beginning January 1, 2014, California expanded Medi-Cal as allowed under the ACA; this resulted in making Medi-Cal available to more low-income adults. MMCHP enrollment reports show an increasing trend of enrolled beneficiaries. By February 2015, there were 9,074,167 enrolled beneficiaries in 58 counties. This has not impacted enrollment into the CCS Program's clients under 21.

The Medi-Cal expansion has allowed for more collaborative opportunities within the local and state MCAH. ACA's expansion on health care access allowed each local MCAH jurisdiction to evaluate their existing systems of care infrastructure by considering opportunities to maximize and leverage resources with local partners, minimize gaps in care and address maternal, adolescent, child and infant health disparities.

MCAH is involved in collaborative activities with the Department of Healthcare Services (DHCS) through stakeholder meeting participation in the “Full Scope Medi-Cal Coverage, Affordability and Benefit Program for Low Income Pregnant Women and Newly Qualified Immigrants.” Discussions continue between MCAH and DHCS as the plans to implement the new eligibility and benefit requirements for pregnant women unfold. Since more beneficiaries are served by a network of providers contracted through MMCHP, a partnership was formed between MCAH and Medi-Cal Managed Care Division (MMCD), the agency that oversees California’s MMCHP. MCAH with MMCHP plan to engage in quarterly meetings to achieve the following: foster information sharing; promote ways to achieve improvements in care access; facilitate improvements in local MCAH and MMCHP coordination; and, address public health issues related to maternal and infant health. In addition to MMCHP and MMCD, MCAH participates in the CHVP SIT, represented by members belonging to different state agencies, local MCAH jurisdictions, and non-profit organizations. The SIT group is represented by members from the Department of Social Services, Department of Housing and Community Development, Center for the Study of Social Policy, Family Resource Center Network of California, American Indian Infant Health Initiative, California Department of Education, California WIC Program, First 5 California and Race to the Top, Early Learning Challenge, CA Department of Health Care Services, SUD Prevention, Recovery and Treatment Services, California Department of Developmental Services, Early Start Program and California Community of Health Agencies. MCAH is involved in the team’s common goal of pursuing opportunities to improve access to services that promote and improve health outcomes for women, children and their families.

MCAH continues to assist with the coordination, facilitation and enrollment of the MCAH population to Covered California, Medi-Cal and related services through the following MCAH programs administered through the LHJs: CPSP, BIH, and AFLP. This is achieved through outreach, education, referral coordination, case management, triaging, and collaborative efforts with providers, internal and external agencies and non-profit organizations.

The increase of beneficiaries enrolled into Medi-Cal Managed Care provided opportunities for local MCAH to work with the local MMCHP through an established Memorandum of Understanding (MOU). This agreement allows Local MCAH and MMCHP to coordinate and leverage resources, services, training, and shared quality improvement strategies to promote improved services to the vulnerable maternal, infant and child population. The local MCAH LHJ annual report submitted for reporting period 2013-2014 indicated 46 counties that reported varying degrees of working relationships with MMCHP network of providers. In addition, there were 42 counties that provided ACA information to community partners, including beneficiaries. Approximately 171,370 pregnant women were referred to ACA and Medi-Cal. Over 50 local MCAH agencies initiated efforts to develop policy and systems changes that facilitate access to Medi-Cal, Covered CA, CHDP, Women, Infants, and Children (WIC), Family Planning, Access, Care, and Treatment (Family PACT), and other relevant programs.

As part of the 2016-2020 Title V Needs Assessment requirement, 61 LHJs comprised of 58 counties and three incorporated cities, participated in a survey that examined and assessed the role of local MCAH programs in assisting with enrollment in the Covered California health

insurance exchange and the Medi-Cal Managed Care (MMC) expansion. The result of a local MCAH survey completed in September 2013 revealed 48 LHJs operated MMCHP. Thirty-five local MCAH programs have a Memorandum of Understanding (MOU) with MMCHP operating within the LHJ.

In addition to interagency and external collaborative work brought forth by ACA implementation, outreach and education remain sustainable activities in support of the evolving role of ACA. During the survey completed by Local MCAH in September 2013 regarding the ACA implementation in local MCAH, 46 LHJs established a process to refer people to an enrollment entity or Covered California or 39 LHJs to enroll eligible women and children into Medi-Cal - a carryover function as part of the larger existing MCAH infrastructure. Twenty seven LHJs were involved with activities to increase public awareness of increased coverage for women's preventive services. The majority of LHJs have been involved in educating partner agencies, providers and beneficiaries in presumptive eligibility awareness, access, and benefit updates.

Disseminating information and making referrals to Covered California emerged as the predominant functions of the local MCAH in ACA implementation. Several LHJs felt that their role was of lead collaborative agency or were in the process of defining their role; however, most LHJs reported that MCAH was not viewed as a key participant in ACA because most of the enrollment activities were happening outside of MCAH.

In 2014, California eliminated the Healthy Families Program and shifted enrollees to Medi-Cal which resulted in more than 900,000 children receiving services through Medi-Cal. California continues in its initiative to promote access to care for children, especially for those children determined no longer eligible for Medi-Cal under the Modified Adjusted Gross Income Methodology (MAGI) based on Assembly Bill (AB) x1 1, Chapter 3, Statutes of 2013, and recent guidance provided by the Centers for Medicare & Medicaid Services on the Affordable Care Act of 2010 (ACA), Medicaid /County Children's Health Initiative Program Section 2101(f) FAQs, dated April 25, 2013. Brought by Section 2101(f) of the ACA rules, the Department of Health Care Services released guidance, in April 2014, ensuring pre-ACA children are protected during the 2014 annual redeterminations of Medi-Cal eligibility until the following annual re-determination date in 2015. This policy change during the ACA transition helped local MCAH minimize disruption in child care, especially those who were due for scheduled immunization and well-child visits. This allowed children to receive continued eligibility during the transition period. Local MCAH continues to address timely well-child visit appointments after cancellations or change in providers, or provide timely access to care for children with special health care needs through different partnerships (community-based, interagency, providers and local MMCHP).

Local MCAH continues to work with their local CHDP program in terms of care coordination, referrals to mental health and developmental services, cross-staff collaboration and training, screening resources, increasing enrollment of children into ACA and improving access to Medi-Cal related services. It should be noted that 14 of the MCAH directors also function as California Children Services Directors. For instance, through the Healthy Kids/Covered Sonoma County, local MCAH launched its 100 percent School Based Campaign pilot, attaining health coverage for over 99 percent of students at one school. In addition, CalFresh outreach to

enroll and retain eligible families increased in Sonoma, and USDA funding is supporting replication of this model in five other counties. There was also an increase in enrollment worker capacity in the local community health centers.

During the reporting period, MCAH partnered with CHVP, in collaboration with the California Mind Institute from the University of California, Davis, regarding accessing and navigating tools and resources in the “California Map to Inclusive Child Care Project” website to increase awareness of providers and practitioners, share knowledge of a child’s healthy development, support child’s growth and early identification of concerns. The website (<http://cainclusion.org/camap/counties.html>). contains information on “Healthy Development,” “Working with Families,” “When Concerns Arise,” “Developmental Screening,” “Referral for Evaluation and Assessment, including county specific resources in California

MCAH looks forward to the implementation of California’s Medi-Cal eligibility expansion for low-income adults that will include the Full Scope Medi-Cal Coverage, Affordability and Benefit Program for Low-Income Pregnant Women and newly Qualified Immigrants, in accordance with Senate Bill 857, (Chapter 31, Statutes of 2014) and Senate Bill x 1-1 (Chapter 4, Statutes of 2013), (Welfare and Institutions (W & I) Code Sections 14102, 14148.65 and 14148.67). Implementation of this program will allow pregnant women with satisfactory immigration status and incomes between 0 percent up to and including 138 percent FPL to be eligible for full scope Medi-Cal Coverage. In addition, pregnant women with satisfactory immigration status and incomes above 138 percent up to 213 percent of the FPL will be provided the option to enroll in the Wrap, thereby receiving premium and out-of-pocket payment assistance and accessing additional Medi-Cal services to the extent services are not covered in the Exchange QHP. Upon implementation, beneficiaries will be required to enroll in a MMCHP in those counties in which a plan is available. Those beneficiaries residing in a county where a MMCHP is not available will be provided services under the Medi-Cal fee-for-service delivery system. The implementation is still subject to federal approvals. This policy expansion change will allow more opportunities for MCAH to work with state MMCD and local MMCHP by strengthening elements in the MOU for increased care coordination, resource sharing and maximizing service capacity for the maternal, infant and child population. MCAH continues to work with DHCS regarding policy changes and implications to maternal health. It is projected that there will be a one-time shift of 11,000 women to Medi-Cal Managed Care for those who are eligible for full scope Medi-Cal coverage.

The ACA offers the opportunity to obtain no-cost preventive services for women. These services address all three goals in the Maternal/Women’s Health Action Plan and can be instrumental in preventing unintended or mistimed pregnancies by providing FDA-approved contraception without cost-sharing, providing annual wellness checkups that include chronic disease screening with no cost-sharing, and providing appropriate referrals for other preventive services for obesity and smoking that also do not require cost-sharing.

5. Emerging Issues

➤ Pregnancy Immunizations

Pregnant women who get the flu are at increased risk for severe illnesses from influenza and their babies are also at risk. Complications from the flu can include premature labor, babies that are small for gestational age, hospitalization, and, rarely, death. Pregnant woman with flu also

have a greater chance for serious problems for their unborn baby, including premature labor and delivery. It is safe, and very important, for a woman who is pregnant to receive the inactivated flu vaccine or “flu shot” to protect both the mother and her baby. Babies younger than 6 months are too young to receive flu vaccine.

Whooping cough or pertussis is a common illness and can very serious for babies, even leading to death. All pregnant women should receive a dose of Tdap during each pregnancy, preferably at 27 through 36 weeks – regardless of whether they have received Tdap in the past - to protect themselves and their baby (from antibodies passed to the fetus during pregnancy) from whooping cough.

Despite national recommendation by American Congress of Obstetricians and Gynecologists (ACOG) and CDC for influenza vaccine and Tdap vaccine during pregnancy, many pregnant women do not receive these important vaccines. Although most women see their Ob-Gyn or prenatal provider regularly during pregnancy, not all prenatal care providers offer the flu vaccine or provide strong recommendation for the vaccine. It will be important to work with prenatal care providers to educate them regarding the importance of these vaccines and assess and provide strategies to overcome current perceived barriers to providing these important vaccines to pregnant women.

➤ Child Health Immunizations

Healthy People 2020 set a goal of increasing the percentage of children aged 19-35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine (the 4:3:1:3[4]:3:1:4 combined series of vaccines) from a baseline of 44.3% to a target of 80.0%. [37] Of California's children aged 19-35 months, 66.8% received the combined series of vaccines in 2012, a figure very close to the national percentage of 68.4. [38] The percentage of children who have received the combined series of vaccines has fluctuated slightly during the 2000 to 2012 time period while overall decreasing slightly. Dr. Tracy Lieu led a study [39] that analyzed electronic health records among children born between 2000 and 2011 with membership in Kaiser Permanente Northern California. The study population included 154,424 children in 13 counties with continuous membership from birth to 36 months of age. Spatial scan statistics were used to identify clusters of under immunization (having missed 1 or more vaccines by 36 months of age) and vaccine refusal (based on International Classification of Diseases, Ninth Revision, Clinical Modification codes). The data revealed under-immunization clusters among children who turned 3 between 2010 and 2012 in the East San Francisco Bay from Richmond to San Leandro; in Sonoma and Napa counties; in an area between Sacramento and Roseville; in northern San Francisco and southern Marin counties; and in Vallejo. There were 5 statistically significant clusters of under immunization among children who turned 36 months old during 2010–2012. The underimmunization rate within clusters ranged from 18% to 23%, and the rate outside them was 11%. Children in the most statistically significant cluster had 1.58 (P, .001) times the rate of underimmunization as others. Underimmunization with measles, mumps, rubella vaccine and varicella vaccines clustered in similar geographic areas. Vaccine refusal also clustered, with rates of 5.5% to 13.5% within clusters, compared with 2.6% outside them.

Parental refusal and delay of childhood vaccines has increased in recent years and is believed to cluster in some communities. Such clusters could pose public health risks and barriers to

achieving immunization quality benchmarks. Knowing precisely where such pockets of under-vaccinated populations are could help physicians and public health departments prevent illnesses. Spatial scan statistics may be a useful tool to identify locations with challenges to achieving high immunization rates, which deserve focused intervention.

➤ Adolescent Immunizations

Healthy People 2020 set a goal of increasing the vaccination coverage level of 3 doses of human papillomavirus (HPV) vaccine for females by age 13 to 15 years from a baseline of 16.6% to a target of 80%. [40] Nationwide, 53.8% of adolescents aged 13-17 have at least 1 dose of the HPV vaccine. [41] California's percentage is higher, with 65.0% of adolescents having received at least 1 dose of the HPV vaccine. The percentage of adolescents who have received the vaccine varies by race/ethnicity group, with 71.9% of Hispanic adolescents having received at least 1 dose of the HPV vaccine whereas 52.2% of White adolescents have received at least 1 dose. Data is not available for other racial groups.

➤ Adverse Childhood Experiences

Adverse Childhood Experiences (ACE), such as childhood abuse, neglect and exposure to violence, has been shown to be major risk factors for illness and death across the life course [42]. In 2012, the percent of California children ages 0-17 with two or more adverse family experiences was 18.2, a lower percentage than the national comparable rate of 22.6%. The percent of children with two or more adverse family experiences varies by age, with a lower percentage of younger children experiencing adverse events: 7.3% of children 0-5, 23.0% of children 6-11 and 23.9% of children 12-17.

Percentages of children with 2 or more adverse family experiences were similar among children at the lowest poverty levels (20.5% for FPL 0-199%; 23.5% for FPL 200-299%, and 25.1% for FPL 300-399%) but much lower among children at the highest poverty levels (9.8% for FPL 400% or higher). Similarly, children with public insurance and who were currently uninsured had higher percentages (22.5% and 27.0%, respectively) than those with private health insurance (14.3%). Percentages of children with 2 or more adverse family events also vary across race/ethnicity. A much higher percentage of Black children (45.3%) experienced 2 or more adverse family events compared to White children (18.4%). Hispanic youth were similar to White youth at 18.0%. Children of other racial backgrounds had the lowest percentage at 8.7%.

There is emerging data to identify risk factors for future intimate partner violence perpetuation or victimization. One of the new objectives is to implement policies to screen for risk factors for future intimate partner violence and refer for appropriate follow up. For several years MCAH has been invested in screening for and understanding the importance of ACEs, but this is the first tangible step that MCAH programs will take to translate the research and framework into public health practice for prevention of ACEs sequelae.

➤ Maternal Mortality

Medical mistakes were listed, as the 3rd leading cause of death nationally following heart disease and cancer. [43] Section 1279.1 of the California Health & Safety (H&S) Code requires all General Acute Care Hospitals to report the occurrence of defined adverse events to their local Licensing and Certification Program district office. An adverse event is defined as a

medical occurrence that caused or is an ongoing threat of imminent danger of death or serious bodily harm at an acute general hospital, acute psychiatric hospital and special hospital. There are 28 "Adverse Events" defined in the California H&S code. Maternal deaths in low risk pregnancy are specifically listed as an adverse event within the law but there are many adverse events throughout this law that could be the cause of, or immediately related to a maternal death in any risk category of pregnancy. Examination of these deaths by the California Pregnancy-Related and Pregnancy-Associated Mortality Review would possibly identify very specific obstetrical services that need to be adhered to more diligently at both the individual level (e.g. nurse, physician assistant, etc.) and hospital level (performance of more trainings, system drills) to assist the provider in better equipping staff in the performance of their job and thus improve quality of care outcomes resulting in a decline in maternal mortality and morbidity rates.

MCAH aspires to see continued improvement in declining maternal mortality rates but shares the concerns of Nancy Chescheir, MD, editor-in-chief of Obstetrics & Gynecology with regard to the high national rates of Pregnancy-associated deaths due to violence. From her editorial in the January 2015 journal Obstetrics & Gynecology- Creanga et al report [44] that more than 5,000 women died during this time period (2006-2010) from pregnancy-associated causes. According to the report, "Deaths due to motor vehicle accidents, suicide, homicide, and intimate partner violence make up the bulk of these." [45] This would entail screening women for issues surrounding domestic violence, mental health, and substance use, providing them with the proper referrals, and to also educate them on seat belt usage and air bags.

➤ Maternal Morbidity

Heart disease is the leading cause of women's pregnancy-related deaths in California — but nearly one-third could be prevented, according to research presented at the American Heart Association's Scientific Sessions 2013. Dr. Afshan Hameed led a research study [46] analyzing why California's maternal death rates have nearly tripled from 5.6 per 100,000 live births in 1996 to 16.9 per 100,000 live births in 2006. In the 2.1 million recorded live births in California from 2002-2005, 732 women died from pregnancy-related deaths. Nearly 25 percent of those 732 deaths were caused by some form of cardiovascular disease. Notably, only six percent of the women had been diagnosed with a heart condition prior to their pregnancy.

In the study, UC Irvine Health researchers also concluded that in 65 percent of the pregnancy-related deaths, the diagnosis was either incorrect or delayed; 47 percent of providers had given ineffective or inappropriate treatments; and 41 percent of pregnant women were misdiagnosed. Specifically, an enlarged and weakened heart accounted for two-thirds of pregnancy-related deaths. One third of the patients who died had delayed or failed to seek care, 10 percent refused medical advice and 27 percent did not recognize their symptoms as cardiovascular. Nearly 30 percent of the expecting mothers did not recognize their symptoms as cardiovascular-related. "Women who have preeclampsia or gestational diabetes and preterm delivery have up to an eight to 10-fold increased risk for developing cardiac disease later in life," says Hameed. "These women need to be identified as high-risk patients and should have a follow-up care three to six months after delivery. If these conditions are treated appropriately, the risk of these women having future cardiac issues is greatly reduced."

Expecting mothers should stick to healthy eating and living as that will promote healthy development of their baby in utero. It's also important to keep making healthy lifestyle decisions once the baby arrives so families can keep their health and wellness on the right track."

"It is imperative that health care providers do a better job recognizing heart disease triggers such as changes in blood pressure, heart rate, or if the woman is experiencing excessive shortness of breath, fatigue, or anxiety. These may be indicators for heart disease and should be evaluated immediately." For pregnant women with multiple cardiovascular risk factors such as obesity, diabetes, high blood pressure or family history of cardiovascular disease, OB-GYNs should maintain a high index of suspicion and may consider consultation with maternal fetal medicine specialist or a cardiologist.

Mental Health in California: This report uses the data from 2009 and 2010. Mental Health Care in California: Painting a Picture [47] provides an overview of mental health in California covering disease prevalence, suicide rates, the state's care delivery system, supply and use of treatment providers, and access to care. Key findings included:

About half of adults and two-thirds of adolescents with mental health needs did not get treatment.

For children and adults, the prevalence of serious mental illness varied by income, with much higher rates of mental illness at lower income levels

Rates of serious emotional disturbance in California children showed more variation across income levels than across gender, age groups, and race and ethnic groups. One in 10 children below the poverty level suffered from a serious emotional disturbance. [48]

Depression is one of the most prevalent mental health disorders among adolescents. Between 2005 and 2009, approximately 8% of teens in California and the US reported that they had experienced an episode of major depression in the previous year. [49]

6. Technical Assistance

Interface with the States currently receiving Project Launch funds and learn how their community councils are assessing local resources and needs, creating strategic plans, and using evidence-based prevention and health promotion strategies. California could review these elements and possibly develop better methods for:

- 1) Screening program participants
- 2) Integrating mental health consultation
- 3) Providing additional trainings for program staff

Family strengthening and parenting skills training

Access to care for the MCAH population is challenging on a couple of fronts. California has approximately 22 rural counties, predominantly in the Northern and Eastern part of the State. In some case residents are actually geographically closer to services in a neighboring county than the one they reside in. In the urban areas geography is not necessarily the issue as much as: lack of transportation (including inefficient transit systems), lack of childcare, inability to take off time from work, poor family support system, cultural barriers, domestic problems, etc. Understanding better how to increase access to care among the population we serve would be welcomed.
