Maternal and Child Health Services Title V Block Grant

State Narrative for California

Application for 2010 Annual Report for 2008

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Table of Contents

I. General Requirements 4
A. Letter of Transmittal 4
B. Face Sheet 4
C. Assurances and Certifications 4
D. Table of Contents 4
E. Public Input 4
II. Needs Assessment 6
C. Needs Assessment Summary 6
III. State Overview 9
A. Overview 9
B. Agency Capacity 26
C. Organizational Structure 40
D. Other MCH Capacity 46
E. State Agency Coordination 50
F. Health Systems Capacity Indicators 60
Health Systems Capacity Indicator 01: 61
Health Systems Capacity Indicator 02: 63
Health Systems Capacity Indicator 03: 65
Health Systems Capacity Indicator 04: 66
Health Systems Capacity Indicator 07A: 68
Health Systems Capacity Indicator 07B: 70
Health Systems Capacity Indicator 08: 72
Health Systems Capacity Indicator 05A: 74
Health Systems Capacity Indicator 05B: 76
Health Systems Capacity Indicator 05C: 78
Health Systems Capacity Indicator 05D: 79
Health Systems Capacity Indicator 06A: 81
Health Systems Capacity Indicator 06B: 82
Health Systems Capacity Indicator 06C: 83
Health Systems Capacity Indicator 09A: 84
Health Systems Capacity Indicator 09B: 86
IV. Priorities, Performance and Program Activities 88
A. Background and Overview 88
B. State Priorities 89
C. National Performance Measures 95
Performance Measure 01: 95
Performance Measure 02: 98
Performance Measure 03: 102
Performance Measure 04: 105
Performance Measure 05: 108
Performance Measure 06: 111
Performance Measure 07: 114
Performance Measure 08: 117
Performance Measure 09: 121
Performance Measure 10: 125
Performance Measure 11: 129
Performance Measure 12: 133
Performance Measure 13: 136
Performance Measure 14: 139
Performance Measure 15: 143
Performance Measure 16: 146
Performance Measure 17: 149
Performance Measure 18: 153

D. State Performance Measures 157
State Performance Measure 1: 157
State Performance Measure 2: 159
State Performance Measure 3: 162
State Performance Measure 4: 165
State Performance Measure 5: 169
State Performance Measure 6: 172
State Performance Measure 7: 176
State Performance Measure 8: 178
State Performance Measure 9: 182
State Performance Measure 10: 186
E. Health Status Indicators 188
Health Status Indicators 01A: 189
Health Status Indicators 01B: 190
Health Status Indicators 02A: 191
Health Status Indicators 02B: 192
Health Status Indicators 03A: 193
Health Status Indicators 03B: 195
Health Status Indicators 03C: 196
Health Status Indicators 04A: 198
Health Status Indicators 04B: 199
Health Status Indicators 04C: 201
Health Status Indicators 05A: 202
Health Status Indicators 05B: 204
Health Status Indicators 06A: 205
Health Status Indicators 06B: 206
Health Status Indicators 07A: 206
Health Status Indicators 07B: 207
Health Status Indicators 08A: 207
Health Status Indicators 08B: 208
Health Status Indicators 09A: 209
Health Status Indicators 09B: 212
Health Status Indicators 10: 215
Health Status Indicators 11: 216
Health Status Indicators 12: 217
F. Other Program Activities 218
G. Technical Assistance 221
V. Budget Narrative 224
A. Expenditures 224
B. Budget 224
VI. Reporting Forms-General Information 227
VII. Performance and Outcome Measure Detail Sheets 227
VIII. Glossary 227
IX. Technical Note 227
X. Appendices and State Supporting documents 227
A. Needs Assessment 227
B. All Reporting Forms 227
C. Organizational Charts and All Other State Supporting Documents 227
D. Annual Report Data 227

I. General Requirements

A. Letter of Transmittal

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

B. Face Sheet

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

C. Assurances and Certifications

/2009/ The State of California's Assurances and Certifications and Memorandums of Understanding are available on request. //2009//

/2010/ The State of California's Assurances and Certifications and Memorandums of Understanding are available on request. //2010//

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

/2009/ An abridged draft of the FFY 2009 Application/Report, including data tables, was posted on the Maternal, Child, and Adolescent Health (MCAH) Program website for review and comment. MCAH partners, including local MCAH Directors, contractors and other stakeholders were advised of the availability of the draft. The Children's Medical Services (CMS) Branch added a Title V link on the CMS website that connected to the MCAH website and made the draft Application/Report available to its partners. A CMS Information Notice was placed on the CMS Website informing stakeholders, including the California Childrens Services (CCS) administrators, local Child Health and Disability Prevention (CHDP) program directors, deputy directors and medical consultants, and CMS Branch staff, about accessing the draft Application/Report.

Input from and dialogue with MCAH partners is maintained throughout the year via stakeholder and other meetings for partner participation. Through semi-annual meetings and solicited dialogue on specific issues and projects MCAH Directors as well as representatives from MCAH programs provide input throughout the year.

MCAH stakeholders, taskforce and other workgroup members are kept apprised of changes in federal legislation and the impact of these changes on MCHB Title V funding, recommendations and requirements. Updates are provided via conference calls or in-person meetings with all MCAH partners including but not limited to meetings for the Preconception Care Council of California, the MCAH Action Committee, the Adolescent Sexual Health Workgroup, the California Perinatal Quality Care Collaborative and California Maternal Quality Care Collaborative Executive Committees and the Regional Perinatal Programs of California. The California CMS Branch has informed children's advocates, stakeholders, and providers for Children with Special Health Care Needs at multiple public meetings of the reduction in Title V grant money to the CMS Branch.

See the attachment to this section for more information about Public Input. Responses to last year's Grant Recommendations are also included in the attachment. //2009//

/2010/ An abridged draft of the FFY 2010 Application/Report, including data tables, was posted on the Maternal, Child, and Adolescent Health (MCAH) Program website for review and comment. MCAH partners, including local MCAH Directors, contractors, and other stakeholders (e.g., statewide associations, health foundations, and collaboratives) were advised of the availability of the draft. The Children's Medical Services (CMS) Branch added a Title V link on the CMS website that connected to the MCAH website and the draft Application/Report, making it available to its partners. A CMS Information Notice was placed on the CMS Website informing stakeholders, including the California Childrens Services (CCS) administrators, local Child Health and Disability Prevention (CHDP) program directors, deputy directors and medical consultants, and CMS Branch staff, about accessing the draft Application/Report.

Public input on the draft FFY 2010 Application/Report was more extensive than in prior years, likely due to the ongoing fiscal crisis in the State of California and the potential for extensive cuts in state funding for local MCAH programs. Comments were received from nearly 70 individuals, including local MCAH Directors or their representatives, other health professionals, educational program providers, and clients who receive MCAH funded services. Common themes that emerged through these comments addressed the impact of past funding cuts on California's local MCAH infrastructure and its ability to keep pace with the growing needs of an increasingly diverse and lower income population, as well as the devastating impact the proposed funding cuts would have on local MCAH programs and services.

In addition to comment on the draft report, input from and dialogue with MCAH partners is maintained throughout the year via stakeholder and other meetings for partner participation. Through semi-annual meetings and solicited dialogue on specific issues and projects MCAH Directors as well as representatives from MCAH programs provide input throughout the year.

MCAH stakeholders, taskforce members and other workgroup participants are kept apprised of changes in federal legislation and the impact of these changes on MCHB Title V funding, recommendations and requirements. Updates are provided via conference calls or in-person meetings with all MCAH partners including but not limited to meetings for the Preconception Care Council of California, the MCAH Action Committee, the Adolescent Sexual Health Workgroup, the California Perinatal Quality Care Collaborative and California Maternal Quality Care Collaborative Executive Committees and the Regional Perinatal Programs of California. The California CMS Branch has informed children's advocates, stakeholders, and providers for Children with Special Health Care Needs at multiple public meetings of the reduction in Title V grant money to the CMS Branch.

See the attachment to this section for more information about Public Input. Responses to last year's Grant Recommendations are also included in the attachment.//2010//

An attachment is included in this section.

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

California's 2006-2010 Title V Needs Assessment, completed July 2005, was the culmination of over three years of planning, analysis and evaluation by local health jurisdictions (LHJs) and stakeholders in partnership with the California Department of Health Services (CDHS). The Maternal, Child and Adolescent Health/Office of Family Planning (MCAH/OFP) Branch and the Children's Medical Services (CMS) Branch of CDHS provided leadership in assessing and prioritizing local and statewide needs of MCAH and CSHCN populations.

Each Branch undertook inclusive efforts to produce a comprehensive needs assessment. From 2003-04, the MCAH/OFP Branch took a multi-level approach that involved collaboration with the University of California San Francisco (UCSF) and the state's 61 LHJs. Fifty-five of the 61 jurisdictions (90%) submitted needs and capacity assessments in 2004. The Branch analyzed this data on local-level needs and process methodology. In April 2005, 46 stakeholders participated in a meeting to discuss data and issues and rank state priorities.

CMS's assessment for CSHCN included an evaluation of internal capacity. The Family Health Outcomes Project (FHOP) at UCSF assisted in the collection and analysis of data and facilitation of the stakeholder process for identifying issues and prioritizing needs. CMS invited 37 stakeholders to participate in the identification and prioritization components of the needs assessment. All-day meetings were held in January and April 2005; criteria for ranking were selected and weighted, issues were identified, data were reviewed, and three priority objectives for CSHCN were chosen.

/2010/Needs assessment has been an ongoing process for CMS. Twelve stakeholder meetings were held from August 2005 to June 2008 to form and implement a strategic plan.//2010//

/2009/Needs assessment is a continuous process for the MCAH program. Multiple efforts are undertaken to update and analyze the health status of the MCAH population and conduct ongoing MCAH community assessments. Examples include: (1) comprehensive assessment of the Black Infant Health (BIH) Program based on review of the scientific literature, data analysis, and program site visits; (2) analysis of folic acid consumption patterns in support of folic acid promotion efforts, subsequently published in a Mortality & Morbidity Weekly Report (MMWR); (3) detailed analysis of pregnancy-associated mortality trends; (4) analysis and dissemination of in-hospital breastfeeding data; (5) dissemination of maternal health behaviors and health status data among subgroups at state and local levels; (6) teen birth rate hot spot report using geographic information system (GIS) maps; (7) survey of perinatal substance abuse screening programs in LHJs; (8) analysis of prenatal alcohol consumption using multiple data sources; (9) preconception health status report; and (10) analysis and dissemination of gestational diabetes trends. In addition, the MCAH Program is collaborating with UCSF and LHJs to develop a capacity assessment tool for the Title V 2010-2014 Local Needs Assessment.//2009//

/2010/The MCAH Division conducts ongoing needs assessment activities to monitor and assess the health of the state's MCAH populations. Ongoing data collection and analysis related to our priority needs inform state level programs and policies. Dissemination of findings to LHJs and stakeholders supports their efforts to effectively address these priorities as well. Examples of needs assessment activities, by priority area, are provided as an attachment.

MCAH's 2010-2014 needs assessment is also underway. MCAH convened an internal steering committee, and sought stakeholder input in developing the local needs assessment guidelines, posted at: http://www.cdph.ca.gov/programs/MCAH/Pages/MCAH-TitleVBlockGrantProgram.aspx.//2010//

Title V Implementation Plan (IP)

The five-year needs assessment was the first phase in a cycle for continuous improvement of maternal, child and adolescent health. Developing an implementation plan, with specific objectives and strategies to address the priorities was the next step. A multi-level approach provided various avenues for input from partners. The MCAH/OFP Branch oversaw the following to ensure a comprehensive process:

• Input from MCAH/OFP Branch Section Chiefs and Program Managers;
• On-site meetings with local MCAH representatives from 9 counties throughout the state;
• Input from local health jurisdiction Maternal and Child Health Directors;
• Review and input from recognized experts in the MCAH field;
• Stakeholder meeting with representatives from research, government and community organizations;
• Public input via Web based posting of the plan.

The CMS Branch partnered with the Champions for Progress project to develop an action plan to address CSHCN priority areas identified in the needs assessment. CMS is a principal in the California Champions for Progress project, an initiative funded by the Health Resources and Services Administration (HRSA); other partners are Family Voices of California, Children's Regional Integrated Service Systems (CRISS), and the Los Angeles Partnership for Special Needs Children at the University of Southern California, University Center of Excellence in Developmental Disabilities at Children's Hospital Los Angeles. The stakeholder group that had helped prioritize needs was expanded to include representatives from local education, mental health, regional center, county welfare, managed health care and foundations.

The Champions stakeholder group met 7 times over nine months in professionally facilitated work group meetings to consider strategies to assist the state to achieve the six MCHB core performance measures and meet the priorities identified in the state's needs assessment. Each stakeholder assisted in developing strategies for action, circulating draft documents within member organizations for feedback, and reaching group consensus on the final plan. CMS extracted the objectives and strategies related to the three CMS priority goals. The CCS Family Advisory Committee reviewed the document and provided feedback.

The purpose of the IP is to focus on the Branches' roles as they relate to the identified priorities. The strategies for each objective illustrate the general direction to be taken by each Branch.

/2009/ The MCAH Program is "pilot testing" a tool and process for monitoring progress in addressing the priority needs and objectives outlined in the IP.

/2010/ Lessons learned will be applied to development of 2010-2014 priority goals and objectives. //2010//

CMS Branch and its partners are organizing four regional conferences to target key stakeholders involved in improving the system of care for children and youth with special health care needs (CYSHCN) and their families. Each conference will provide skill-building information on such topics as creating and maintaining local coalitions focused on systems of care for CSHCN. //2009//

/2010/ A regional conference on building and sustaining local coalitions and partnerships was held in May 2008. Due to low participation and state and local staffing cuts, additional conferences will not be held; resources have been redirected to the 2010 needs assessment. //2010//
An attachment is included in this section.

III. State Overview

A. Overview

Demographics

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

/2009/The population of young people age 0-20 in California increased by 71,000 from 2006 to 2007. Hispanic/Latino, Asian, Pacific Islander, and American Indian youth populations combined rose 110,000, while White, Black, and Multirace youths declined 39,000. [3] Many (44%) new mothers in California were born outside the US. Of these, 66% are from Mexico, with the rest primarily from Central America and Asia. [4] A language other than English is spoken at home by 40% of Californians over age 5, and by 41% of new mothers. [5,6] California has been hard hit by the recent real estate and mortgage crises. In 2007, more than 1 in 5 of all US foreclosure filings was in California. [7] Of the 18 major US metropolitan areas that posted the largest increases in mortgage delinquency rates, 12 were in California. [8]//2009//

/2010/California's population surpassed 38 million by July 2008, largely due to new births. [73] Hispanic, Asian and Multirace populations increased their shares of the state's population, while White and Black shares declined. [74]//2010//

The population increase is the result of natural increase (the difference between births and deaths), which accounts for a little over half of the total increase, plus net migration to the state. Foreign immigration to the state (1,165,624 persons) far exceeded domestic migration (220,165) for the period 2000-05. [9]

California residents are younger on average than the nation as a whole. The median age in 2004 was 34, significantly lower than the US median age of 36. [10]

In 2003, there were almost 7.6 million women of childbearing age (15-44) in California. Women of childbearing age represent 22% of the state's population. The 10.2 million children under age 19 account for 29% of the population, including 2.5 million under the age of 5 (7%), and over 500,000 under one year (1.5%). [11] Nationally, children under 19 make up 28 percent of the population, and those under 5 make up 7 percent. [12] From 2003 to 2009, the female teen population (ages 15-19) in California is projected to increase by 14 percent, with the Hispanic teen female population up 28 percent. [13]

Although the overall teen birth rate has declined steadily since 1991 (from 71 in 1991 to less than 38 in 2004), the decline among Hispanic teens has been slower, and Hispanics are disproportionately represented in California's teen births. [14] Hispanics accounted for 71 percent of teen births in 2004 [15], while only 42 percent of the total teen population (age 15-19). [16]

The aging of the state's population is impacting the health and well-being of mothers and children. In California, 16% of all households contain at least one caregiver for someone aged 50 or older. Three quarters of those caregivers are women, and 31% have their own children living at home. This can pose a financial and emotional burden on families, particularly those who are low-income and/or have working mothers. [17] Addressing this growing stress on families is likely to become an increasing challenge in the future, as the proportion of the population over age 50 grows and the cost of living forces many households to consolidate.

Diversity

In addition to its overall population expansion, California continued to experience growth in its ethnic diversity. The fastest growing group is Hispanics. Hispanics, as a proportion of the state population, increased from 26 percent in 1990 to 32 percent in 2000. [18] By the year 2050 the percentage of Hispanics is projected to reach 54 percent, making it the majority ethnic group in the state, as well as the majority ethnic group for twenty counties. [19] In 2000, Whites comprised 47 percent of California's population, followed by Hispanics (32 percent), Asian/Pacific Islanders (12 percent), African Americans (7 percent), and American Indian/Alaska Natives (1 percent). [20]

In 2004, 27 percent (9.5 million) of California's population was foreign-born. [21] In 2002, 27 percent of the nation's immigrants (291,191) settled in California. Nearly half (49 percent) of these immigrants were born in Latin America and the Caribbean, primarily Mexico, and 39 percent were born in Asia. [22]

In California, Hispanics are younger on average than members of other racial/ethnic groups, and this age differential is increasing. The median age of Hispanics in California in 2004 was 26, eight years younger than that of the total population (34). Among Whites, the median age was 40, and for Asians, the median age was 36. [23] Hispanic children comprised the largest proportion of school children during the 2004-05 school year, making up 47 percent of students in California. [24]

Racial/ethnic diversity and a large immigrant population contribute to linguistic diversity in California. In 2004, 41 percent of California residents over the age of five spoke a language other than English at home, compared to 19 percent nationwide. Most often this language is Spanish, however, a variety of Asian and Pacific Island languages are also spoken. [25]

Geography

California is comprised of 61 LHJs, including 58 counties and three incorporated cities. These LHJs vary widely in geographic size, number of residents, and population density. In terms of geographic area, San Bernardino is the largest county, and San Francisco, San Mateo, and Marin Counties are the smallest. Los Angeles County is the largest in terms of population, with over 10 million residents, 28 percent of the state's total population. Alpine County has the smallest population, with fewer than 1,300 residents. [26]

Most of the state's population (98 percent) resides in urban areas [27]. Los Angeles, San Diego, Orange, Santa Clara, and San Francisco Counties all have large urban populations. Some counties, such as Fresno, Monterey, and Santa Barbara, are primarily rural but contain urban centers where most of the population resides.

Most counties in the state experienced population growth between 2000-04, although the rate of growth appears to be slowing. Riverside and Placer Counties grew at the highest rate, increasing by approximately 4 percent each year. [28] Other counties projected to experience large increases in population include San Joaquin, Merced, and Madera. [29]

Economy

In 2004, California's gross product ranked eighth in the world. [30] This is in spite of the fact that California has not shared completely in the economic growth the nation experienced recovering from the recent economic recession. California's unemployment rate in 2005 was 5.4 percent, compared to a national rate of 5.1 percent. The drop in unemployment in Fiscal Year (FY) 2003-04 was the first drop in unemployment since FY 1999-00. [31] The forecast through 2008 projects

California's unemployment rate will not fall or change significantly, suggesting the slow pace of economic growth in the state will continue. [32]

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

Restrictions on State programs and services compound existing challenges faced by California's residents who live near or below the federal poverty level (FPL). The US Census Bureau estimates that in 2004, 13.3% of California residents lived below the FPL. This is worse than the national rate of 13.1% and ranks California as the 20th worst state in terms of percent of residents in poverty. [33] Three counties in California's Central Valley ranked among the most impoverished in the nation: Tulare, with 20.3% of residents living below the FPL, Kern (19.3%) and Fresno (17.9%). [34]

The federal definition for low-income is household income of less than 200% of FPL; however, in parts of California, the high cost of living creates stress for families whose incomes are not necessarily low by this definition. In 2004, California had the highest median monthly rental housing costs ($914 per month) in the nation, and ranked 49th for home ownership among residents. [35] California's population growth only compounds this problem, as construction of new housing units cannot keep pace with increasing demand.

While the actual cost of housing varies between different regions in California, the problem exists throughout the state. Even in lower-cost areas, affordable housing is becoming increasingly scarce. In California's rural counties, a family would need to earn at least $10.33/hour (153 percent of minimum wage) working full-time in order to afford a Fair Market Rent apartment ($537/month for a two bedroom apartment). [36]

Homelessness is also an ongoing problem for the state. For example, in Alameda County an estimated 12,000 people are homeless on a given night, and approximately 40 percent of those are families with children. [37]

Of the 4.6 million households with one or more children under 18 in California, 22 percent are headed by a single female parent. [38] These households are more likely to struggle to support themselves with less than adequate income.

Single parenthood, low income, and high housing costs, along with welfare reform, force most women with children into the labor force. Of the almost 6.5 million women in California between the ages of 20 and 44 (as of March 2004), 70 percent worked. [39]

The proportion of women in the labor force, coupled with the number of single-parent households in California, creates an enormous need for childcare for working parents. Unfortunately, licensed childcare is available for only 26 percent of children with parents in the labor force. The cost of childcare for a preschooler typically consumes 53 percent of a parent's income if the parent is working full time at minimum wage. [40]

Hispanics and African Americans are disproportionately low income. The 2003 median household income was $36,000 for Hispanics and $40,000 for African Americans, both well below the state's median household income of $49,320. The median household income for Whites and Asians was $71,474 and $67,064 respectively. The proportion of California residents living in poverty (<100 percent FPL) shows similar racial/ethnic disparities: 22 percent for African Americans, 21 percent for Hispanics, 11 percent for Asians, and 8 percent for Whites. Fifty percent of Hispanics and 43 percent of African Americans were classified as low income (<200 percent FPL). [41]

Hispanic students comprise the largest and fastest growing racial/ethnic group in California schools. Of the student population, 49 percent receive subsidized school lunches. Over one quarter are classified as English learners; most of these English learners' first language is Spanish. [42]

/2009/ The outlook for the California economy is for little growth in 2008 followed by slow growth in 2009 and moderate growth in 2010. [43] Due to the slower rates of economic growth, decreasing state revenues and increased costs the estimated budget deficit for California is over $14 billion. In response to the State deficit, the 2008-2009 Governor's budget proposes 10 percent across-the-board State General Fund reductions resulting in a greater than dollar for dollar impact for local health jurisdiction as less monies will be available to obtain matched program funds. //2009//

Access to Health Care

In California, 18 percent of the population did not have health insurance in 2002, compared to 15 percent of the US population. Among California's Hispanic population, 31 percent were uninsured. Among California children under the age of 18, 14 percent were uninsured. Among California children, 28 percent were covered by Medicaid or Healthy Families, compared to 25 percent for the US. [44] Among the poor and low-income population in California, children were more likely to be covered by public programs than adults. Increasing the enrollment in public insurance programs, especially among immigrants and non-English speaking populations, remains a challenge for the state.

Another challenge is meeting the health care needs of the large number of undocumented immigrants, many of whom are migrant workers. While the number of undocumented immigrants in California is difficult to measure, a recent study suggested that 2.4 million undocumented immigrants were in California in 2002, over a quarter of the nation's estimated 9.3 million. Forty percent of these undocumented immigrants are women. [45] In one sample of undocumented immigrants in Fresno and Los Angeles Counties, half were between the ages of 18 and 34, and one quarter were children under 18. [46]

It is not surprising that, given the complicated nature of eligibility for public assistance coupled with fear of the consequences of having to reveal one's status as undocumented, access and participation in available services among the undocumented population is very low. Still, the most common reason given by undocumented immigrants for not seeking health care was that it was too expensive. [47] Other complications arise for undocumented immigrants who seek services in one county and move on to another region for work. Frequent moving for employment makes it difficult to provide consistent and comprehensive services and to track services for this population.

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

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

/2010/The unemployment rate jumped to 10.6% in January 2009--the highest since 1983--and threatens to restrict access to employer-based insurance, the usual source of health coverage for most families. [75] Decreased state revenues will affect California's ability to sustain existing state health programs, even prior to the anticipated increase in need.

Another concern is the shrinking network of care for children, even as the population grows. Many hospitals have shifted resources toward adults, for whom they receive higher state and federal subsidies, or shut down altogether. [76] In 2007, 28.2% (140/496) of hospitals had pediatric beds, down from 34.7% (202/582) in 1998. [77] In all, about 740 inpatient pediatric beds were lost from 1998 to 2007. In late 2008, voters approved $980 million in bonds for construction and expansion of children's hospitals.//2010//

Major State Initiatives

/2010/

For more detailed information about California's Major State Initiatives, please see the attachment to this section.

>Safe Motherhood

MCAH funds and collaborates with the California Maternal Quality Care Collaborative (CMQCC) to address maternal morbidity by measuring maternal quality of care and identifying hospital-level outcomes for maternal/neonatal infections and postpartum hemorrhage. CMQCC convened a Hemorrhage Task Force to create and disseminate protocols and guidelines for earlier detection of hemorrhage and a rapid response team approach to intervention. Task forces on other maternal care and morbidity topics are being established, including 3rd & 4th degree lacerations, labor induction, and post-partum depression.

The CMQCC Executive Committee meets quarterly. Most recently, invited experts worked with the Committee to identify strategies to address the alarming data on racial disparities in California's maternal mortality rates. The CMQCC's Data arm is exploring rising rates of cesarean section, the Program arm is about to release the Obstetrical Hemorrhage Toolkit, and the Policy arm is planning a legislative briefing in June 2009.

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

The Maternal Quality Improvement (MQI) work group is conducting morbidity analysis on OSHPD 1999, 2002, and 2005 data, as this is when maternal deaths spiked. Data will be stratified by county and hospital, looking at rates of cesarean delivery, peripartum hysterectomy, and complications such as chorioamnionitis, gestational diabetes, preeclampsia and premature labor.

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

In July 2007 MCAH and CMQCC began work to implement the Local Assistance Maternal Health Project (LAMH). The LAMH project focuses on the Local Health Jurisdictions' (LHJs) role and activities to improve pregnancy and birth outcomes. Four pilot LAMH projects have been funded to address quality improvement in maternal health care; 1) reducing fragmentation in maternal care by promoting patient carried prenatal records; 2) improving measuring and recording of obstetrical hemorrhage using standardized methods;3) improving baseline health of women by increasing enrollment in interconception care programs; and 4) reducing non-medically indicated rates of labor induction.

MCAH also developed the first statewide Pregnancy-Associated Mortality Review (PAMR) Project in partnership with UCSF and the Public Health Institute (PHI). The goal is to examine the medical and psychosocial morbidities and events leading to death for women who died from pregnancy-related causes or within one year of pregnancy (pregnancy-associated deaths) so MCAH and its stakeholders can develop a public health component to reduce such morbidities and deaths. The PAMR Advisory Committee, administered by CMQCC, reviewed 60 cases selected for the first year's (2002) cohort and 50 cases from the 2003 cohort. African American women were over-sampled to address the disparity in maternal mortality and morbidity.

The sample cases from both the 2002 maternal death cohort (194 deaths; 20% pregnancy-related) and the 2003 cohort (192 deaths; 26% pregnancy-related) have been abstracted and reviewed by the committee. Numerous opportunities for quality improvement were identified in the course of the reviews, including the need for improved pre-conception care, exploring a regionalized approach to risk-appropriate levels of maternal care, and continued monitoring of cesarean section and non-medically indicated labor induction as contributing factors to mortality. The report of findings and recommendations from the first Pregnancy Associated Mortality Review is expected to be complete in late 2009.

PHI is currently abstracting the 2004 (171 deaths; 29% pregnancy related) and 2005 (251 deaths; 27% pregnancy related) cohorts for review over the next two years. The Committee was expanded to include specialists in emergency medicine/critical care and anesthesiology. A process evaluation meeting in December 2008 identified minor methodologic issues in the pilot period, which will be addressed this year.

>Preconception Health

MCAH is collaborating with various stakeholders to improve preconception health in California. A key strategy is the promotion of preconception health and healthcare initiatives by integrating messages and activities into patient education within existing Title V programs in primary care, family planning, and pregnancy care settings. Local MCAH jurisdictions have undertaken preconception care activities, including the Los Angeles Collaborative, which is monitoring the success of various preconception care models.

The Preconception Care Council of California (PCCC) was established to provide direction for the integration of preconception health in public health practice, the development of policy strategies to support preconception health care, and the promotion of preconception health messages to women of reproductive age. The PCCC formed three workgroups that have developed action plans: Research/Clinical Practice; Finance/Public Policy; and Public Health/Consumer. Workgroup members collaborate with local partners to implement these plans, which have been combined into a set of comprehensive recommendations that inform the preconception activities outlined in the State MCAH Division's Title V Implementation Plan.

PCCC partnered with the Centers for Disease Control and Prevention (CDC) to host the

2nd National Summit on Preconception Health and Health Care in October 2007, with numerous public and private partners represented. Best practices to implement the CDC's recommendations on preconception care were presented. MCAH prepared and distributed a publication detailing the state of preconception health in California.

In 2008, the PCCC changed its name to the Preconception Health Council of California (PHCC) to reflect a focus on not only clinical interventions but also health education and promotion efforts and community-based health improvement strategies. The workgroups remain active. Current activities include:

- Development of clinical guidelines to optimize the post partum visit as a first step in providing interconception care, especially for women who have had a poor pregnancy outcome.
- Launch of a comprehensive preconception health website (www.everywomancalifornia.org) for the state in Spring 2009, with low literacy fact sheets for consumers, and provider resources such as toolkits, best practice models and website links.
- With MCAH, a full-day training for LHJ MCAH Directors on preconception health.
- Ongoing education of the California Legislature about preconception health, and advocacy for inclusion of preconception health in state and federal health care reform proposals.

Past production and dissemination of a patient/provider resource packet laid the groundwork for further efforts to promote preconception health in California and for the MCAH Preconception Health and Healthcare Initiative (PHHI). In lieu of updating the packet, MCAH has collaborated with the PHCC to integrate the resource information into the new comprehensive preconception health website mentioned above. MCAH has undertaken other state level activities:

- In response to California data showing decreased folic acid consumption among Latina women, MCAH sponsored a multi-pronged folic acid awareness campaign targeting Latinas of reproductive age in Spring 2009. This campaign included radio PSAs, mini-dramas and talk shows; revised folic acid brochures and posters; development of a training curriculum for health promoters; a small-scale vitamin distribution campaign at selected WIC centers and family planning clinics; and provider education that folic acid is a covered benefit under Medi-Cal.
- The 2006 CityMatCH, AMCHP, CDC Healthy Women's Weight Action Learning Collaboratives in Los Angeles and Sonoma counties were co-facilitated by an MCAH nutritionist. Accomplishments of the Healthy Women's Weight Collaboratives were featured in a report entitled "Promoting a Healthy Weight in Women of Reproductive Age: Experiences & Lessons Learned from Eight State/Local Health Department Teams" published by AMCHP and CityMatCH. Achievements include development of new materials, promotion of worksite wellness programs, teen cooking classes and integration of healthy weight messaging into promotores de salud training curricula.
- Collaboration with the California Family Health Council (CFHC) to develop reproductive life planning tools for consumers and providers, which will be integrated into services at Title X family planning clinics.

Local preconception health promotion activities with potential for replication include:

- LA County Preconception Health Collaborative produced a curriculum for public health providers called the "ABCDEs to Envisioning a Healthy Future." About 100 nurses, physicians and health educators were trained in the curriculum. Collaborative members are involved in other projects, such as integration of preconception and interconception health messages into Family Planning clinics; development of a reproductive life planning toolkit for providers and patients; and interconception care coordination for WIC clients

with previous poor pregnancy outcomes.
- Contra Costa County Health Services' Family, Maternal and Child Health Programs launched a 15-year Life Course Initiative (LCI) in 2005. In 2008, Building Economic Security Today (BEST) was launched as a new component of the LCI. BEST promotes financial security and stability as protective factors that may help achieve health equity and improve birth outcomes.

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

The California Birth Defects Monitoring Program (CBDMP) was established in 1982 to conduct research and surveillance of birth defects and maintain a birth defect registry. CBDMP was moved to CDPH in July 2007. Legislation passed in September 2006 expanded the program's capacity to discover causes, develop prevention strategies, and increase surveillance of birth defects and genetic diseases throughout the state. CBDMP collaborates with the Genetic Disease Screening Program (GDSP) to maintain the Pregnancy Blood Bank, which stores blood samples from GDSP's Prenatal Screening Program.

A prenatal screening fee increase implemented in 2007 enabled CBDMP to collect, process, and store more blood samples than previously, and expand the birth defect registry. These improvements will increase research opportunities and provide more representative statistics on birth defects in the state. The increased fee also supported modernization and expansion of GDSP's Prenatal Screening Program to expand to a quadruple maternal serum marker test, which will improve the early diagnosis and management of genetic and congenital disorders. First trimester testing began in March 2009.

CBDMP links birth defects registry data with the pregnancy blood sample inventory, as well as with other vital statistics databases. CBDMP is planning to reestablish a link to GDSP's Test Request Form (TRF) database of prenatal genetic screening results. This will provide scientists the opportunity to test hypotheses about genetic and environmental causes of many children's and women's diseases. CBDMP is also analyzing its pregnancy blood collection demographics, and may change the counties assigned for blood collection.

MCAH worked collaboratively with GDSP to add educational information to GDSP's prenatal screening booklet regarding women's options for public and private umbilical cord blood banking. In July 2009, MCAH applied for Health Resources and Services Administration funding to develop umbilical cord blood banking education materials for prenatal care providers and the public.

>Teen Birth Rate Resource Project (TBRR)

MCAH and OFP collaborated with UCSF and the Office of Statewide Health Planning and Development (OSHPD) to develop comprehensive maps of teen birth rates using geographic information system tools. "Teen Births in California: A Resource for Planning and Policy" was released in May 2009, identifying geographic locations in California with higher or lower teen birth rates. Maps and tables--including breakdowns by race/ethnicity, comparisons at the Medical Service Study Area (MSSA) level, and change over time--will assist organizations to better target interventions to locations with greater need.

>Neonatal Quality Improvement Initiative

CMS and California Children's Hospital Association (CCHA) sponsored a statewide Quality

Improvement Collaborative (CCHA-CCS QI), partnering with CPQCC, to decrease catheter associated blood stream infections (CABSIs) in neonatal intensive care units (NICUs) using the Institute for Healthcare Improvement (IHI) model for quality improvement (QI). Neonatologists, nurses, infection control staff, and administrators from 13 Regional NICUs participated in 2006-07, collectively reducing CABSIs by 25 percent for all weight groups. In the second year, all 22 Regional NICUs participated, aided by a Blue Shield Foundation grant.

The CABSI rate in 2008 was 2.33 per 1000 line days and 3.22 in 2007, but some of this reduction was due to a CDC definitional change for CABSIs beginning Jan. 1, 2008. Data from 2008 cannot easily be compared to 2007. The NICUs learned the importance of doing a root cause analysis for each infection and auditing for compliance to the QI change bundles. The culture of community among the 22 NICUs has developed beyond expectation; collaboration fostered collegiality, practice exchange, and a belief in CABSI reduction and elimination. The Collaborative is exploring funding options for July through December 2010.

>Pediatric Critical Care

CMS has structured a system of 19 California Children's Services (CCS)-approved pediatric intensive care units (PICUs) to assure that infants, children, and adolescents have access to appropriate quality specialty consultation and intensive care services throughout the state. CCS sets standards for all CCS-approved PICUs and conducts site visits to ensure standards are followed, including submission of annual morbidity and mortality data to CCS.

CMS and the University of California, Davis (UCD) are developing an infrastructure for Pediatric Critical Care quality improvement. This project will assess the need for statewide benchmarking standards to direct QI efforts and develop a methodology and reporting tool to analyze PICU QI. Database design and data collection will be addressed. Due to staffing shortages and budget cuts, this project is on hold.

>Pediatric Palliative Care

CMS submitted a palliative care waiver to the Federal Centers for Medicare and Medicaid Services, which was approved January 2009. Over 65 stakeholders participated in development of the waiver concept, which will promote a comprehensive Pediatric Palliative Care demonstration program for selected children enrolled in CCS with life limiting or life threatening conditions.

The stakeholders identified eligibility criteria, the benefit package and the support system for service delivery. The waiver is designed to provide a range of services to improve the quality of life for the child and family, including care coordination and additional support services; respite care; bereavement counseling for caregivers; art, music and play therapy; and family training. The three year pilot program will initiallly be implemented with 300 participants in five counties (Alameda, Monterey, Santa Cruz, Santa Clara, and San Diego), expanding to 1,800 participants in 13 counties in the third year.

>Mental Health

MCAH is working to address the mental health needs of infants, children, adolescents, and mothers. California's Proposition 63 Mental Health Services Act (MHSA) provides funding for the expansion of mental health services for adults and children. MCAH staff participate in the MHSA stakeholder group. Many MCAH programs include a mental health component, including the Adolescent Family Life Program (AFLP), the Black Infant Health (BIH) Program, the California Diabetes and Pregnancy Program (CDAPP) and the

Comprehensive Perinatal Services Program (CPSP). All include assessment and referral, and some include counseling and treatment.

MCAH participates in statewide efforts to implement coordinated mental health services. The California Early Childhood Comprehensive Systems (CA ECCS) project provides state-level leadership for programs that help prepare children for kindergarten. CA ECCS staff participate in several early mental health efforts and activities, including: 1) the First 5 Association's initiative to support early childhood mental health; 2) grant writing teams to obtain funds for training child care education staff on social-emotional learning and autism; 3) the Child Welfare Early Education Work group; and 4) the Infant/Toddler Mental Health Work Group.

The Assuring Better Child Health and Development (ABCD) Screening Academy is building on lessons learned through its predecessor, Behavioral, Emotional, and Social Screening and Treatment for Primary Care Providers (BEST-PCP). Policy activities focus on recommending the use of standardized screening tools within the revised Child Health Disability Program (CHDP) Health Assessment Guidelines. Although the ABCD Screening Academy project ended in July 2008, work to standardize the use of validated screening tools for young children continues through the Statewide Screening Collaborative. Multiple key partners are working to leverage resources, staff and policies once a child is identified with a developmental or mental delay or disability.

In June 2007, the Maternal and Child Health (MCH) Program of the UC Berkeley School of Public Health, in collaboration with MCAH, the California March of Dimes and the California Department of Mental Health, received a grant from HRSA to provide continuing education activities to MCH professionals in the area of maternal mental health over a three-year period. A planning workgroup of major stakeholders and partners was established to determine the goals and objectives of the continuing education activities for MCH professionals.

The first Bright Beginnings Conference was held in November 2008 in Berkeley, with over 100 participants. Objectives included examining women's current experiences in dealing with mental health issues during pregnancy and postpartum; and ways to address barriers and implement promising practices. Participants learned about: (1) the impact of mental disorders on maternal health and pregnancy outcomes; (2) current practices for screening, assessment, referral and treatment of mental health issues during pregnancy and postpartum; (3) innovative models that integrate mental health and primary care services, and ways to adapt these models to fit available resources; (4) successful approaches to addressing mental health treatment barriers for women during pregnancy and postpartum; and (5) procurement and blending of funds from the Mental Health Services Act and other sources to address prevention and primary care collaboration at the local level. Planning is ongoing for the second continuing education conference, to be held in November 2009 in Los Angeles.

>Human Stem Cell Research and Women's Reproductive Health

California is leading the nation in supporting the advancement of human stem cell research (HSCR) that may lead to treatments and cures for childhood and adult diseases. MCAH created the HSCR Unit, now the HSCR Program, to fulfill legislative mandates through the development of statewide research guidelines, protections for women donating oocytes for research, requirements for HSCR review and approval, and state HSCR reporting requirements.

MCAH first convened the HSCR Advisory Committee in 2006, and continues to utilize the expertise of this group. In June 2007, CDPH approved the statewide guidelines for human stem cell research submitted by the Advisory Committee. The HSCR Program and the

Committee incorporated extensive stakeholder input in the guidelines development process, and consulted with the California Institute for Regenerative Medicine to promote consistency between its stem cell regulations and those of CDPH. The statewide guidelines were revised once in 2008 to address emerging issues in HSCR, and the Committee is deliberating additional revisions.

After extensive Advisory Committee review and several public comment periods, the HSCR Program finalized reporting forms for research involving human embryonic stem cells and human oocyte retrieval in spring 2008 and distributed these to research institutions and scientific review committees. In the first round of data submission, covering January 2007 through June 2008, the HSCR Program collected reports from 15 different Stem Cell Research Oversight Committees covering a total of 244 human embryonic stem cell research projects. The HSCR Program analyzed these data and developed the first biennial HSCR legislative review report, submitted to the California Legislature in late Spring 2009.

>Preventing Childhood Obesity

California is experiencing the health related consequences of a high prevalence of obesity. CDPH has developed a statewide obesity prevention plan to address this epidemic through a public education campaign, local assistance grants, and multi-sectoral policy strategies that promote healthy eating and active living. In addition, the Governor has joined the Alliance for a Healthier Generation, which seeks to prevent childhood obesity by working with schools, the food industry, and healthcare professionals. In late 2008, California was the first state in the nation to require major restaurant chains to post calorie information on menus and indoor menu boards. This will make it easier for consumers to make more informed, healthier food choices. Earlier in 2008, California became the first state to ban trans-fats from restaurants and locally-baked products.

The Pediatric Nutrition Surveillance System (PedNSS) surveyed 1.5 million California low-income children in 2007. California has the second highest PedNSS obesity prevalence rate for ages 2-5. Data show overweight prevalence rates for children 2-5 years (16.2% overweight, 17.4% obese) and children 5-20 years (18.4% overweight, 23.1% obese) are unchanged from recent years. CHDP programs measure their county performance on PedNSS data and develop nutrition and physical activity projects to improve outcomes.

MCAH and the CMS Branch are actively planning the 2009 Childhood Obesity Conference, "Creating Healthy Environments For All Children," scheduled for June 9-12 in Anaheim, California. MCAH and CMS will moderate conference sessions and present posters. CMS is instrumental in planning the health care track and MCAH the research track. The conference will promote collaboration, showcase evidence-based prevention interventions, accelerate the obesity prevention movement, and feature community efforts.

MCAH and CMS have representatives on the CDPH Obesity Prevention Group, which coordinates obesity policy and program efforts and provides obesity prevention concepts to the Governor's Office.

The California Physical Activity, Nutrition, and Obesity Prevention Collaborative consists of multiple efforts within CDPH working toward the common goals of increasing physical activity, improving nutrition, and preventing obesity among all Californians. The CDPH Coordinating Office for Obesity Prevention (CO-OP) ensures department-wide coordination on obesity prevention efforts; serves as a single point of contact for organizations looking to partner with CDPH on obesity prevention; and enhances the capacity of CDPH partners to address and prevent obesity in their own work. In Fall 2008 a CDC-funded "Connector Team" was hired within the Epidemiology and Prevention for Injury Control Branch (EPIC) to promote linkages between projects. MCAH and CMS

participate in an advisory capacity in efforts to obtain stakeholder input and develop a Strategic Plan for leveraging resources and coordinating statewide efforts involving multiple partners. Target areas include: 1) increased physical activity; 2) increased consumption of fruits and vegetables; 3) decreased consumption of sugar sweetened beverages; 4) increased breastfeeding initiation, duration and exclusivity; 5) reduced consumption of energy dense foods; and 6) decreased television viewing.

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

In November 2008, MCAH began the "Here is Where Healthy Starts" campaign, which offers a "Certificate of Excellence" to LHJs implementing a comprehensive worksite wellness initiative, including nutrition, physical activity, injury prevention, and breastfeeding promotion. The certificate program was modeled after a healthy hospital award program coordinated by MCAH in response to the Governor's obesity summit.

CHDP collaborated with Kaiser Permanente on a poster with evidence-based messages regarding childhood obesity for local CHDP programs, CHDP providers and health plans.

>Breastfeeding

MCAH has initiated Birth and Beyond California (BBC), a quality improvement project that works through three Regional Perinatal Programs to provide training, technical assistance and resources to hospitals with low in-hospital exclusive breastfeeding rates. The 3 selected RPPC regions, which are in the lowest quartile of exclusive breastfeeding according to 2006 breastfeeding initiation data, account for over half the births in the state.

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

In addition to the three regions noted above, MCAH assisted a group of six hospitals in San Joaquin County to attend trainings in RPPC Region 6 (Los Angeles), patterned on BBC materials.

The creation of "Networks" in each of the RPPC Regions has shown the value of this project in modeling collaborative relationships among agencies that normally do not share information, tools and methods. All hospitals have needed assistance developing these QI programs, as maternity services are usually not included in hospital QI projects. Hospitals have found they need to include their QI staff in the Interdisciplinary Teams created to implement Breastfeeding Policies.

In addition to these efforts, CCS is partnering with CPQCC in 2009 to improve breastmilk nutrition for NICU infants in CA. This collaborative will also utilize the IHI model for quality

improvement.

>Comprehensive Black Infant Health (BIH) Program Assessment

"The Black Infant Health Program: Comprehensive Assessment Report and Recommendations" was completed by UCSF and distributed to California BIH and MCAH programs in April 2008. The report recommended the development and implementation of a single core model for all 17 local BIH program sites to enhance its impact on Black maternal and infant health.

To develop the core model, MCAH convened the BIH Program Development Workgroup, consisting of representatives from state MCAH, the UCSF Center for Social Disparities in Health, and local BIH and MCAH programs. The workgroup has developed a new conceptual framework for BIH that integrates current scientific findings and state and national best practices. The revised model was presented at the Statewide BIH Meeting and approved by local health officers, MCAH Directors, BIH Coordinators and staff. Utilizing experts from local BIH programs, the workgroup is in the process of finalizing the model.

>High-risk Infants

The CCS Program has structured regional affiliation among the 118 CCS-approved NICUs to assure access to appropriate quality specialty consultation and intensive care services. NICUs are designated as Intermediate, Community, or Regional and are required to comply with CCS standards, including the submission and report review of annual morbidity/mortality data. All CCS-approved NICUs submit annual data through CPQCC.

Each CCS-approved NICU facility is required to have an organized High-Risk Infant Follow-Up (HRIF) program or a written agreement for these services by another NICU. HRIF programs began collecting and submitting data to CMS in July 2006. Through the CCS/CPQCC HRIF Quality of Care Initiative (QCI), CMS worked with CPQCC, HRIF Coordinators, neonatologists, and developmental specialists to develop a web-based HRIF reporting system to collect HRIF data. The system, which began April 1, 2009, will (1) help identify quality improvement opportunities for NICUs in the reduction of long term morbidity; (2) allow programs to compare their activities with all sites statewide; (3) enhance program consistency and efficiency; (4) allow the state to assess site-specific successes; and (5) support real-time case management. Most programs have received training on the reporting system, and a webcast will be available.

>Improving Quality of Vital Statistics Data

MCAH promoted changes to birth, death, and fetal death certificates to increase the quality of vital statistics data collected by the state. In a complementary action, the RPPC Coordinators teamed up with the Office of Vital Records (OVR) to provide local trainings of birth certificate clerks to improve birth certificate data collection methods, resulting in significant improvements in data completeness and quality. In collaboration with OVR, 8 birth clerk workshops were held throughout the state in 2008, focused on reducing the number of missing data items and sharing best practices.

MCAH is collaborating with OVR and RPPC to provide 7 additional Birth Clerk Trainings from April through October 2009. In addition to focusing on missing data, the RPPC will provide simple explanations for technical medical terms not reported or under reported. Examples will be provided to demonstrate the extensive use of vital statistics data. Training will cover where to obtain information from medical records, as well as strategies for gathering data from mothers who are reluctant to provide information. Birth clerks will receive copies of recently developed information sheets from CBDMP, and will learn to

use gestational wheels supplied by March of Dimes to assist them in correctly determining the date of last menstrual period for birth certificates.

Additionally, MCAH is working with OVR to determine whether MCAH's Sudden Infant Death Syndrome (SIDS) and FIMR data collection can be incorporated into the OVR electronic death registry system.

>Newborn Hearing Screening Program (NHSP) Expansion

Legislation expanding the NHSP to all general acute care hospitals with licensed perinatal services was effective January 1, 2008. Prior to expansion, the program was operational in 175 hospitals that deliver over 411,000 infants per year. The expansion adds 95 more hospitals and results in an additional 130,000 infants receiving hearing screening each year. A total of 1000 infants with hearing loss should be identified each year after full implementation.

The NHSP has numerous infrastructure building blocks in place to support expansion of the program. Each Hearing Coordination Center (HCC) is responsible for a specified geographic service area to assure compliance with standards; tracking and monitoring of infants who need outpatient follow-up; and linkage of families of children identified with hearing loss to early intervention, medical, and support services.

Three HCCs were selected to perform the expansion. As of December 2008, 224 hospitals were certified to participate in the NHSP. All hospitals with licensed perinatal services will be certified during 2009. In June 2008, the program selected Neometrics, a division of Natus Inc., to provide a data management service to the NHSP. Due to the fiscal crisis, it is anticipated that the delayed contract will begin July 1, 2009 with statewide implementation completed by June 30, 2010.

>Child Health Insurance Coverage

DHCS has been working to improve the health of the Title V population through expanded health insurance coverage. Efforts to increase enrollment the state-sponsored children's health care programs, including Medi-Cal and Healthy Families (HF), appear to be reducing the percentage of uninsured children.

From July 2003 through December 2008, over 3.9 million children receiving CHDP assessments were pre-enrolled for up to two months of no cost, full-scope Medi-Cal benefits.

In December 2008, First 5 California provided emergency funding to the Healthy Families Program to continue to enroll infants and children, ensuring them access to much needed health care services. As of May 2009, however, the Governor has proposed elimination of the HF program as one strategy to deal with the state's massive budget deficit.

>Oral Health Promotion

MCAH has collaborated with numerous partners to conduct dental screenings in elementary schools in order to assess the oral health status of children in California. MCAH is currently collaborating with other state and advocacy groups to educate medical/dental providers about the importance of proper oral health care before and during pregnancy. A Perinatal Oral Health Consensus Conference with an expert panel was held in February 2009, and the conference advisory committee members and the technical writer are creating a set of oral health clinical guidelines for medical and dental providers caring for pregnant women and their children. These guidelines will be distributed in late 2009. MCAH participates on the advisory committee.

CHDP program providers are encouraged to provide fluoride varnish in children ages 0-6, and to provide dental referrals beginning at age one. A CHDP provider handbook to promote establishment of a dental home early in the child's life is under development. In 2007-08, 1,683,900 children received dental screenings through the CHDP program.

CDPH contracts with UCSF to oversee the Office of Oral Health's California Children's Dental Disease Prevention Program (CCDDPP), which operates 33 school-based programs in 31 counties. CCDDPP serves approximately 300,000 California preschool and elementary school children annually, providing fluoride rinses, oral home care instruction, and dental sealants.

>Eliminating Racial and Ethnic Disparities in Health

Racial and ethnic disparities persist in infant mortality, neonatal mortality, preterm delivery, low birthweight and maternal mortality in California. Disparities in morbidities and risk factors also exist, such as in-hospital exclusive breastfeeding, untreated tooth decay and folic acid consumption.

Increasing the quality and years of healthy life, reducing disparities and promoting health equity is one of the goals identified in the CDPH Strategic Plan. MCAH is taking the lead on the proposed objective for reducing infant mortality by developing an action plan to directly address the persistent disparity between African American and White infant mortality rates. Cultural competency is a cornerstone of every MCAH program.

One program central in efforts to eliminate these racial health disparities is the Black Infant Health (BIH) program. BIH program sites provide women, their families and the community with services addressing factors that negatively impact birth outcomes. Current efforts to develop an updated, evidence-based BIH model have the potential to inform programs nationwide that serve this population.

In February 2009, the California Maternal Quality Care Collaborative hosted a special discussion at its Executive Committee meeting on pregnancy-related deaths among African-American women in California, as the 2004-06 maternal mortality rate (46.7 deaths per 100,000 live births) is nearly 4 times higher than rates for Whites or Hispanics (12.2 and 11.9 per 100,000 live births, respectively). Invited presenters include Paula Braveman, MD, MPH, Professor of Family & Community Medicine and Director, Center on Social Disparities in Health, UCSF; Michael C. Lu, MD, MPH, Associate Professor, Department of Obstetrics & Gynecology, David Geffen School of Medicine Department of Community Health Sciences, School of Public Health, UCLA; Amani Nuru-Jeter, PhD, MPH, Assistant Professor, UC Berkeley School of Public Health; and Paul Wise, MD, MPH, Professor of Child Health and Society, Stanford University. This discussion generated considerable interest and engagement among Executive Committee members to develop strategies for further action.

MCAH analyses routinely include racial/ethnic subgroups to monitor trends and inform program activities. After analysis of California data showed decreased folic acid consumption among Latina women, MCAH sponsored a multi-pronged folic acid awareness campaign targeting Latinas of reproductive age in Spring 2009. This included radio PSAs, mini-dramas and talk shows; brochures and posters; a training curriculum for health promoters; a small-scale vitamin distribution campaign; and provider education on Medi-Cal folic acid coverage.

>Adolescent Health Promotion

The California Initiative to Improve Adolescent Health is based on the National Initiative to

Improve Adolescent Health by the Year 2010. In response to the interest among county MCAH Directors and local agencies, MCAH contracted with the National Adolescent Health Information Center (NAHIC) at UCSF to produce the Guide to Adolescent Health Data Sources to assist those interested in adolescent health to better assess the needs of youth in their community. MCAH has again contracted through UCSF/NAHIC to have the California Adolescent Health Collaborative (CAHC): 1) provide information, resources and expertise to support the provision of quality health care services to adolescents; 2) increase the capacity of local MCAH jurisdictions and adolescent health practitioners to promote adolescent health; and 3) influence policy to improve adolescent health.

The California Adolescent Sexual Health Workgroup (ASHWG) is a standing workgroup committed to effectively addressing the sexual and reproductive health of adolescents. MCAH continues to have an active role on the ASHWG Steering Committee and in the workgroup's two major activities:1) creation of online, standardized, and annually updated data sets for HIV, STD, and teen births statewide and for high-priority LHJs; and 2) finalization of the 2008 edition of the Core Competencies through a process involving California experts from various disciplines; a Web-based survey of teachers and practitioners; and a panel of national experts. ASHWG is disseminating the Core Competencies for Adolescent Sexual and Reproductive Health through the MCAH and CAHC websites. The workgroup is also considering developing a curriculum, as well as a user's guide and tools for applying the core competencies.

The CAHC is actively providing support to ASHWG priority activities and is hosting the standardized statewide integrated data tables. CAHC just completed a review of adolescent health indicators to develop a statewide profile of hot and cold spots for adolescent health. CAHC will conduct qualitative assessments of services and youth support in these communities in order to correlate these with adolescent health indicators, and will develop a tool for LHJs to use in assessing local community elements that support positive youth outcomes.

>Fetal Alcohol Spectrum Disorder (FASD) and Perinatal Substance Use

MCAH and LHJs are active in numerous FASD prevention and intervention efforts throughout the state. MCAH is part of the statewide FASD Task Force, which held a Strategic Planning meeting in March 2009 to review its objectives and strategies, re-examine its focus, and identify action steps for completing its objectives.

Dr. Ira Chasnoff's report on perinatal substance use screening in California was released in October 2008 and is available on MCAH's website. As of early 2009, 22 LHJs are using the 4P's Plus screening tool to identify pregnant women at risk for alcohol and illicit drugs.

The State Epidemiologic Outcomes Workgroup (SEOW) was created to develop a system for assessing the prevalence and consequences of substance use statewide. MCAH provided data to assess the prevalence and effects of substance use during pregnancy, among women of reproductive age, and among children under age 18. The system will provide county jurisdictions with local data and analytic capacity to use these data for prevention planning, design and evaluation.

Based on the California Women's Health Survey (CWHS) and the Maternal and Infant Health Assessment (MIHA) Survey, MCAH staff compiled data on alcohol consumption among women 18-44 years of age, and alcohol consumption during pregnancy among women 15-44 years. In September 2007, these data were presented at the 36th Semi-Annual Substance Abuse Research Consortium Meeting.

MCAH also participates in the Alcohol and Other Drug (AOD) Workgroup of the State Interagency Team (SIT), which aims to identify interagency and systems-related

opportunities to improve identification and treatment of families and children impacted by alcohol or drugs. The workgroup recently assessed and prioritized ways to strengthen services to children and families where there is a nexus between AOD and child safety, education, workforce readiness/success, maternal and child health, and mental health, and reconvened in April 2009 to begin examining ways to lower the incidence of FASD in California.

> Impact of California budget deficit

In February, the Governor signed a 2009-10 budget with dramatic spending cuts--primarily in health, social services, education and corrections--to address California's projected $41.6 billion deficit, the largest budget gap in the state's history. Over the past several months, the deepening recession has added billions more to the projected deficit. Revised budgets proposed in May 2009 include deep cuts that would impact the state's most vulnerable populations, including pregnant women and children. While likely that not all the Governor's currently proposed cuts will be implemented, it is clear the safety net will be compromised to some extent. MCAH grants to local health jurisdictions (LHJs)--crucial pieces of the statewide MCAH system--would be reduced by $10 million under the initial proposal, fifty percent of the State General Funds in local program budgets. A proposal to cut the remaining $10.3 million in General Funds for MCAH would further weaken infrastructure at the statewide level, resulting in reduction or elimination of key programs such as the Adolescent Family Life Program (AFLP), Black Infant Health (BIH), Comprehensive Perinatal Services Program (CPSP), California Birth Defects Monitoring Program (CBDMP), and the Human Stem Cell Research (HSCR) Program, as well as cuts to State operations including training, travel and staff support, and the potential elimination or reduction of contractual services or agreements.

Access to basic medical and dental care services would also be severely compromised under the Governor's proposed changes. While eligibility restrictions for the Healthy Families program (California's SCHIP) would cut healthcare coverage for approximately 225,000 children, elimination of the entire Healthy Families program--and coverage for over 940,000 children--is now being considered. The dental disease prevention program serving low-income schools would be suspended, and some funds would be diverted away from programs including the Access for Infants and Mothers program. Rate cuts for family planning could impact access to reproductive health and contraceptive services.

Other wide-ranging cuts would certainly be felt by MCAH populations as well. The California Work Opportunity and Responsibility to Kids (CalWORKS) Program--which provides temporary financial assistance and employment services to low-income families with minor children--is slated for elimination, as is funding for ninety-four domestic violence shelters throughout the State of California that provide emergency shelter, transitional housing, and supportive services. Cuts to Medi-Cal, substance abuse treatment, HIV education and prevention, regional centers for physical and developmental disabilities, and child welfare services have also been identified.

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

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

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

> Impact of federal Title V reductions on California programs

Due to reductions in California's Title V funding in recent years, MCAH programs and LHJs were already operating leanly prior to the current fiscal crisis. Title V funding cuts in FY 2006-07 eliminated efforts such as the Adolescent Sibling Pregnancy Prevention Program, technical assistance to LHJs for adolescent health improvement, and training for AFLP case managers, and led to significant funding reductions for AFLP; the Childhood Injury Prevention Program; the Oral Health Program; MCAH program development; and technical assistance to LHJs. A $1.5 million reduction in Title V funding in 2008 further impacted LHJ ability to continue work in preconception care, obesity prevention, childhood injury prevention, breastfeeding, and oral health. LHJs are still feeling the impact of these past cuts, which have decimated local MCAH leadership capacity for linking programs, leveraging resources and applying science to concerns such as rising unintended pregnancy rates, resurging teen sibling pregnancies, and childhood obesity.

Although spared further Title V funding cuts in 2009, flat funding does not allow the MCAH system to recover from past cuts or keep pace with the rising needs of a growing and increasingly diverse MCAH population.//2010//
An attachment is included in this section.

B. Agency Capacity

Programs affiliated with the MCAH Division and the CMS Branch include:

Adolescent Family Life Program (AFLP)
AFLP Management Information System
Adolescent Health Program
Advanced Practice Nursing Program (APN)
Battered Women's Shelter Program (BWSP)
Black Infant Health (BIH)
BIH Management Information System
California Birth Defects Monitoring Program (CBDMP)
California Children's Services (CCS) Program
California Diabetes and Pregnancy Program (CDAPP)

California Early Childhood Comprehensive Systems (CA ECCS)
California Maternal Quality Care Collaborative (CMQCC)
California Perinatal Quality Care Collaborative (CPQCC)
California Perinatal Transport System (CPeTS)
Child Health and Disability Prevention Program (CHDP)
Childhood Injury Prevention Program (CIPP)
Comprehensive Perinatal Services Program (CPSP)
Comprehensive Perinatal Services Provider Training
Emergency Triage Transport System (ETTS)
Family Health Outcomes Project (FHOP) and Local MCAH Data
Family Planning, Access, Care and Treatment (Family PACT)
Fetal Infant Mortality Review Program (FIMR) and BIH FIMR
Genetically Handicapped Persons Program (GHPP)
Health Care Program for Children in Foster Care (HCPCFC)
High Risk Infant Follow-up (HRIF)
Human Stem Cell Research (HSCR) Program
Local Health Department Maternal Child and Adolescent Health Program (LHDMP)
Medical Therapy Program (MTP)
Newborn Hearing Screening Program (NHSP)
Nutrition and Physical Activity Initiative
Oral Health
Perinatal Profiles and Improved Perinatal Outcomes Data Reports Website
Regional Perinatal Programs of California (RPPC)
Sudden Infant Death Syndrome (SIDS) Program
Teen Pregnancy Prevention Programs

/2008/
- The Adolescent Sibling Pregnancy Prevention Program (ASPPP) eliminated in 2006 due to Title V funding cuts.
- The Adolescent Health Program eliminated in 2006 due to Title V funding cuts; reinitiated in 2008 with redirected funding.
- Effective January 2007, CBDMP moved from Prevention Services to the MCAH Branch.
- The Emergency Triage Transport System is a new project funded through an Inter Agency Agreement with the CA Emergency Preparedness Office; HRSA grant.
- The Youth Pilot Program and Integrated Health and Human Services Pilot removed from the list of MCH programs as MCAH/OFP no longer has responsibility for it. Oversight moved to another Branch of the Department.
- The Medically Vulnerable Infant Program combined into the High Risk Infant Follow-up Program in July 2006.
//2008//

/2009/ The CA ECCS is in the final year of the five year grant period.//2009//

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

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

Agency capacity is presented for each of the three population groups, and broken down into subsections as follows:

1. Preventive and Primary Care Services for Pregnant Women, Mothers and Infants
> Support to local infrastructure
> Quality of maternity services

> Infants' access to care
> Infant Health Promotion

2. Preventive and Primary Care for Children
> Access to care
> Childhood/adolescent health promotion

3. Services for Children with Special Health Care Needs (CSHCN)
> Rehabilitation services to Supplemental Security Income (SSI) beneficiaries under the age of 16
> Family-centered, community-based coordinated care for CSHCN
> Transition of Care for Children with Special Health Care Needs (CSHCN)
//2010//

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

> Support to local infrastructure

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

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

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

> Quality of maternity services

The California Perinatal Quality Care Collaborative (CPQCC) is a cooperative effort of public and private obstetric and neonatal providers, insurers, public health professionals and business groups. It develops perinatal and neonatal quality improvement infrastructure at state, regional, and hospital levels. CPQCC membership has grown to over 100 hospitals.

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

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

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

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

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

/2009/The CPQCC/PQIP updated the "Early Onset Sepsis Toolkit" in March 2007 (developed in 2002).
CPQCC/PQIP has formed a quality improvement collaborative (CPQCC/CCS Hospital Associated

Infection (HAI) Collaborative) in partnership with the CMS Branch addressing catheter associated blood stream infections in 19 Community NICUs.//2009//

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

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

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

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

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

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

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

/2009/"Guidelines for Care" updates continue.

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

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

>Infants' access to care

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

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

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

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

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

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

> Infant Health Promotion

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

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

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

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

/2010/California Senate Bill 22 passed in 2007 requires CDPH to recommend specified training intended to improve breastfeeding rates and notify hospitals with low exclusive breastfeeding rates of its availability.
WIC and MCAH are finalizing a web-based model curriculum on hospital breastfeeding policies.//2010//

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

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

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

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

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

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

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

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

/2009/CMS disseminated guidelines on authorizations for infants referred to CCS by the NBS Program for CF or BD. As of February 2008, 8 cases of profound BD and 17 cases of classical CF were detected. False positive rates for CAH in premature infants continue to concern neonatologists. In 2008, the NBS Program will add the extended MS/MS second tier testing to the 1000-1500g birth weight group to reduce their 5% false positive rate.//2009//

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

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

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

California's Fetal Infant Mortality Review (FIMR) Program, which took a significant budget cut in FY 2002-03, was expanded this year. This reallocation of Title V funding established the Black Infant Health FIMR (BIH/FIMR) Program to reduce African American fetal and infant deaths through community level review. Eight of the 17 FIMR jurisdictions with the greatest proportion of African American births and fetal deaths were selected for participation.

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

/2008/As of March 2007, 175 hospitals are certified and participating in the NHSP, down from 177 the previous year. This decreased due to the closure of delivery units in some CCS approved hospitals. Of babies born in CY 2005, over 411,000 received newborn hearing screening and 713 were identified with hearing loss, an incidence rate of 1.7 per 1000. Of those with hearing loss, 450 were identified before 3 months of age (63%), and 598 were enrolled in Early Start,

California's early intervention program (84%). Of those in Early Start, 403 enrolled before 6 months of age (67%).//2008//

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

California was one of 8 states to participate in the National Initiative for Children's Healthcare Quality (NICHQ) collaborative. Key outcomes include: improved hospital identification of primary care provider and collection of an additional contact person (to 100%), a decrease in no-shows for outpatient screening and diagnostic evaluation appointments (by 25%). The California team participated in panel presentations with NICHQ faculty at national meetings and is now focusing on improving age-appropriate language acquisition for infants and toddlers with hearing loss.//2009//

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

2. Preventive and Primary Care for Children

> Access to care

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

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

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

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

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

The CMS Branch administers the screening component of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, called the Child Health and Disability Prevention Program (CHDP) in California. CHDP provides preventive services and referral to diagnostic and treatment services for Medi-Cal participants up to age 21. Uninsured children up to age 19 in households at or below 200% of the FPL can pre-enroll in Medi-Cal through the Gateway process.

/2008/In FY 2005-06, 2,038,833 children received screening and health assessments through CHDP, similar to the previous year. (The number receiving services declined by 3% in FY 2005-

06, after having been quite stable at about 2.1 million for the previous five years.) The funding for the CHDP program remains the same as the previous year: 98% funded by Medi-Cal and 2% by state only funding.//2008//

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

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

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

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

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

CA Early Childhood Comprehensive Systems (ECCS) provides CHDP with guidance on validated and standardized development/social-emotional health screening tools for earlier identification of children at risk or with developmental delays.//2009//

> Childhood/adolescent health promotion

To reduce injury-related mortality and morbidity among children and adolescents, MCAH/OFP contracts with the Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University. CIPPP provides technical support for local MCAH programs via conferences, a list serve, and literature reviews of the latest injury prevention research. MCAH/OFP funds five local MCAH jurisdictions to increase injury prevention capacity within their community.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Services for Children with Special Health Care Needs (CSHCN)

The CMS Branch administers the CCS program, providing case management and payment of CSHCN services. The program authorizes medical and dental services for the CCS eligible condition, establishes standards for providers, hospitals, and Special Care Centers (SCCs) for the delivery of care, and provides physical and occupational therapy and medical case conference services at selected public school sites for children with specific medically eligible conditions.

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

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

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

/2008/The estimated caseload for CCS in Federal Fiscal Year (FFY) 2005-06 was 182,800. This is a 4% increase from the prior year of 175,920. Approximately 80% of these children were enrolled in Medi-Cal, 10% were enrolled in HF and 10% were enrolled in state-only CCS. CHDP providers continue to facilitate referrals to CCS of children with CCS eligible or potentially CCS eligible conditions.//2008//

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

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

The CCS program is responsible for case management and Medi-Cal reimbursement for services related to the CCS eligible condition. Additionally, CCS case manages and authorizes payment of services for children enrolled in HF. Through a system of CCS-approved SCCs, quality specialty and subspecialty care is provided. Thirty-one "independent" counties fully administer their own CCS programs, and 27 "dependent" counties share administrative and case management activities with CMS Branch Regional Offices. Through the Case Management Improvement Project, dependent counties are encouraged to assume activities for case management functions.

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

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

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

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

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

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

/2008/ The 43 HRIF programs submitted 3169 registration forms between July 1, 2006 and May 15, 2007. //2008//

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

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

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

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

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

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

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

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

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

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

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

> Family-centered, community-based coordinated care for CSHCN

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

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

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

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

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

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

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

CCS.//2010//

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

/2010/CMS, in collaboration with the Statewide Workgroup on Transition of Care for CSHCN, drafted Transition Planning recommendations for county CCS program staff. They were released April 30, 2009, as a CCS Information Notice. http://www.dhcs.ca.gov/services/ccs/Documents/ccsin0901.pdf//2010//

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

/2007/ The transition workgroup completed a survey to better understand what local and state CCS programs are doing to foster transition services and what the needs are for transition resources, technical assistance and training. This workgroup will also be reviewing the transition strategies from the Champions stakeholder group to help determine an implementation plan for these strategies. //2007//

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

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

/2007/ CHLA, UCLA Child and Family Health Program, LA Partnership for Special Needs Children, CRISS, CCS, and CMS Branch collaborated on a conference entitled "Family-Centered

Strategies for Effective Transition for Youth with Special Health Care Needs: A Training for Providers and Families" in April 2006 in Los Angeles. Experts in the field provided information to agency staff, providers, youth and their families about the system of care for transitioning youth, transition resources, and strategies for assisting youth and their families. //2007//

/2008/ The CRISS Project and Family Voices of California presented a workshop in English and Spanish on "Negotiating Multiple Transition Hurdles, One at a Time" in November 2006 in Oakland for nurses, physicians, CCS staff, regional center service coordinators, and youth and families. //2008//

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

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

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

C. Organizational Structure

Arnold Schwarzenegger is the Governor of California, a position he has held since November 2003. S. Kimberly Belshé is the Secretary for the California Health and Human Services Agency (CHHSA), which is a cabinet-level position reporting directly to the Governor. Sandra L. Shewry is the Director of the California Department of Health Services (CDHS), which is one of twelve departments in CHHSA. CDHS is designated to administer the MCAH program by the California Health and Safety Code Div. 106, Part 2, Chapter 1, Article 1 Sections beginning with 123225.

/2008/Effective July 2007, CDHS was reorganized into two departments: a California Department of Public Health (CDPH) and a Department of Health Care Services (DHCS). Mark Horton, MD, MSPH is the Director of CDPH, and Sandra Shewry is the Director of DHCS. Organizational charts for the two new departments can be found on pages 2-3 of the following website: http://intranet.dhs.ca.gov/reorganization/FinalOrgChartsUpdated31407.pdf.

The MCAH/OFP Branch has primary responsibility for carrying out Title V functions in California. The MCAH/OFP Branch is in the Center for Family Health of the CDPH. The CMS Branch, in DHCS, handles activities related to care of CSHCN.

The Deputy Director of the Center for Family Health is Catherine Camacho. The Chief of the MCAH/OFP Branch is Susann J. Steinberg, MD, and the Chief of the CMS Branch is Marian Dalsey, MD, MPH. //2008//

/2010/David Maxwell-Jolly, PhD, replaced Sandra Shewry as Director of DHCS in January 2009. Vickie Orlich was named Assistant Deputy Director of CDPH's Center for Family Health in November 2008.//2010//

Information about the MCAH/OFP Branch is provided below. Information about the CMS Branch is included in Section III D. For updated organizational charts for the MCAH/OFP and CMS Branches, see the attachments to Sections III C and III D, respectively.

> Maternal Child and Adolescent Health/Office of Family Planning Branch (MCAH/OFP)

In March 2005 the MCAH Branch was formally merged with the Office of Family Planning Branch

to form the MCAH/OFP Branch. Prior to 2004, the MCAH Branch was known as the Maternal and Child Health Branch, or MCH.

Susann Steinberg, MD is Chief of the MCAH/OFP Branch, a position she has held since the two branches merged in March 2005. Prior to that, she had been Chief of the MCAH Branch since December 2002 and Acting Chief of the Office of Family Planning since May 2004. Dr. Steinberg is Board Certified in Family Practice as well as Preventive Medicine and has an MBA.

/2008/ Since June 2007, Dr. Steinberg is on extended leave. Shabbir Ahmad, DVM, MS, PhD, is the Acting Chief of the MCAH Program, and Laurie Weaver is the Chief of the Office of Family Planning. //2008//

/2009/ In July 2007 the MCAH/OFP Branch was reorganized into two separate Programs: the MCAH Program and the OFP Program. Dr. Steinberg retired in May 2008; Dr. Ahmad continues as the Acting Chief of the MCAH Program and Laurie Weaver is the Chief of the OFP Program. //2009//

/2010/The MCAH Program is referred to as the MCAH Division. OFP Program is referred to as OFP.//2010//

Laurie Weaver is the Chief of the Office of Family Planning, a position she has held since May of 2005. Prior to coming to MCAH/OFP, Ms. Weaver was employed with the California Department of Corrections, Health Care Services Division.

Les Newman is the Assistant Chief of the MCAH/OFP Branch, a position he has held since the two branches merged in March 2005. Prior to that, he had been Assistant Chief of the MCAH Branch since February 2001. He has over twenty years working in leadership positions in California government and was previously Operations Section Chief within the MCAH/OFP Branch.

The MCAH/OFP Branch staff includes senior consultants in a variety of clinical, public health, and scientific disciplines. Emeterio Gonzalez, MD, an Obstetrician/Gynecologist and Eileen Yamada, MD, MPH, a Pediatrician, serve as medical consultants to the Branch. John Mikanda, MD, MPH assists in the evaluation of the Family PACT Program.

/2007/ Dr. Yamada has accepted an alternate assignment as a Public Health Medical Officer and was replaced by Karen Ramstrom, DO, MSPH, effective May 2006. //2007//

/2009/ Dr. Gonzalez accepted another position and was replaced by Connie Mitchell, MD, effective February 2008. //2009//

Lori Llewelyn, MPP is Title V Principal Author, a position she has held since February 2004. Mike Curtis, PhD and Eugene Takahashi, PhD oversee the compilation of state statistics for the Title V report. This Title V team works under the direction of Shabbir Ahmad, DVM, MS, PhD, Chief of the Epidemiology and Evaluation Section of MCAH/OFP.

/2009/ Lori Llewelyn accepted another position and was replaced by Kate Marie, MPA effective December 2007. //2009//

/2010/ Dr. Ahmad is now Acting Division Chief of MCAH, and Dr. Curtis is Acting Chief of the Epidemiology, Assessment and Program Development Branch. Christopher Krawczyk, PhD replaced Dr. Takahashi in January 2009. Katie Martin, PhD, MPH replaced Kate Marie in March 2009. Renato Littaua, DVM, MPVM and Elizabeth Carson-Cheng, MPH are Title V Co-Principal Authors.//2010//

The MCAH/OFP Branch consists of seven sections: Programs and Policy, Epidemiology and

Evaluation, Operations, Administration, Clinical Services and Quality Improvement Utilization Management, Teen Pregnancy Prevention, and Domestic Violence. The last three of these sections comprise the Office of Family Planning.

/2008/The number of sections in the Branch has increased from seven to nine: In January 2007 the California Birth Defects Monitoring Program was moved from Prevention Services to the MCAH/OFP Branch, becoming the eighth section in MCAH/OFP. In the spring of 2007 the Programs and Policy Section was split into two sections (a Programs Section and a Policy Section), thereby increasing the total number of sections in the Branch to nine. //2008//

> Programs and Policy Sections

The Programs and Policy Section of MCAH/OFP coordinates the implementation of standards of care for pregnant women, children, and infants in the AFLP, APN, BIH, BIH/FIMR, CPSP, FIMR, CDAPP, CPeTS, and SIDS Programs. Program consultants develop standards and provide consultation and technical assistance to local MCAH jurisdictions and other organizations.

Anita Mitchell, MD is the Chief of the Programs and Policy Section, effective July 2005. Dr. Mitchell is board certified in Pediatrics. Before coming to MCAH/OFP, she was the Chief Medical Officer, Medical and Public Health Programs, at the California Department of Corrections.

The Programs and Policy Section consists of four program units: two Perinatal Health Units, the Statewide Specialized Services and Programs Unit, and the MCAH in Schools Program.

The Perinatal Health Units are supervised by Nurse Consultant Supervisors Joyce Weston, BS (Nursing), MS (Healthcare Services Administration) and Leona Shields, MN, CNP. These two units consist of a staff of nine. The Perinatal Health Units provide technical assistance and consultation to 61 health jurisdictions regarding their MCAH Scope of Work and Allocation, AFLP/ASPPP, Breastfeeding Support Programs, FIMR programs, and BIH/FIMR.

The Statewide Specialized Services and Programs Unit has overall responsibility for the BIH and SIDS programs and the perinatal quality improvement contracts with the RPPC, CDAPP, CPeTS, APN and CPSP. The unit is also responsible for technical assistance and consultation to eighteen community-based organizations that provide AFLP services, eight of which also provide ASPPP services. The unit consists of five staff positions.

The MCAH in Schools Program (formerly called School Health Connections) currently has a staff of one, down from eight in 2002.

/2007/ The Programs and Policy Section has been reorganized into two program units, which cover all the responsibilities of the previous four units. The Statewide Specialized Services and Programs Unit and the MCAH in Schools Program are now within the Perinatal Health Units. The two Perinatal Health Units are now supervised by Nurse Consultant Supervisors Leona Shields, MN, CNP, and Angela Furnari RN, BSN, MPA; they currently consist of a staff of thirteen. //2007//

/2008/ In early 2007 the Program and Policy Section was split into two Sections: the Programs Section, led by Anita Mitchell, MD, and the Policy Section, led by Karen Ramstrom, DO, MSPH. Dr. Mitchell is Board-certified in Pediatrics, and Dr. Ramstrom is Board-certified in Preventive Medicine and Family Medicine.

The two Perinatal Health Units described above are in the new Programs Section. Effective November 2006, these two Units are supervised by Angela Furnari, RN, BSN, MPA and Laurel Cima, MPA.

/2009/ In September 2007 Virginia Flemming replaced Laurel Cima as the Perinatal Health Unit B

Supervisor. In March 2008, Angela Furnari accepted another position; recruitment for a replacement is in the final stages. The Program Standards Branch now consists of 14 staff. //2009//

/2010/Candice Zimmerman, MPH, CHES replaced Virginia Fleming as Perinatal Health Unit B Supervisor in March 2009. Dr. Mitchell now also supervises Perinatal Health Unit A. Laurel Cima has been Health Program Manager II for the Policy Development Branch since September 2007.//2010//

The Policy Section consists of a staff of nine, including one Public Health Medical Officer, who is certified in Preventive Medicine and Family Medicine. The Policy Section develops the policy and procedures in support of all MCAH programs and collaborates on Federal, State and local levels, providing expertise on multiple health priorities including nutrition, obesity, breastfeeding, physical activity, oral health, and the State Early Childhood Comprehensive System. The staff identifies relevant data points for annual reporting to ensure that local health jurisdictions address state priorities and program requirements.//2008//

/2009/ The Policy Development Branch now has a staff of eight.//2009//

/2010/ The Policy Development Branch continues to have a staff of eight.//2010//

> Epidemiology and Evaluation Section (EES)

The Epidemiology and Evaluation Section provides program information for monitoring MCAH/OFP program implementation, evaluating program effectiveness, and policy development. Program and population-based data are analyzed to support California's application for Federal Title V Grant Funds and Needs Assessment. The Section also provides assessment and surveillance information for use in program related research, program policy planning, and allocation of resources.

Shabbir Ahmad, DVM, MS, PhD, is Chief of the EES, a position he has held since May 2003.

/2009/ The EES has been renamed the Epidemiology, Assessment and Program Development (EAPD) Branch, effective July 2007. Since September 2007, Mike Curtis, PhD, has been the Acting Chief of EAPD.//2009//

The EES consists of two units with a total of 21 staff: Surveillance and Program Evaluation; and Epidemiology. The Chief of the Surveillance and Program Evaluation Unit is Mike Curtis, PhD. The Chief of the Epidemiology Unit is Eugene Takahashi, PhD, MPH.

/2007/ As of November 2005, the EES was reorganized to include a third unit on Health Services Research. The new unit is supervised by Lori Llewelyn, MPP. The total number of staff in the EES is now 25. //2007//

/2009/ As of December 2007, Kate Marie, MPA supervises the Assessment Section (formerly the Health Services Research Unit). //2009//

The MCAH/OFP Branch has been given the additional responsibility of implementing legislation mandating the monitoring of stem cell research in California. The Branch will provide support to the Human Stem Cell Research Advisory Committee, which will advise CDHS on the development of minimum standards for Institutional Review Boards to use in reviewing human embryonic stem cell research projects.

/2008/ EES has added a fourth unit, the Human Stem Cell Research Unit (HSCR), to implement stem cell research legislation and collaborate with the HSCR Advisory Committee. The Unit

consists of two staff positions. //2008//

/2009/ The total number of staff in EAPD is now 16. //2009//

/2010/ EAPD has 18 staff.//2010//

> Operations Section

The Operations Section assumes the contract monitoring functions for the Branch, including fiscal forecasting, budget related work, management of over 400 contracts, auditing functions, and working with Department of Finance and other control agencies.

Nancy Smith has been the Chief of the Operations Section since 2001.

The Operations Section consists of 22 staff in three units: the Accounting and Business Operations Unit, the OFP Contracts and Grants Unit, and the MCAH Contracts and Grants Unit.

/2009/ The Operations Section has been renamed the Financial Management and Contract Operations Branch, effective July 2007.

In April 2008 Nancy Smith retired; Jo Miglas is now the Chief of the Financial Management and Contract Operations Branch. //2009//

> Administration Section

The Administration Section undertakes activities associated with contract management, allocation and matched funding of MCAH programs; program integrity and enrollment activities associated with the Family PACT Program; special projects and administrative activities associated with more than fifteen MCAH/OFP programs, including bill analysis and regulation development; policies and procedure development; administrative activities related to management analysis, personnel, training, and procurement; and information technology management, including website maintenance, local area network support, and management of servers, hardware, software, and inventory.

Linda LaCoursiere is Chief of the Administration Section.

The Section consists of 25 staff and three units: Allocation and Matched Funding Unit, Special Projects and Administrative Support Unit, and Information Technology Unit.

/2008/ Effective March 2007, Fred Chow is Chief of the Administration Section. //2008//

/2009/ The Administration Section has been renamed the Program Allocation, Integrity and Support Branch, effective July 2007. //2009//

/2010/Special Projects, Program Integrity and Support was renamed the Administrative and Business Services Section in January 2009.//2010//

> Clinical Services and Quality Improvement Utilization Management Section

The Clinical Services and Quality Improvement Utilization Management Section consists of the Clinical Services Unit and is responsible for the administration and support of the Family Planning Access Care and Treatment (Family PACT) Medicaid Waiver Demonstration Project. The Section consists of a staff of seven.

Amy Krawiec, MD is the Chief of the Clinical Services and Quality Improvement Utilization Management Section, a position she has held since March 2005.

/2007/ In January 2006 Amy Krawiec, MD, was replaced by Laurie Werner, MD, as Section Chief. //2007//

/2008/ In May 2006 Laurie Werner, MD, was replaced by John Mikanda, MD, MPH, as Section Chief. The Section now has nine staff positions. //2008//

/2009/ The Section now has 11 staff positions.//2009//

> Teen Pregnancy Prevention Section

The Teen Pregnancy Prevention Section (eight staff) consists of four grant programs (Community Challenge Grant, Information & Education, Male Involvement, and Teen Smart) to reduce the incidence of teen pregnancies. The program serves approximately 460,000 teens and parent participants through nearly 200 grants and contracts annually. Martha Torres-Montoya, MSPH, is the Section Chief; she has over twenty-five years experience in family planning, teen pregnancy prevention, and multilingual/multicultural health education programs.

/2008/ The Teen Pregnancy Prevention Section now has nine staff positions. //2008//

/2010/ Effective July 2008, the Teen Pregnancy Prevention Section administers the Community Challenge Grants and Information & Education programs, with over 160 grants and contracts. James Collopy replaced Martha Torres-Montoya as Acting Section Chief in December 2008.//2010//

> Domestic Violence (DV) Program

For the DV program, FY 2005-06 marked the beginning of the first year of a five-year grant cycle and consolidation of the shelter, prevention and unserved/underserved (U/U) grants. Under the guidance of the Agency Secretary, MCAH/OFP is providing all 94 shelters with Shelter, Prevention and U/U funding. The two technical assistance training support contracts will continue. The Program consists of seven staff positions and is managed by Carolynn Michaels, MBA.

/2008/ The Program now consists of six staff positions and is managed by Stephanie Roberson, MSW. There are currently three technical assistance and training contracts to assist shelters in serving specific U/U populations; disabled and developmentally disabled, those with mental health and substance abuse issues, and the lesbian, bisexual, gay, transgendered and questioning population. //2008//

/2010/ Effective July 2008, the 5-year grant cycle of the DV Program was extended two years, through June 2011. //2010//

/2008/
> California Birth Defects Monitoring Program

By act of the California State Legislature, the California Birth Defects Monitoring Program (CBDMP) moved from Prevention Services to the MCAH/OFP Branch in January 2007. CBDMP, operated jointly by CDPH and the March of Dimes, conducts research and surveillance of birth defects and maintains a birth defect registry.

Effective July 2007, the Chief of the CBDMP Section is Marcia Ehinger, MD. //2008/

/2009/ The CBDMP now has four staff positions. //2009//

/2010/CBDMP has 3 staff positions.//2010//

An attachment is included in this section.

D. Other MCH Capacity

Information about the MCAH/OFP Branch is provided in Section III C (Organizational Structure) above. Information about the CMS Branch is provided below.

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

> Children's Medical Services (CMS) Branch

Marian Dalsey, MD, MPH is the Branch Chief, a position she has held since July 2006. She had been the Acting Branch Chief since April 2004. Dr. Dalsey is a Board-certified pediatrician with a Medical Degree from the University of Illinois College of Medicine, and a Master's of Public Health degree from the University of Illinois School of Public Health. She has held positions in healthcare administration and policy development at the local level in California and Illinois and with Medi-Cal and CMS at CDHS. Harvey Fry is the Assistant Branch Chief, a position he has held since January 2005.

/2007/ The CMS Branch was reorganized in 2005. The Branch is composed of the following five sections: Program Development, Regional Operations, Statewide Programs, Program Support, and Information Technology. //2007//

/2010/ Dr. Marian Dalsey retired in December 2008. Luis Rico, Chief, Systems of Care Division will be the Acting Chief for the CMS Branch until a replacement can be recruited for the position. //2010//

> Program Development Section (PDS)

PDS is responsible for the development and implementation of program policy, regulations, and procedures for the programs administered by the Branch and for provision of statewide consultation in a variety of professional health disciplines.

/2007/ Marian Dalsey, M.D., M.P.H., Board-certified pediatrician and Branch Chief, is also Acting Chief of this section, a position she has held since 2002. PDS has 20 positions. //2007//

/2008/ Chester J. Randle, Jr. M.D. became the Chief of the Program Development Section in August 2006. He is Board certified in Pediatric Critical Care Medicine. Dr. Randle has a Medical Degree from the Stanford School of Medicine and has held positions in healthcare administration as a Medical Director of a Community Health Care Center in Illinois, and as a Director of Pediatric Critical Care Services at a University based teaching hospital in California. He has also served as a Medical Consultant at a local CCS program. PDS has 19 positions. //2008//

/2010/ Jill M Abramson MD, MPH became the Chief of the Program Development Section in July 2008. She is board certified in pediatrics and board eligible in Preventive Medicine.//2010//

/2009/ PDS has 17 positions. //2009//

The PDS Section consists of two units: the Program Policy and Analysis Unit and the State Consultation Unit.

The Program Policy and Analysis Unit is responsible for development and implementation of program policy, regulations, and procedures for all programs administered by the Branch. Unit staff develop provider standards for CCS; develop policies and procedures to assist in the implementation of Medi-Cal Managed Care and the Healthy Families program; review and approve/deny all requests for organ transplants for children covered by CCS and Medi-Cal; and provide pediatric consultation to Medi-Cal and other CDHS programs. The unit is also responsible for research and program analysis functions and development and implementation of a pharmaceutical rebate program for CCS and GHPP.

/2008/ The Program Policy and Analysis Unit has added two research analyst positions to increase the research and program analysis capacity of the Program Development Section. //2008//

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

/2010/ PDS has 16 positions. A Research Unit was added, which has 3 staff responsible for program data retrieval, aggregation and analysis. The health educator position was removed from the Statewide Consultation unit.//2010//

>Regional Operations Section (ROS)

ROS is composed of three CMS regional offices located in Sacramento, San Francisco, and Los Angeles. The section provides case management services for CCS-eligible clients residing in dependent counties (those with populations of less than 200,000). Case management services include, but are not limited to, determination of medical eligibility and authorizations for services, including review and approval of Early and Periodic Screening, Diagnosis, and Treatment Supplemental Services requests, resolution of financial appeals, determination of eligibility for Medical Therapy Unit services, and program consultation/technical assistance.

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

Staff in the regional offices are responsible for coordinating and facilitating on-site reviews of hospitals, special care centers, neonatal and pediatric intensive care units, and medical therapy units for compliance with established program standards, policies, and procedures and for certifying outpatient rehabilitation centers located within CCS medical therapy units.

/2007/ Maurice Robertson is the ROS Section Chief, a position he has held since March 2005. He has held management positions in both health care and social services programs at the county and state level over his 30 years of government service. ROS has 49 positions. //2007//

/2010/ V. David Banda is the ROS Section Chief, a position he has held since December 2008. He was manager of the CMS Hearing & Audiology Services Unit/Newborn Hearing Screening Program for 10 years and has more than 30 years of experience in the Department.//2010//.

/2008/ ROS now has 52 positions. //2008//

/2009/ The San Francisco ROS office relocated to a state owned building in Oakland in January 2008.

The Governor's budget proposal would eliminate 9 positions and would decrease the position numbers from 52 to 43. //2009//

> Statewide Programs Section (SPS)

The Statewide Programs Section is responsible for administration of specialty programs with statewide responsibilities.

/2007/ Joleen Heider is the Section Chief of SPS as of May 2005. She has an MS in Biology, a BS in Dietetics and is a registered dietitian. She has been in state service for eleven years, with her last position as a HPM II with the MCAH Branch overseeing the Domestic Violence Program. SPS has 27 positions. //2007//

/2009/ Joleen Heider-Freeman is the Section Chief of SPS which currently has 25 positions. //2009//

/2010/ The SPS section currently has 16 filled positions. The Section has been cut due to the Governor's Balanced Budget Reduction Act and has vacant positions. The High Risk Infant Follow-up Program oversight responsibilities were moved to another Section in the CMS Branch. The bioterrorism project was phased out as funding was time-limited.//2010//

There are three units within the section: Specialty Programs, Hearing and Audiology Services, and the Genetically Handicapped Persons Program (GHPP).

/2007/ The Specialty Programs Unit is responsible for implementation and monitoring of specialty programs under the purview of the CMS Branch such as the Health Care Program for Children in Foster Care, the High Risk Infant Follow-up Program, and a bioterrorism project entitled, "Caring for California's Children Project." Staff in the unit are responsible for collaboration efforts with local programs in implementation activities and for ensuring that providers, hospitals, Special Care Centers, other State programs, local agencies, community-based organizations, and the general public are informed and assisted in the process of providing services to eligible populations. //2007//

/2009/ The Specialty Programs Unit is developing and implementing statewide guidelines on transition planning. //2009//

/2010/ The CMS Branch SPS staff, in collaboration with the Statewide Workgroup on the Transition of Care for CSHCN, drafted Transition Planning recommendations with various templates for county CCS programs to use with their staff and families. The recommendations were released April 30, 2009 as a CCS Information Notice.//2010//

/2007/ The Hearing and Audiology Services Unit is responsible for implementation and monitoring of the Newborn Hearing Screening Program (NHSP) and for providing consultation/technical assistance to providers and local programs regarding program benefits. Staff in the unit (1) monitor contracts with NHSP Hearing Coordination Centers providing follow-up testing and treatment services to infants with suspected hearing loss; (2) evaluate and certify school audiometrists; and (3) support the training of CHDP providers to perform hearing testing in schools. //2007//

/2008/ The Hearing and Audiology Services Unit develops and implements NHSP and CCS policy relating to hearing services. Monitoring and quality assurance activities are conducted with NHSP contractors and CCS providers. //2008//

/2010/ Due to the loss of positions, the NHSP only provided technical assistance for the CHPD providers on the audiometric testing of hearing for children in the school setting.//2010//

/2007/ GHPP provides all medical and administrative case management services for approximately 1550 clients statewide with serious, often life threatening, genetic conditions (e.g., hemophilia, cystic fibrosis, sickle cell anemia). //2007//

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

/2010/ GHPP client enrollment has increased to approximately 1700 clients.//2010//

> Program Support Section (PSS)

PSS is composed of three units and has responsibility for a variety of activities in support of Branch operations. The Section Chief of PSS is Erin M. Whitsell. She has held this position since 2003.

/2007/ There are currently 27 positions in this Section. //2007//

/2008/ There are currently 24 positions in this Section. //2008//

/2009/ There are currently 22 positions in this Section.//2009//

/2010/ There are currently 21 positions in this Section. //2010//

The Administration Unit is responsible for fiscal, personnel, contracting, purchasing, and business services for the Branch. Staff in the unit review, approve, and monitor CCS county programs and CHDP county/city budgets; resolve county budgeting/invoicing issues; develop and implement administrative and fiscal procedures for new programs administered by the Branch; develop and manage contracts and interagency agreements; process contract and county expenditure invoices; and maintain personnel and business services transactions for all CMS Branch staff. Unit staff also develop and participate in training programs for State and county program staff relating to the above areas of responsibility.

The Provider Services Unit (PSU) is responsible for enrolling providers for the CCS, CHDP, and GHPP programs and acts as a liaison between CMS Branch programs, their providers, the Medi-Cal Payment Systems Division, and the State fiscal intermediary, Electronic Data Systems (EDS). The PSU works with individual providers, hospitals, and CCS/GHPP Special Care Centers to resolve provider reimbursement issues.

/2008/ Staff in the Provider Services Unit also develop and conduct provider training to individual and group health care providers, hospitals, special care centers, clinics, etc. in statewide formal

training seminars. //2008//

The Clerical Support Unit provides general clerical support services to CMS Branch management and staff. The unit is responsible for completion of complex typing assignments, formatting of proposals, regulations, program standards, reports, research papers, etc. The Clerical Support Unit also assists in organizing and filing all program documents; responds to telephone calls, faxes, and e-mails; disseminates program information to State staff, local agencies, the general public, and various other organizations; coordinates meetings; and makes travel arrangements for Branch staff.

> Information Technology Section (ITS)

ITS is responsible for all aspects of information technology support for the CMS Branch and CMS Net, the Branch's automated case management system. This includes CMS Branch office products, CMS Net network support, CMS Net operations, and CMS Net Help Desk operation. The section provides consultation to the State Health and Human Services Agency Data Center regarding county LAN/WAN connectivity and is responsible for corrections and modifications to CMS Net application. William White has been the Section Chief since 2003.

/2008/ The CMS Net system is used by the county and State Regional CCS offices to manage the health care of approximately 170,000 children. //2008//

The section is divided into two units: Information Systems and Information Technology. There are 11 state staff, two student assistants, and 12 contract staff.

/2008/ There are now 14 state staff and 10 contract staff. //2008//

/2009/ This section provides consultation to State of California Department of Technology Services (DTS), formerly the California Health and Human Services Agency Data Center (HHSDC).

Brian Kentera was appointed Chief in February 2008 to replace retired William White. His background is in Computer Science and IT Systems Analysis. He has held a variety of IT positions for the California Department of Health Care Services over the past 15 years. Brian's last position was managing the Treatment Authorization Request (TAR) system statewide network infrastructure and IT client support groups for Medi-Cal.

ITS currently consists of 14 State staff and 10 contractors. //2009//

An attachment is included in this section.

E. State Agency Coordination

The MCAH/OFP and CMS Branches coordinate with departments and offices within and outside of CDHS, and with university and professional organizations on programs and projects related to Title V.

Inter- and intra-agency collaboration is vital for meeting the needs of children and CSHCN. Numerous collaborations exist with state and local public health agencies with organizations such as local foundations, medical professional associations, coalitions and children's advocacy groups.

CPQCC is a cooperative effort of public and private obstetric and neonatal providers, insurers, public health professionals and business groups working to develop an effective perinatal and neonatal quality improvement infrastructure at state, regional, and hospital levels.

/2007/The MCAH/OFP Branch received a multi-year grant from HRSA in 2003 for the State Early Childhood Comprehensive Systems (SECCS) project. The goal is to provide state-level leadership for early childhood health programs to help California's children be emotionally, socially, and physically healthy and ready for kindergarten. The project, now in the implementation phase, coordinates a myriad of health-related programs at the state and local levels. //2007//

/2010/The SECCS grant was extended through May 2009; 3 more years of funding has been requested.//2010//

The State Interagency Team (SIT) is a collaborative effort to provide better strategies and service coordination for California's children and families. Deputy Directors from several state agencies are represented. The SIT promotes alignment of planning, funding and policy development across state agencies to build capacity, maximize funding, remove regulatory barriers, ensure accountability, promote strength-based practices and share information.

/2009/MCAH participates in the Alcohol and Other Drug (AOD) Workgroup of the SIT, working to improve services to children and families in the areas of child safety, education, and workforce readiness/success, maternal/child health, and mental health. The workgroup assessed the effectiveness of various substance use screening processes.

In September 2007 MCAH convened the State Screening Collaborative. CDPH and 9 other state agencies focus on coordination and identification of best approaches to program improvements.//2009//

/2010/The AOD Workgroup will reconvene in April 2009 as the FASD Prevention Workgroup of the SIT.//2010//

Department of Education (CDE)

The MCAH/OFP Branch collaborates with CDE on the SECCS grant to coordinate early childhood health programs for California's children.

MCAH/OFP, CDE and the Sexually Transmitted Disease (STD) Control Branch work to improve the sexual health of California's youth. A larger stakeholder group comprised of the Office of AIDS, DSS, and other CDHS programs identify important cross-cutting issues for future collaboration.

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

/2007/The CCS Medical Therapy Program (MTP) works with CDE on interagency coordination. The interagency agreement was renewed in 2005. The MTP continues working with CDE on structuring new and remodeled school-based Medical Therapy Units.//2007//

/2009/MCAH is a part of the California Adolescent Sexual Health Workgroup (ASHWG) collaborative comprised of representatives from CDPH, CDE and non-governmental organizations to address sexual and reproductive health issues of California adolescents.//2009//

/2010/The CMS Liaison to CDE participates on the Improving Special Education Services (ISES) Stakeholders Group to achieve objectives of the State Improvement Grant (SIG).

SECCS and CDE secured a Center on Social and Emotional Foundations for Early Learning (CSEFEL) grant to train staff and establish best practices in early child care

settings.//2010//

Department of Developmental Services (DDS)

/2007/CCS and Medi-Cal provide medical services to eligible infants and toddlers receiving services through the Early Start Program. Through participation on the Interagency Coordinating Council (ICC) and Health Services Committee, CMS maintains ongoing communication with DDS. Some CCS clients also receive Regional Center Services and care coordination between CCS and DDS.//2007//

/2009/CMS continues participation on the statewide ICC for the Early Start program and on the ICC's Integrated Services and Health Committee. CMS executed a Data Use Agreement with DDS to obtain outcome data on Early Start program enrollment of infants identified with hearing loss through the Newborn Hearing Screening Program.//2009//

The MCAH/OFP Branch collaborates with DDS's Early Start program on planning and implementation of the SECCS grant.

Department of Social Services (DSS)/Children in Foster Care

/2007/The Health Care Program for Children in Foster Care (HCPCFC) is a collaboration between DSS and CMS to improve access to and oversight of health care for children and youth in out-of-home or foster care settings. The HCPCFC works closely with local foster care programs to coordinate preventive and specialty health services for fostered children. CMS initiated a performance measure to evaluate the effectiveness of HCPCFC case management. Data collection for this measure has been challenging, but solutions including a statewide database are being pursued.//2007//

/2008/The DSS Child Welfare Services/Case Management System is undergoing a major overhaul, with completion of a new database system in the next five years. The HCPCFC Executive Subcommittee is consulting with DSS on redesigning the Health and Education Passport (HEP) document utilized for foster children to make it more user-friendly.//2008//

/2009/The HCPCFC Executive Subcommittee PHNs continue to collaborate with the DSS CWS/CMS redesign committee to provide input for the new database system. Emphasis is placed on continuity of statewide documentation in the HEP.

The MCAH AFLP continues to collaborate with the DSS/CalLearn as part of case management oversight for pregnant and parenting teens.//2009//

/2010/The CWS/CMS database redesign is on hold due to the state budget deficit.

SECCS supports implementation of the Child Abuse Prevention and Treatment Act (CAPTA) at the state and county level, providing expertise on developmental screening in provider settings.//2010//

Managed Risk Medical Insurance Board (MRMIB)

The CMS Branch and MRMIB coordinate quarterly meetings throughout the state for medical plans, and separate meetings for dental plans. Ad hoc subcommittees comprised of members from CCS and MRMIB work together to train providers and resolve program issues.

/2010/Bi-annual MRMIB/CCS meetings include Healthy Families Program (HFP) medical

and dental plans.//2010//

Childhood Lead Poisoning Prevention Branch (CLPP)

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

/2007/The MCAH/OFP and CMS Branches participate in the statewide planning process led by CLPP to eliminate childhood lead poisoning and meet the HP 2010 goal. A federal interagency strategy and objectives have been developed.//2007//

/2009/CMS and CLPP continue to participate in the statewide planning process to eliminate childhood lead poisoning. CHDP revised its performance measures to address provider compliance with the CHDP Periodicity Schedule, including age appropriate lead testing. CHDP and CLPP developed and implemented a protocol for providers utilizing the Lead Care II Analyzer to perform lead testing in provider offices, with electronic reporting of results to CLPP. To date, 27 providers have completed the process.

CHDP and CLPP are updating the Health Assessment Guidelines section on management of elevated blood lead levels in accordance with revised recommendations published in the November 2007 MMWR.//2009//

/2010/CHDP and CLPP released a joint letter in December 2008 outlining the updated CDC recommendations on childhood lead poisoning prevention.//2010//

Immunization Branch (IZ)

/2007/The CMS and IZ Branches collaborate with the Vaccines for Children (VFC) program by providing vaccination coverage and modifications through the CHDP program, including: tetanus, diphtheria and acellular pertussis (Tdap) vaccine; FluMist; meningococcal conjugate; measles, mumps, rubella, and varicella; hepatitis A, and rotavirus vaccines.//2007//

/2008/In addition to working on a second dose of varicella vaccine for children 12 months through 12 years and on a policy for human papillomavirus (HPV) vaccine, CMS and IZ Branches worked with Medi-Cal on understanding one another's procedures and streamlining reimbursement processes. //2008//

/2009/CMS and IZ Branches, Medi-Cal, and MCMC meet three times per year to discuss results of the Advisory Committee on Immunization Practices (ACIP)-VFC National Meetings. CMS and IZ work together on the following: 1) adding Tdap vaccine as a CHDP benefit for purchase for clients age 19 to 21, 2) expanding the lower age limit for FluMist™ (VFC) from 5 years to 2 years, 3) expanding the lower age limit for Meningococcal Conjugate vaccine (VFC) from 11 years to 2 years, 4) adding preservative free Influenza vaccine for children 6 months through 35 months at increased reimbursement, and 5) adjusting reimbursement rates to equal Medi-Cal rates for purchased vaccines Hepatitis A, Hepatitis B, HiB, and Pneumococcal Polysaccharide.//2009//

/2010/CMS and IZ Branch worked to increase CHDP reimbursement rates for MMR, varicella, and IPV and add Pentacel,™ Kinrix™ and Rotarix™ as CHDP benefits.

MCAH and IZ Branch met to improve coordination of messaging.//2010//

Sexually Transmitted Disease (STD) Control Branch

MCAH/OFP and STD Control Branches work with CDE to improve the sexual health of California's youth. A multi-agency stakeholder group work to determine important cross-cutting issues for future collaboration.

Medi-Cal Managed Care Division (MCMC)

Memoranda of Understanding (MOUs) between county health plans, CHDP and CCS are mandated by CDHS, and map out procedures for working together. Ad hoc subcommittees comprised of members from CCS and MCMC plans work together on provider training and resolving program issues. Liaison activities continue on policy, care coordination, and education issues.

The MCAH/OFP Branch and the MCMC Division work on improving the rate of adolescent preventive health care visits. The MCAH/OFP and CMS Branches collaborate with MCMC on their Interagency Work Group for the Behavioral, Emotional, and Social Screening and Treatment for Primary Care Providers (BEST-PCP). The MCMC project aims to develop and implement a model for changing provider practice for broader collaborative quality improvement efforts.

/2008/BEST-PCP ended in March 2007.//2008//

/2009/ California WIC Association, WIC, and MCAH meet monthly with Medi-Cal to clarify and simplify access to breastfeeding supportive Medi-Cal benefits.//2009//

Epidemiology and Prevention for Injury Control Branch (EPIC)

MCAH collaborates with EPIC on injury prevention activities, including local training programs, SIDS and the Child Death Review Team, SAFE-KIDS California Advisory Committee, the Strategic Coalition on Traffic Safety, and the Battered Women Shelter Program.

/2010/MCAH and EPIC are working together to address Electronic Death Recording System data issues related to Shaken Baby Syndrome and SIDS. MCAH and EPIC also collaborated on participation in the National Center for Child Death Review's May 2009 "Keeping Kids Alive" symposium.//2010//

Birth Defects Monitoring Program

Coordination between MCAH/OFP and the California Birth Defects Monitoring Program (CBDMP) is essential to California's efforts to reduce birth defects. CBDMP is recognized worldwide for the quality and scope of its birth defects surveillance data and its research to identify causes of birth defects. Title V partially funds birth defects surveillance in 5 California counties.

/2008/By act of the California State Legislature, CBDMP was moved from the CDHS Prevention Services Branch to the MCAH/OFP Branch in January 2007. The 2006 legislation expands capacity to discover causes, develop prevention strategies, and increase surveillance of birth defects and genetic diseases throughout the State.//2008//

/2010/MCAH provided input on new CBDMP congenital anomaly fact sheets.//2010//

Office of Audits and Investigations

MCAH/OFP work closely with the CDHS Audits and Investigations Division to ensure the integrity of MCAH/OFP programs.

Primary Care and Family Health Division (PCFH)

In addition to the MCAH/OFP and CMS Branches, there are three other branches in the PCFH Division of CDHS: Genetic Disease Branch (GDB), Primary and Rural Health Care Systems Branch (including the Indian Health Program), and WIC. MCAH/OFP and CMS work closely with all of these.

/2008/CDHS was reorganized into two departments effective July 2007. The CMS Branch will be in the Department of Health Care Services, and MCAH/OFP, GDB, and WIC will be in the California Department of Public Health (CDPH). In the new CDPH, there will not be a PCFH Division; the MCAH/OFP, GDB, and WIC Branches will be in the Center for Family Health.//2008//

Genetic Disease Branch
/2009/Genetic Disease Screening Program (GDSP)//2009//

CCS provides services for conditions identified on newborn screening tests, develops standards, and approves Metabolic, Endocrine, and Sickle Cell Special Care Centers (SCCs) for treatment. MCAH is working with GDB on a campaign to educate women about pre-pregnancy folate use.

/2009/MCAH collaborates with GDSP on infant feeding questions on the Newborn Screening (NBS) Program test form. MCAH uses infant feeding data as a key indicator for hospital quality assessments.//2009//

/2010/GDSP presented information on Prenatal Screening Program expansion at various MCAH statewide meetings.//2010//

GDB services such as newborn, prenatal and Tay Sachs screening are provided by contracted private providers. GDB enforces quality standards via contract requirements or regulations, monitors quality standards for Rh testing, genetic counseling and mandated laboratory reporting of cytogenetics, and engages in research to develop new or improved tests.

/2007/The NBS Program expanded in 2005 to include congenital adrenal hyperplasia and other inborn errors of metabolism. The CMS Branch works closely with GDB to ensure infants with abnormal endocrine, metabolic and sickle cell screening results receive expeditious diagnostic evaluations and treatment.//2007//

/2008/CMS participates in both the Endocrine and Genetic Specialty statewide meetings, at which CCS issues are discussed and solutions proposed. As the NBS Program expands to include Cystic Fibrosis and Biotinidase Deficiency testing beginning August 2007, the CMS Branch will work with GDB to ensure that infants with abnormal screening results receive expeditious diagnostic evaluations and treatment.//2008//

/2009/CMS continues participation in the NBS Program's Endocrine and Genetic Specialty statewide meetings. CMS and GDSP worked together in 2008 to develop a CCS Policy Letter and a letter to the Metabolic and Pulmonary SCCs regarding authorizations and expediting referrals for newborns screening positive for Cystic Fibrosis or Biotinidase Deficiency.//2009//

/2010/Expedited authorizations for babies screening positive for endocrine and metabolic disorders may face delays due to CCS staffing cuts.//2010//

Women, Infants & Children (WIC) Supplemental Nutrition Branch

MCAH/OFP and CMS collaborate with WIC in a variety of areas, including improvement of prenatal care, linkages between MCAH/OFP and WIC data files, obesity prevention, oral health, childhood injury prevention, and breastfeeding.

/2008/Another area of collaboration is ensuring children's access to healthcare by referring families to CHDP if not enrolled in healthcare.//2008//

/2009/MCAH and WIC collaborate to develop an 8-hour web-based hospital administrator training curriculum, legislated by Senate Bill 22.//2009//

Staff from MCAH/OFP, CMS, and WIC meet quarterly for nutrition coordination meetings. CMS ensures that PedNSS data are available to WIC local agencies and assists with data interpretation.

/2008/WIC added the PedNSS link to its webpage for local programs to access when developing their annual nutrition education plans.//2008//

/2009/CMS continues to provide local WIC agencies with current data from PedNSS and technical assistance on interpretation.//2009//

/2008/WIC participates in bimonthly CHDP Nutrition Subcommittee workgroup meetings.//2008//

/2010/CMS and MCAH collaborated with WIC on updating WIC food packages to ensure foods address the nutritional needs of women, infants and children and are consistent with the 2005 Dietary Guidelines for Americans. The modifications enhance the nutritional quality of foods available to WIC families, improve health outcomes, expand the cultural food options and overall food choices for WIC's diverse populations. CMS also collaborated on the regulations for medical providers. MCAH partnered with WIC to facilitate diffusion of the new information, with WIC presenting at MCAH statewide meetings.

WIC field-tested MCAH's revised folic acid pamphlets, and participated in a small-scale vitamin distribution program.

WIC, MCAH, California WIC Association, and the Nutrition, Physical Activity and Obesity Prevention Program are co-developing a California Breastfeeding Roundtable to develop and implement a breastfeeding strategic plan.//2010//

/2008/
Universities

MCAH/OFP and CMS work closely with the University of California and other universities in the state. Partnerships include the National Adolescent Health Information Center and the Bixby Center for Reproductive Health Research & Policy at UC San Francisco (UCSF), Stanford University (on CPQCC issues), and the Center for Injury Prevention Policy and Practice at San Diego State University (SDSU). The UCSF Family Health Outcomes Project (FHOP) provides consultation and training to local MCAH jurisdictions in monitoring and updating local 5-year plans, data collection, identification of data sources, data analysis and survey development. FHOP also provides consultation, data analysis, stakeholder meetings and interviews for the Title V Needs Assessment. UCSF conducts, analyzes, and reports on the Maternal and Infant Health Assessment Survey.

/2010/UCLA's Center for Healthy Children, Families and Communities participates in the

Statewide Screening Collaborative.

MCAH provides MPH student internships, and mentoring for students and physicians in training.//2010//

Through the Advanced Practice Nursing (APN) Program, MCAH/OFP funds nine California universities to maintain accredited advanced and midlevel nursing programs. Participating universities provide clinical preceptorships in medically underserved areas and provide MCAH/OFP with program evaluation data.

/2008/There are now 8 APN programs. One university hospital terminated its contract.//2008//

/2009/The MCAH Program contracted with the UCSF Center on Social Disparities in Health to assess Black Infant Health (BIH) Program services. UCSF's recommendations will serve as a foundation to develop a standardized intervention and evaluation plan to measure the program's impact on African Americans in the 17 BIH jurisdictions.//2009//

/2010/UCSF is helping revise the BIH Program; revised language for CHDP's Health Assessment Guidelines; and helps coordinate SECCS activities.//2010//

CMS has two contracts with SDSU Institute for Public Health (IPH) beginning in FY 2005-06, one being a project to analyze CCS/Healthy Families expenditures and determine how they compare to the expenditures for the other CCS subgroups.

/2008/The SDSU IPH completed the data analysis, and a final report will be completed in the coming year.//2008//

/2009/The final report was received from SDSU IPH. The sharp increase in CCS/Healthy Families expenditures was due to delays in claims submitted or paid. In FY 2002-03, more than 60% of expenditures were for services provided in previous years (compared to a 15-38 percent lag in claims payment in the prior years). //2009//

The second contract involves developing a Quality Improvement Initiative for CCS eligible clients. CMS and SDSU IPH plan to facilitate two quality improvement collaboratives at the children's hospitals and university medical centers. One initiative will focus on reducing nosocomial infections in the NICU, and the second will focus on improving the outpatient care for children with either Type 1 or Type 2 diabetes.

/2008/CMS, SDSU IPH, and the California Children's Hospital Association implemented the Neonatal Quality Improvement Initiative (NQI) with 13 hospitals throughout the state. The focus of the initiative is to reduce catheter-associated blood stream infections in the NICU. Each facility collected baseline data by birthweight category, and reviewed the toolkit on preventing nosocomial infections developed by the CPQCC. Each site selected areas of neonatal care they wanted to address in their units, such as hand washing or closed line systems. With the NQI ending its initial term, the group is discussing whether to continue focus on blood stream infections, change focus to another area (such as ventilator-associated infections), or disseminate the current best practices to other CCS-approved NICUs.//2008//

/2009/The 13 hospital collaborative reduced catheter-associated blood stream infections (CABSI) by 29 percent in all weight groups during its first year, translating to a savings of $3 million. The collaborative expanded to include all 22 CCS-approved regional NICUs. NICUs are selecting one or more special interest groups to address antibiotic use, vascular access devices, use of checklists and root cause analysis, infections in surgical patients, and ventilator-associated pneumonia.//2009//

/2010/The CABSI NICU Collaborative is ongoing.//2010//

California District of the American Academy of Pediatrics (AAP)

/2007/CMS collaborated with the AAP to develop guidelines for local CCS programs regarding the definition of a "medical home" and authorization of pediatricians and other primary care providers to provide these services for CSHCN.//2007//

/2008/Additional partnering activities will be initiated with the upcoming expansion of the Newborn Hearing Screening Program (NHSP).//2008//

Four AAP Chapter Champions for NHSP participate in local and statewide forums to educate hospitals, pediatricians, families and service providers on newborn hearing screening issues and the need for medical homes.

/2008/There are quarterly conference calls with the state NHSP staff. The Chapter Champions were instrumental in the passage of the 2006 NHSP expansion legislation, and one participates on the California team for the National Initiative for Children's Healthcare Quality learning collaborative to improve the rate of lost-to-follow-up from the NHSP.//2008//

/2009/ Quarterly conference calls between the AAP Chapter Champions and the state NHSP staff continue. Two Chapter Champions participated in the national Early Hearing Detection and Intervention meeting in 2008. One continues to be an active participant in the NHSP quality improvement learning collaborative. //2009//

/2010/SECCS worked with AAP on the ABCD Screening Academy.//2010//

California Association of Neonatologists (CAN) and Stanford University

/2007/CMS and MCAH/OFP work with these groups on a perinatal and neonatal morbidity and mortality reporting system that provides information on quality of care, and serves as a basis for quality improvement in participating hospitals. Approximately 80% of CCS-approved NICUs submit CCS data through CPQCC, with the anticipation that all 114 CCS-approved NICUs will for CY 2006. CCS continues to work with CAN through the CMS NICU Technical Advisory Committee and representation of CMS on CAN's Executive Board.//2007//

/2008/CMS and MCAH/OFP relationships with CAN and Stanford continue to strengthen. CMS participates in CAN/District IX Meetings. Both Branches are expanding collaboration with Stanford to improve statewide perinatal, maternal and neonatal quality care. All but one of 118 CCS-approved NICUs submitted CY 2006 data through CPQCC.//2008//

/2009/CMS continues to participate in CAN/District IX Board Meetings and annual conferences. Collaboration with Stanford and CPQCC expanded to High Risk Infant Follow-up data, and most recently a CPQCC/CCS Healthcare Associated Infection (HAI) Quality Improvement Collaborative involving 20 Community Level NICUs working to reduce CABSIs.//2009//

/2010/CMS continues to collaborate with Stanford and CPQCC on NICU and HRIF data collection and the HAI QI project, and on a new breastmilk nutrition QI collaborative.//2010//

Children's Specialty Care Coalition

The Children's Specialty Care Coalition is an organization of pediatric specialty and subspecialty providers practicing at CCS-approved tertiary hospitals and SCCs.

/2007/CMS works closely with the Coalition as part of the Title V Strategic Planning process to identify and resolve programmatic issues, assist with successful adoption and use of the web-based CCS authorization system, and advocate for children's services.//2007//

/2008/Representation from the Coalition continues at stakeholder meetings for the Title V strategic planning and implementation process. The Coalition was one of the sponsors of the CCS Best Practices Conference 2006. CCS staff and others involved with CCS from children's hospitals, physician offices, and SCCs came together to learn new ways to improve business practices related to CCS, and identify and discuss issues pertaining to authorizations and claims.//2008//

/2009/The Coalition continues to be a stakeholder at Title V strategic planning and implementation meetings, and provided input into a CCS Outpatient SCC Policy Letter introduced in January 2008 to clarify SCC billing issues.//2009//

California Conference of Local Health Officers (CCLHO)

CMS works with CCLHO on issues related to county program operations for CSHCN, preventive health services for children, and the CMS Net Data system. MCAH/OFP leadership participates in ongoing activities and committees of the CCLHO.

California Children's Hospital Association (CCHA)

/2007/The Children's Hospitals are vital providers of services to children in the CCS program. CMS works closely with hospitals in the Title V Strategic Planning Process; develops quality improvement initiatives; assists with adoption and use of the web-based CCS authorization system; and advocates for children's services.//2007//

CMS collaborated with CCHA and the California Medical Assistance Commission (CMAC) on developing hospital payment and policy for inhaled nitric oxide therapy in neonates and for botulism immune globulin.

/2008/In collaboration with CCHA, CMS is sponsoring a Neonatal Quality Improvement Initiative. The eight Children's Hospitals, four University of California Hospitals and Sutter Memorial Hospital are participating in a 9-month effort to reduce CABSIs.//2008//

/2010/CMS collaborates with CCHA in the NQI, which includes all 22 Regional NICUs.//2010//

Other Professional Organizations

CMS collaborates with the California Dental Association, the California Association of Orthodontists, the Oral Health Access Council, the California Orthopedic Surgeons Association, the California Association of Home Health Agencies, and the Hemophilia Council and Foundations to improve working relationships, recruit providers, and address barriers to access to services.

/2007/CMS also collaborates with the California Association of Ophthalmologists to improve provider recruitment and address access barriers.//2007//

/2008/CMS is collaborating with the California Association of Medical Products Suppliers (CAMPS) to identify best practices for access to medical supplies and durable medical equipment (DME) for CCS clients discharged from inpatient hospital settings.//2008//

/2009/CMS continues to meet with CAMPS and Medi-Cal Benefits Branch to address obstacles for children and their families to receive necessary medical supplies and DME. CMS works with Medi-Cal to reimburse providers for medical supplies and low cost DME without a product specific CCS Service Authorization (SAR). CMS is developing a Service Code Grouping for hospital discharge that will contain home health codes and frequently used medical supply codes.//2009//

/2008/CMS is collaboratiing with the Children's Hospice and Palliative Care Coalition to develop a federal Medicaid waiver to allow CCS clients to access 'hospice-like' services while still receiving treatment services for their eligible conditions. There are 60 members of the stakeholder group providing input into the waiver design and development, including representatives from the Children's' Hospitals, University of California hospitals, Children's Specialty Care Coalition, hospices and home health agencies.//2008//

/2009/CMS met with stakeholder groups and County CCS offices to review progress on the waiver development and seek feedback. The waiver application was submitted in May 2008.//2009//

/2010/The Palliative Care Waiver was approved by Federal Centers for Medicare and Medicaid Services with a start date of July 1, 2009.

SECCS partners with many others through the Statewide Screening Collaborative, including First 5, the California Academy of Family Physicians, the California Association of Health Plans, and the Advancement Project.

MCAH contracts with the California Adolescent Health Collaborative (CAHC) to support local health jurisdictions' efforts on adolescent health.

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

MCAH and CMS are involved in strategic planning for California's CDC-funded Nutrition, Physical Activity and Obesity Prevention Program.//2010//

Managed Care Plans

There is ongoing collaboration between CMS and the California HealthCare Foundation, Family Voices and the Children's Regional Integrated Service System (CRISS) on the CSHCN medical home project, and statewide issues with the carve-out of CCS services in Medi-Cal and HF managed care plans.

/2010/Medi-Cal Managed Care, the Department of Managed Health Care and MRMIB are key partners in the Statewide Screening Collaborative.//2010//

F. Health Systems Capacity Indicators

Introduction

This section covers the following Health Systems Capacity Indicators for California:

1) Rate of asthma hospitalizations among children (age < 5 years);

2) Percent of Medicaid enrolled children (age < one year) who received at least one EPSDT health assessment;

3) Percent of SCHIP enrolled children (age < one year) who received at least one EPSDT health assessment;

4) Percent of women (age 15-44) with a live birth whose observed to expected prenatal visits were greater than or equal to 80 percent on the Kotelchuck Index;

5) Comparison of health system capacity indicators for Medicaid and non-Medicaid populations;

6) Percent of poverty for eligibility in Medicaid and SCHIP Programs for infants, children, and pregnant women;

7) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program, and Percent of EPSDT eligible children (age 6-9 years) who received any dental services;

8) Percent of SSI beneficiaries (age < 16 years) who received rehabilitative services from the State CSHCN Program; and

9) Data capacity, including general MCH data capacity and capacity for monitoring adolescent tobacco use.

Please note that in California, the Medicaid Program is called Medi-Cal; the State Children's Health Insurance Program (SCHIP) is called Healthy Families; the Early and Periodic Screening component of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is called the Child Health and Disability Prevention (CHDP) Program.

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

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	30.6	24.6	24.3	22.8	22.8
Numerator	7905	6458	6559	6186	
Denominator	2582390	2630401	2698813	2710425	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2007. Primary diagnoses of each discharge abstract were tabulated, secondary diagnoses were not included. Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050.

Sacramento, California, July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006-2007 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 35.1; 2001 = 32.8; 2002 = 33.6; 2003 = 31.6; 2004 = 29.6; 2005 = 23.9

Notes - 2006
Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2006. Primary diagnoses of each discharge abstract were tabulated, secondary diagnoses were not included. Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 35.1; 2001 = 32.8; 2002 = 33.6; 2003 = 31.6; 2004 = 29.6; 2005 = 23.9

Narrative:
The child asthma hospitalization rate decreased to 22.8 in 2007, continuing its decline. In prior years, the rate had steadily decreased from 33.6 in 2002 to 24.3 in 2006. Nationally, asthma prevalence increased between 1980 and 2002 for children and adults [48, 49]. Since 2005, California has consistently achieved the Healthy People 2010 objective of 25 hospitalizations per 10,000 children under age 5.

HSCI-1 data are based on primary diagnoses codes in 2007 hospital discharge data. Changes in this indicator may involve many factors not discernible from hospitalization data alone. National guidelines for asthma prevention emphasize that asthma is an inflammatory disorder of complex etiology involving interaction between genetic heritability, environmental exposures, and immunology across the life course. [50]

Efforts to address child asthma in the state are guided by the California Asthma Public Health Initiative (CAPHI) sponsored by the CDPH Chronic Disease Control Branch. CAPHI's mission is to improve the quality of life for all children and adults with asthma through implementation of effective programs and policies in asthma education, management, and prevention. CAPHI seeks to reduce preventable asthma morbidity and mortality, and to eliminate disparities in asthma practices and outcomes through coordinated approaches and partnerships with communities, state and local organizations, health care providers, health departments, foundations, and academic institutions.[51] CAPHI engages in the following activities:

1) Maintaining a state website linking information about various asthma programs within state government. [52]

2) Supporting the California Interagency Asthma Interest Group (CIAIG), which promotes collaboration and cooperation among state agencies and programs related to asthma.

3) Collaborating with other stakeholders to create and promote resources including: Guidelines for the Management of Asthma in California Schools; Asthma Action Plan for Schools and Families; Best Practices for Communicating Air Quality and Related Health Information to Schools; Better Asthma Care for California Kids (for health care providers); and Asthma Care Training for Child Care Providers.

4) As of January 2007, funding 18 local agencies under the program entitled, Best Practices in Childhood Asthma (BPCA): Community-Level Effective Interventions for Reducing and Eliminating Asthma Morbidity and Disparities in Children. The program aims to improve the quality of clinical care, reduce asthma morbidity, and reduce asthma health disparities for California children ages 0 through 18. BPCA is funded by an appropriation from the Cigarette and Tobacco Products Surtax Fund (Proposition 99). The program ended on June 30, 2008. [53]

Recent accomplishments of CAPHI include convening the Asthma Disparities Summit in February 2007, and development of a Strategic Plan for Asthma in California for 2008-2012, officially released in April 2008. This new plan was developed through a detailed process beginning in 2006, with collaboration and input from asthma experts, agency partners, and stakeholders throughout the state. Many state agencies are involved in the new plan, including CDPH, DHCS, Emergency Medical Services Authority, Department of Education, Department of Social Services, Environmental Protection Agency, Air Resource Board, and the Occupational Safety and Health Administration. Building on the substantial achievements of the 2002 plan, recommendations are intended to mobilize individuals and organizations to collectively take clearly defined, comprehensive, and coordinated action over the next five years. The new plan highlights five cross-cutting priorities for action: eliminating asthma disparities; providing education and awareness; focusing on asthma across the lifespan; creating institutional and systems change; and promoting effective asthma policies. These were addressed under five updated plan goal areas: 1) Implementation, monitoring, and evaluation; 2) Surveillance and Research; 3) Health Care; 4) Indoor Environment; and 5) Outdoor Environment. [54]

California Breathing, a program of the California Department of Public Health's Environmental Health Investigations Branch, released a surveillance report in June of 2007, "The Burden of Asthma in California." This was the first comprehensive presentation of California asthma data. [55]

On December 10-11, 2008 California Breathing and the American Asthma Foundation hosted a two-day summit in San Francisco highlighting the latest in asthma research. The summit brought together asthma stakeholders from across the nation to discuss the most current findings in asthma etiology and identify gaps and future directions for research.

California Breathing and its strategic partners at the National Center for Healthy Housing will hold a symposium entitled "Healthy Housing for California: Reducing the Burden of Asthma and Other Health Impacts" on June 16-17, 2009 in San Francisco. This symposium will bring together professionals and advocates in the fields of housing, health, policy, code enforcement, legal assistance, property management, community development and green building to discuss the link between health and housing, especially as it relates to asthma and efforts to reduce health disparities.

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

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	66.3	73.7	71.3	82.5	82.5
Numerator	418190	455151	460738	580680	
Denominator	630754	617571	646633	703949	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Manual indicator for 2008 is based on 2007. 2008 data will be available in March 2010.

Notes - 2007
This measure is the percent of Medi-Cal enrolled children less than one year of age who received at least one CHDP service in the reporting year.
Source is CHDP program data and State Medi-Cal claims files.
Numerator is the number of children under one year of age enrolled in Medi-Cal who received at least one CHDP service in FY 2006 -2007
Denominator is the unduplicated number of children under one year of age enrolled in Medi-Cal in FY 2006-2007.

Notes - 2006
This measure is the percent of Medi-Cal enrolled children less than one year of age who received at least one CHDP service in the reporting year.
Source is CHDP program data and State Medi-Cal claims files.
Numerator is the number of children under one year of age enrolled in Medi-Cal who received at least one CHDP service in FY 2005 -2006
Denominator is the unduplicated number of children under one year of age enrolled in Medi-Cal in FY 2005-2006.

Narrative:
Health Systems Capacity Indicator 02 (HSCI-02) is the percent of Medi-Cal enrolled children less than one year of age who received at least one CHDP health assessment in the reporting year. In FY 2006-07, HSCI 02 was 82.5 percent, an increase of 15.4% from FY 2005-06. The denominator--unduplicated Medi-Cal enrolled children less that one year of age (703,949 for FY 2006-07)--has increased by 8.9% since 2005-06. The continued increase in this indicator is most likely due to CHDP Gateway pre-enrollment and infant deeming.

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

Quarterly meetings between CHDP programs and MCMC plans are occurring in some counties and less frequently in other counties. Though funding for the CA Medical Home Project has ended and therefore this specific ongoing collaboration with MCMC plans has stopped, there have been opportunities to collaborate with MCMC through the Statewide stakeholder group (with MCMC representation) developing a strategic plan for the state priorities for CYSHCN identified through the Needs Assessment process and implementing that plan. The CMS Branch continues to collaborate with MCMC plans on statewide operational problems that occur with the carve-out of CCS services in Medi-Cal and HF managed care plans.

The CHDP Gateway pre-enrollment process and infant deeming appear to be having the greatest effect on this performance measure. In August 2007, the California HealthCare Foundation (CHCF) funded a study of the CHDP Gateway. Through interviews, site visits, focus groups and an analysis of program data collected from October 2005 to September 2006 the study

highlighted program successes, best practices and recommendations for strengthening the Gateway two years after implementation. The study found that more than one-third of the 600,000 children who went through the CHDP Gateway in 2005-2006 were under the age of one. It highlighted the effectiveness in pre-enrolling large numbers of children, giving them temporary Medi-Cal coverage. A notable challenge mentioned was the concern of achieving continuous coverage for eligible clients, due to the elevated number of families not returning the requested joint application. Recommendations included technological and policy changes to improve follow-up, as well as improved training, coordination and outreach. Local CHDP programs continue to provide education, training and outreach to CHDP provider office staff and the community in order to assist the number of eligible children into health care.

California has made a strong commitment to reducing the number of uninsured children and ensuring access to healthcare services for children. MCAH Division programs, such as the Adolescent Family Life Program, Black Infant Health Program and Comprehensive Perinatal Services Program screen and assess children and adolescents for Medi-Cal eligibility and assist them in obtaining services.

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

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1	1	1	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data is not availble for analysis.

Notes - 2007
Data is not availble for analysis.

Notes - 2006
Data is not available for analysis.

Narrative:
Health Systems Capacity Indicator 03 (HSCI-3) is the percent of Healthy Families (HF) enrollees under one year of age who received at least one CHDP health assessment. These data are not available. HF plans do not conduct CHDP health assessments, but instead perform preventive examinations based on the American Academy of Pediatrics guidelines. The HF Program relies on the Health Plan Employer Data and Information Set (HEDIS) to evaluate the performance of the health plans.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	78.5	78.4	78.7	78.6	79.0
Numerator	413004	422294	434411	427600	416314
Denominator	526090	538752	552317	544255	527150
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Observations with missing values were subtracted from the denominator when calculating the percents shown.

Notes - 2007
Source: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Observations with missing values were subtracted from the denominator when calculating the percents shown.

Notes - 2006
Source: State of California, Department of Public Health, Center for Health Statistics, 2006 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Observations with missing values were subtracted from the denominator when calculating the percents shown.

Narrative:
Health Systems Capacity Indicator 04 (HSCI-4) is the percent of women ages 15 to 44 with a live birth during the year whose observed to expected prenatal visits are at least 80 percent on the Kotelchuck Index. This index considers the mother's timing of initiation of prenatal care and the number of prenatal care visits recommended by the American College of Obstetricians and Gynecologists.

In 2007, 78.6 percent of California women received adequate prenatal care, essentially unchanged from the prior four years. The rate was 58.7 percent in 1989. [56] While California has made much progress, the 2007 rate is still considerably lower than the national Healthy People 2010 goal of 90 percent. Race/ethnicity data indicate that moderate disparities exist. In 2007 the indicator ranged from a low of 65.1 percent for Pacific Islanders to a high of 82.1 percent for Asians. Whites (81.9) Hispanics (76.7) and African Americans (74.9) are closer to the upper end of the range.

Local MCAH programs perform outreach, client education and case-finding functions, including a toll-free telephone information service and targeted activities designed to assist high risk MCAH populations in receiving early and continuous prenatal care. Programs also provide critical social support services, case management and client follow-up.

Local Adolescent Family Life Programs (AFLP) use public service announcements, radio talk shows, home visitation, and individual follow-up with pregnant women to educate clients and stakeholders on the importance of prenatal care. Regional AFLP representatives meet to discuss strategies for improving prenatal care utilization.

A primary goal of the Black Infant Health program (BIH) is to increase the number of African American women receiving adequate prenatal care. BIH increases community awareness about black infant morbidity and mortality through street outreach, health fairs, provider coordination, presentations to community groups, church partnerships and media campaigns; and enhances prenatal care through the provision of case management and social support. This year several Bay Area BIH programs pooled their resources to conduct a successful awareness campaign on cable TV. Some programs provide transportation to prenatal visits if resources permit.

MCAH and local BIH staff developed a new draft model for all BIH sites, which will be piloted in 2009. The new model will ensure that BIH provides standardized services based on best practices, and will include an evaluation component to assess effectiveness in meeting program goals.

The Comprehensive Perinatal Services Program (CPSP) provides statewide support to obstetrical service providers to enable them to provide comprehensive prenatal care that includes clinical services, nutrition assessment, health education and psychosocial support. Prenatal care providers receive a financial incentive to initiate prenatal care in the first trimester of pregnancy.

The Women, Infants and Children (WIC) program in California serves 1.4 million women, infants, and children in California by providing checks for wholesome supplemental food. Local MCAH programs partner with WIC to provide prenatal care referrals to WIC clients.

Other state programs that support improvements in adequate prenatal care through direct and indirect delivery of services and support include the American Indian Infant Health Initiative (AIIHI) in the Department of Health Care Services and the Access for Infants and Mothers (AIM) Program in the Managed Risk Medical Insurance Board.

AIIHI addresses the high American Indian infant mortality rate by providing home visiting and case management services to high-risk Indian families in the five California counties with the most severe Indian MCH disparities. The program provides health education and connects families with resources including prenatal care.

AIM offers low-cost health prenatal care coverage for pregnant women. AIM is for families with incomes between 200 and 300% of federal poverty level who do not have Medi-Cal or other insurance, or who have health insurance with a deductible or co-payment for maternity services that is more than $500. Local MCAH programs refer eligible women to AIM as well as Medi-Cal or other insurance.

Prenatal care is critically important for the health of the fetus and the mother. However, prenatal care should not be viewed as a separate entity from preconception and interconception care, but rather part of a continuum of care and one that requires greater service integration. Most risk factors, such as chronic medical conditions, tobacco use, alcohol use, and obesity, are present before conception occurs. Since any woman of reproductive age may become pregnant, providing high quality health care to maximize the health of all women of reproductive age is also likely to improve the health of mother and fetus should a pregnancy occur.

MCAH convened the Preconception Health Council of California (PHCC) in 2006 to encourage providers to address risk factors before pregnancy and educate women of childbearing age about preconception health, including reproductive life planning in order to reduce unintended pregnancy, which contributes to delayed entry to prenatal care. Representatives from MCAH

actively participate on the PHCC. The Council plays a pivotal role in relaying the message of the importance of reproductive life planning and preconception health promotion to local communities.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	90.0	87.9	92.4	98.7	98.7
Numerator	3276077	3236633	3644145	4400662	
Denominator	3641413	3680740	3945697	4459912	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Numerator: All persons 1 to 21 years of age who received a service paid by the Medi-Cal program during the Federal fiscal year: October 2006-September 2007 (this is an unduplicated count), including both Fee-for-Service and Managed Care beneficiaries, as well as certified and uncertified beneficiaries (i.e., those who shared a cost for their care). Source: Fiscal Forecasting and Data Management Branch, California Department of Health Care Services.

Denominator: Consists of the sum of two indicators: (1) An estimate of uninsured children (1-21 years old) eligible for Medi-Cal. Source: 2007 California Health Interview Survey http://www.chis.ucla.edu/main/DQ2/easy/output.asp; (2) All persons 1 to 21 years of age who were enrolled in Medi-Cal at the end of the Federal fiscal year: September 2007 count. Source: Fiscal Forecasting and Data Management Branch,, California Department of Health Care Services.

Note: Data prior to 2004 should not be compared because of the change in methodology beginning in 2004.

Notes - 2006
Numerator: All persons 1 to 21 years of age who received a service paid by the Medi-Cal program during the Federal fiscal year: October 2005-September 2006 (this is an unduplicated count), including both Fee-for-Service and Managed Care beneficiaries, as well as certified and uncertified beneficiaries (i.e., those who shared a cost for their care). Source: Medical Care Statistics Section, California Department of Health Care Services.

Denominator: Consists of the sum of two indicators: (1) An estimate of uninsured children (1-21 years old) eligible for Medi-Cal. Source: 2005 California Health Interview Survey http://www.chis.ucla.edu/main/DQ2/easy/output.asp; (2) All persons 1 to 21 years of age who were enrolled in Medi-Cal at the end of the Federal fiscal year: September 2006 counts. Source:

Medical Care Statistics Section, California Department of Health Care Services.

Note: Data prior to 2004 should not be compared because of the change in methodology beginning in 2004.

Narrative:
Health Systems Capacity Indicator 07a (HSCI-7a) is the percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program. HSCI-7a (formerly National Performance Measure 14), was 98.7 percent in 2007, higher than the rate reported for the past three years.

California has made a strong commitment to reducing the number of uninsured children in California and ensuring access to healthcare services. Activities have included:

1) Support of streamlined Medi-Cal eligibility processes that encourage continuous coverage;
2) Support for MCAH and OFP programs such as AFLP, BIH, BWSP, and CPSP to screen and assess children and adolescents for Medi-Cal eligibility and assist them in obtaining needed services;
3) Public education media campaigns and other community education efforts to encourage eligible families to obtain medical services, such as family planning, well child care, prenatal care, childhood immunizations, and dental care; and
4) Facilitation of the provision of Medi-Cal paid prenatal care services to adolescents by providing financial incentives to prenatal care providers.

Prior to and after launching the CHDP Gateway, many changes in policies and procedures at the state, local, and provider level have occurred. The CHDP local program staff serve an important role in recruiting and enrolling new providers, and assisting and encouraging established providers about the CHDP program, including the Gateway, and provision of preventive services for children from families with incomes at or below 200 percent of the FPL. A Provider Manual and a Local Program Guidance Manual are available online to assist providers and local programs. The Local Program Guidance Manual was developed for use by local program staff to ensure statewide standardization of the CHDP provider requirements for participation in the CHDP program. The Provider Manual is an up-to-date resource for program responsibilities, policy, eligibility and billing. Local CHDP programs and their health departments assist children and their families to access preventive health examinations through health fairs and interagency agreements with WIC and Head Start. Local CHDP staff participate on the Head Start Advisory Board.

In 2006 the CHDP Program updated their Interagency Agreement with the U.S. Department of Health And Human Services, Region IX, Administration for Children and Families, Office of Head Start, Child and Youth Development Unit. Plans are being developed to engage local CHDP and Head Start programs in training around the Interagency Agreement and its impact on local programs.

The CHDP local program staff continues to recruit and enroll new providers utilizing the Local Program Guidance Manual as a resource. Providers and their sites are assessing using the new Facility and Medical Review Tools contained in the Local Program Guidance Manual. The CHDP Health Assessment Guidelines for CHDP providers are undergoing revision. Methods to provide family-centered care and culturally competent care are being interwoven throughout the manual. There will be continuing CHDP collaboration with schools, Head Start and providers in order to assist more low-income children to receive preventive exams.

The MCAH Division allocates funds annually to support local MCAH programs that are developed, operated and managed by Local Health Jurisdictions (LHJs) throughout California. There are 61 LHJs funded to accomplish the MCAH Program mission and goals, which include

assuring access to quality health care services for pregnant women and children, with a special focus on low--income populations. Several LHJs, such as, Humboldt County and Mendocino County, have developed local initiatives that assist families with uninsured children to enroll in government funded health insurance programs or pay for health insurance costs for children who are not eligible for government funded programs. The San Diego Kids Health Assurance Network (SD-KHAN) Community Collaborative assisted the local Medi-Cal program in the development of educational materials to inform Medi-Cal eligible clients about the new citizenship verification requirements for Medi-Cal enrollment. Additionally, LHJs perform a wide variety of community outreach activities in multiple venues to facilitate enrollment in Medi-Cal and educate target populations about Medi-Cal services.

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

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	37.8	44.2	41.1	43.0	43
Numerator	352522	353166	344152	357212	
Denominator	933287	798779	838216	830868	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Manual indicator for 2008 is based on 2007. 2008 data will be available in March 2010.

Notes - 2007
This measure is the percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.
Source is the revised HCFA-416 Form, element numbers 1 and 12a.
Numerator is the revised HCFA-416 Form element number 12a for FY 2007-08.
Denominator is the revised HCFA-416 Form element number 1 for FY 2007-08.

Historical Information:
Medical Care Statistics had been providing the numerator and denominator for this performance measure until FY 2003-04 when the numerator and denominator began being provided by Medstat using the Management Information System/Decision Support System (MIS/DSS) data base. The performance measure for FY 2004-05 can be compared with FY 2003-04, but not with prior years.

Notes - 2006
This measure is the percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.
Source is the revised HCFA-416 Form, element numbers 1 and 12a.
Numerator is the revised HCFA-416 Form element number 12a for FY 2006-07.
Denominator is the revised HCFA-416 Form element number 1 for FY 2006-07.

Historical Information:
Medical Care Statistics had been providing the numerator and denominator for this performance

measure until FY 2003-04 when the numerator and denominator began being provided by Medstat using the Management Information System/Decision Support System (MIS/DSS) data base. The performance measure for FY 2004-05 can be compared with FY 2003-04, but not with prior years.

Narrative:
Health Systems Capacity Indicator 07b (HSCI-7b) is the percent of EPSDT eligible children (CHDP in California) aged 6 through 9 years who received any dental services during the year. The goal of this indicator is to increase dental health services to Medi-Cal eligible children at an important stage of dental development. In FY 2007-08, HSCI-7B was 43%, a 4.6% increase from the prior year but a 2.7% decrease from FY 2005-06.

Beginning in FY 2003-04, the numerator and denominator for this measure have been provided by Medstat using the Management Information System/Decision Support System (MIS/DSS) data base. (Data from this source are not comparable to data provided for years prior to FY 2003-04.)

It is anticipated that CHDP tools such as the revised two-sided full color "PM 160 Dental Guide" that was first distributed in 2003 to all CHDP providers will continue to improve the quality of dental screenings and facilitate more precise referrals to a dentist. The CHDP program made providers aware of a statewide training program to address early childhood caries through the First 5 California Initiative. CHDP encouraged medical providers to attend one of the local trainings. First 5 trainings have been completed throughout the state and funding has ended. CHDP Dental Subcommittee members are currently looking for any other available trainings on dental screenings for CHDP providers.

Fluoride varnish application (3/year) was made a benefit of the Medi-Cal program and CHDP providers were informed of this new benefit and fluoride varnish application procedures. A brochure entitled, "Fluoride Varnish-- Helping Smiles Stay Strong" for providers to distribute to families is in the last stage of development. This brochure will be available for downloading on the Denti-Cal website. CHDP providers will be notified when this happens. There is currently work being done to encourage CHDP providers to refer children to a dentist around ages 6 and 12 for dental sealants.

Another brochure entitled, "Every Child Needs a Dental Home" is being developed by the CHDP Dental Subcommittee. It discusses: What is a child's dental home, why does your child need a dental home, when should you find a dental home for your child, tips for visiting your child's dental home, and how to find a dental home. This brochure will be available for downloading off the Denti-Cal website.

Current activities related to this indicator include: the CHDP Gateway covers dental services for pre-enrolled children for up to two months and has increased access to dental services for this group of children; the CHDP Gateway offers the opportunity for children to apply for permanent enrollment in Medi-Cal or HF with dental services as benefits. A survey of local programs was done to see how many dentists are accepting "Gateway" pre-enrollment receipts and providing dental services during this two month period. Only 17% of programs reporting were not usually able to get children dental services during this period. Also in this survey was a question to identify dentists who will see children under age 3; 75% of those responding indicated dentists had been identified who will see children under age 3.

The State Dental Hygienist Consultant in conjunction with the Dental Subcommittee of the CHDP Executive Committee continues to work on dental updates and revisions to other CMS publications to broaden the knowledge-base of providers, local program staff, families, and communities. There is currently a complete revision of the dental sections of the Health Assessment Guidelines and anticipatory guidance dental section to align with the Bright Futures dental guide. Changes specific to California's children are being added.

The Subcommittee has completed a final draft for a revised brochure on baby bottle tooth decay called, "Prevent Tooth Decay in Babies and Toddlers." This presents new knowledge of the parent/caregiver spreading the bacterial infection known to initiate dental caries to the child.

Simple to read instructions on prevention are included along with bright colors and photographs. This brochure will be available to download on the Denti-Cal website. The Subcommittee is currently working on a portfolio of information entitled "Oral Health Handbook and Resources for CHDP Providers" which includes such topics as transmission of bacteria, prenatal oral health, the age one dental referral, anticipatory guidance, a visual guide for screening infants and toddlers, caries risk factors assessment, fluoride varnish, xylitol, fluoride supplementation, eruption patterns and available resources. This manual is planned to be available on CD, and includes two power point presentations for the county staff to learn more about oral health and to use to train CHDP providers.

In conjunction with the "Handbook" the CHDP Health Education Subcommittee has prepared a document entitled, "Patient Oral Health Education: Resources for CHDP Providers." This resource will enable county CHDP staff to offer providers information and brochures on 23 different oral health topics. Another resource developed by the Bay Area Dental Subcommittee with guidance from the State Dental Hygienist Consultant is almost completed which is a resource for materials available for patient education for children ages 6 through 20.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	10.9	8.7	32.5	31.1	28.2
Numerator	8944	7318	27623	27058	25554
Denominator	82343	84235	85106	86914	90464
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

This measure is the percent of SSI beneficiaries through age 15 years receiving rehabilitative services through the CCS program. Source of data for the numerator is from CMS Net and CCS program data and for the denominator is from the publication: Social Security Administration Office of Policy, Children Receiving SSI.

Numerator: Children under 16 years of age enrolled in CCS with aid codes of 20 and 60 (disabled children with SSI) for FY 2007-08. Since active cases on CMS Net represent an estimated 72.3 percent of all active CCS cases for CA for FY 2007, the number with aid codes 20 and 60 from CMS Net is extrapolated for CA.

There is a large increase in the number of children with aid code 60 for FY 2005-06 which can not be explained but is more consistent with data in FY 2001-02 and FY 2002-03, and is more in line with what would be anticipated.

The denominator is from the Social Security Administration Office of Policy, Children Receiving SSI under 16 years of age for 2008.

Notes - 2007
This measure is the percent of SSI beneficiaries through age 15 years receiving rehabilitative services through the CCS program. Source of data for the numerator is from CMS Net and CCS program data and for the denominator is from the publication: Social Security Administration Office of Policy, Children Receiving SSI.
Numerator: Children under 16 years of age enrolled in CCS with aid codes of 20 and 60 (disabled children with SSI) for FY 2006-07. Since active cases on CMS Net represent an estimated 69 percent of all active CCS cases for CA for FY 2006, the number with aid codes 20 and 60 from CMS Net is extrapolated for CA.

There is a large increase in the number of children with aid code 60 for FY 2005-06 which can not be explained but is more consistent with data in FY 2001-02 and FY 2002-03, and is more in line with what would be anticipated.

The denominator is from the Social Security Administration Office of Policy, Children Receiving SSI under 16 years of age for 2007.

Notes - 2006
This measure is the percent of SSI beneficiaries through age 15 years receiving rehabilitative services through the CCS program. Source of data for the numerator is from CMS Net and CCS program data and for the denominator is from the publication: Social Security Administration Office of Policy, Children Receiving SSI.
Numerator: Children under 16 years of age enrolled in CCS with aid codes of 20 and 60 (disabled children with SSI) for FY 2005-06. Since active cases on CMS Net represent an estimated 63.6 percent of all active CCS cases for CA for FY 2005, the number with aid codes 20 and 60 from CMS Net is extrapolated for CA.

There is a large increase in the number of children with aid code 60 for FY 2005-06 which can not be explained but is more consistent with data in FY 2001-02 and FY 2002-03, and is more in line with what would be anticipated.

The denominator is from the Social Security Administration Office of Policy, Children Receiving SSI under 16 years of age for 2006.
This is the first year that data have been available for children less than 16 years of age, so no comparative data for previous years are available.

Narrative:
Health Systems Capacity Indicator 08 (HSCI-8) is the percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program. HSCI-8 is 28.2 percent for FY 2007-08, compared to 31.1 percent in the previous year. The numerator, 25,554 (27,058 FY 2006-07), is the number of open CCS cases under 16 years of age with aid codes of 20 and 60. The denominator, 90,464 (86,914 for FY 2006-07), is the percent of SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special HealthCare Needs (CSHCN) Program.

There have been several changes in how this indicator has been calculated over the last few years. The current methodology is as follows. The numerator is the number of children in the CMS Net system with eligibility aid codes of 20 or 60 (disabled children with SSI), most of whom will be receiving Medical Therapy Program (MTP) services. The number from CMS Net is then extrapolated to all counties. The denominator is from the Social Security Administration Office of Policy, Children Receiving SSI for December, the midpoint of the current fiscal year, for children under 16 years of age.

The CCS MTP provides physical therapy, occupational therapy, and Medical Therapy Conference (MTC) services to children who meet specific medical eligibility criteria. The majority of children have cerebral palsy. The children eligible for the MTP do not have to meet the CCS financial requirement to receive therapy or conference services through the MTP. Services are provided in a Medical Therapy Unit (MTU), an outpatient clinic setting that is located on a public school site. Coordination of services in the MTU is under the medical management of a physician/therapy team.

CMS has introduced a web-based software program for clinical documentation of MTP services called MTU Online. This software allows for single entry of identification data and narrative description by occupational and physical therapists and Medical Therapy Conference physicians that is compliant to Medi-Cal standards for Outpatient Rehabilitation Center certification and CCS Medical Therapy Program Guidelines.

Nineteen counties are actively using MTU Online as of January 2009. Another two to four counties are in the process of becoming equipped for MTU Online use. The software is version 6 and is close to being a complete electronic record. Users of MTU Online have found a decrease in the time needed for documentation of patient visits.

The CMS program introduced statewide outcome measurements for the MTP effective July 2004. Two tools developed for the MTP for program management were the (1) Functional Improvement Score (FISC), to measure the amount of functional change that a child achieves in a 6-12 month period, and the (2) Neuromotor Impairment Severity Scale (NISS), to measure the amount of neuromotor impairment for children with cerebral palsy or similar upper motor neuron conditions. The FISC was revised in 2005 (FISC II) and implemented statewide July 2005. FISC II has separated and expanded the number of functional activity items to include 20 mobility items specific for physical therapy and 20 self care items specific for occupational therapy. Statewide data from the FISC II and NISS continues to be collected annually. Those counties using MTU Online can easily submit aggregate data to the State. Analysis of the data is still under review for the purpose of program management and quality control. This is an ongoing process and will take several years to develop meaningful baselines and targets.

Data from FY 2007-2008 is currently being reviewed by the State Staff. The data demonstrates the effectiveness of the Medical Therapy Program. Going forward the data is expected to assist in program management and quality control.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2007	payment source from birth certificate	6.8	6.9	6.9

Notes - 2010

Source: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File. Expected payer source for delivery was used. Infants with missing birthweight were subtracted when calculating the percentages. Infants with missing payer source are included in the Total. Tabulations (by place of residence) were done by the MCAH Program.

Narrative:
Health Systems Capacity Indicator 05a (HSCI-5a) compares Medicaid and non-Medicaid in the percent of low birth weight (<2,500 grams) babies. In California, Medicaid is called Medi-Cal. Payment source data are obtained from birth certificates. Non-Medi-Cal payment sources include private insurance, self-pay, no charge, other government programs, and medically indigent.

The percent low birth weight babies was similar for Medi-Cal and non-Medi-Cal in 2007: 6.8 percent and 6.9 percent, respectively. These percentages were unchanged from 2006, and there were no striking differences by payor for any race/ethnic group. Neither population reached the Healthy People 2010 target of 5.0 percent.

MCAH Division programs, including CPSP, AFLP, BIH, and RPPC, work to decrease the incidence of low birth weight infants by providing at-risk women with comprehensive services including prenatal care, education, and psychosocial support.

CPSP is a voluntary program for pregnant Medi-Cal beneficiaries. More than 1,500 Medi-Cal obstetrical providers are approved to provide CPSP services, serving approximately 165,000 women annually. By providing Medi-Cal eligible women with comprehensive perinatal services, CPSP works to decrease the incidence of low birth weight. CPSP providers are eligible for early-entry-into-care and case coordination bonuses for each of their CPSP patients receiving assessments each trimester and the initial pregnancy office visit within four weeks of entry into care.

Pregnant adolescents are at increased risk of delivering low birthweight infants. A primary goal of AFLP is to improve birth outcomes for babies born to its adolescent clients, many of whom also receive Medi-Cal services. AFLP assists and encourages pregnant adolescents to access prenatal and other necessary health care early in their pregnancy, provides nutritional counseling, and works with teens to eliminate behaviors such as smoking and alcohol use, which can contribute to poor birth outcomes.

African American infants are twice as likely as infants of other racial/ethnic groups to be born at low birthweight in California. The BIH program identifies pregnant and parenting African American women at risk for poor birth outcomes and assists them in accessing and maintaining appropriate health care and other supportive services. BIH served more than 14,339 pregnant and parenting African American women, infants, and children in 2007. Many BIH clients also receive Medi-Cal services. BIH is active in 17 local health jurisdictions, which together account for over 90 percent of the state's African American births. [57] The new single core model, discussed above in HSCI-04, will incorporate the latest evidence-based approaches to decrease low birthweight in African American infants in California.

The MCAH Division and CMS Branch collaborate with the California Perinatal Quality Care Collaborative (CPQCC), which advocates for performance improvement in perinatal and neonatal outcomes. CPQCC has over 120 member hospitals, accounting for over 90 percent of the newborns requiring critical care in California. In 2007, the Perinatal Quality Improvement Panel (PQIP), a workgroup of the CPQCC, developed the Care and Management of the Late Preterm Infant Toolkit to assist hospitals in the care of infants 34 to 36 6/7 weeks gestation. The toolkit, available on the MCAH Division website in the Regional Perinatal Programs of California (RPPC) web page, is designed to enhance awareness and sensitivity to issues of transition, infection, nutrition, discharge readiness and parenting. Two of the RPPC Regions, Community Perinatal Network in Los Angeles and Orange County, collaborated on development of the Toolkit.

The fourteen RPPCs provide consultation to all delivery hospitals in California, using current statewide and hospital-specific outcomes data. The RPPCs support the implementation of clinical quality improvement strategies by collaborating with maternal and neonatal providers to address

evidence-based quality improvement projects and improve risk-appropriate care. They disseminate current perinatal literature and provide hospitals with clinical competency standards as well as published hospital standards of care.

MCAH Division staff actively participate on the Preconception Health Council of California (PHCC) which provides information, tools and resources to local communities about the importance of achieving optimal health for women before pregnancy as a new strategy for improving poor birth outcomes.

The MCAH Division and CMS collaborate with the March of Dimes on its multi-year Prematurity Campaign (2003-2010), the goal of which is to invest in research, education and community programs to identify the causes of prematurity and develop strategies to improve birth outcomes.

The MCAH Division and CMS also participate in the Premature Infant Health Coalition (PIHC), a public-private effort organized by March of Dimes California and MedImmune in late 2007 to help California reduce the rate of premature births and improve outcomes for children born prematurely and their families. PIHC is involved in a three-year gap analysis project gathering data and information about all aspects of prematurity in California including preconception issues, hospital issues, and long term care. Several MCAH Division and CMS staff presented at PIHC's California-focused Prematurity Policy Summit on June 1-2, 2009 in Sacramento.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2006	matching data files	5.7	4.5	5.2

Notes - 2010
Source: State of California, Department of Public Health, Center for Health Statistics, 2006 Birth Cohort file. Expected payer source for delivery was used to compute rates. Cases with missing payer source included in Total. Tabulations (by place of residence) were done by the MCAH Program.

Narrative:
Health Systems Capacity Indicator 05b (HSCI-5b) compares Medi-Cal and non-Medi-Cal on the infant death rate. Payment source data are obtained from birth certificates. Non-Medi-Cal payment source includes private insurance, self-pay, no charge, other government programs, and medically indigent.

The infant death rate was higher among Medi-Cal births (5.7 per 1,000) than among non-Medi-Cal births (4.5 per 1,000) in 2006. Both rates were lower than they had been in 2005, with the Medi-Cal rate declining most (from 6.0 per 1,000 in 2005). Over the past five years the infant death rate for the Medi-Cal population has fluctuated between 5.7 and 6.1 deaths per 1,000 live births, while the rate for the non-Medi-Cal population has slowly declined from 4.7 to 4.5 per 1,000 live births. The non-Medi-Cal population achieved the Healthy People 2010 goal of 4.5 per 1,000 for the first time in 2006.

The infant death rate was greater among Medi-Cal births than among non-Medi-Cal births for all

race/ethnic groups. This disparity by payor source is most apparent for Whites, for whom the infant death rate among Medi-Cal births (7.1 per 1,000) is nearly twice that for non-Medi-Cal births (3.8 per 1,000). Infant death rates are highest for African Americans, for whom the rates among Medi-Cal (12.2 per 1,000) and non-Medi-Cal (10.2 per 1,000) births are more similar.

Child Death Review Teams (CDRTs) are expanding their capacity to make recommendations to agencies and communities about how to prevent infant deaths and take findings to action. The Epidemiology and Prevention for Injury Control (EPIC) Branch of CDPH has completed a series of trainings for CDRTs to promote the recruitment of injury prevention specialists in order to strengthen their prevention recommendations.

The State Child Death Review Council created a prevention committee that has generated interest in prevention within CDRTs. The Safe Surrender Baby Law and remedies for unsafe sleeping environments and practices have been emphasized by CDRTs.

A goal identified in the CDPH Strategic Plan is to increase quality and years of healthy life, reduce disparities and promote health equity. The MCAH Division is taking the lead on the goal's proposed objective for reducing infant mortality. MCAH developed an action plan to directly address the persistent disparity between African American and White infant mortality rates.

The MCAH Program initiated the Black Infant Health/Fetal Infant Mortality Review (BIH/FIMR). The goal of BIH/FIMR is to reduce African American fetal and infant deaths through review of these deaths at the community level. Eight BIH jurisdictions were selected for participation; all had an African American combined fetal and infant death rate above the average for the 17 BIH jurisdictions statewide, and all had a FIMR program.

BIH/FIMR uses the National FIMR model to collect more detailed information about African American fetal and infant deaths than is available from vital statistics. Data are centrally collected and reportable at the state and county level. The program forms a partnership between FIMR and BIH and increases collaborative community involvement.

The FIMR Program in Contra Costa County has integrated preconception/interconception care information into the maternal interview. The interview is one component in the spectrum of case management and family support services offered to clients following a fetal or infant death.

Given its size and large number of birthing hospitals, the Los Angeles (L.A.) County uses a survey tool, the L.A. Health Overview of a Pregnancy Event (HOPE) to conduct its FIMR program. The survey questions are designed to focus on maternal behaviors and health system variables that can be addressed by public health interventions.

All MCAH programs have active and ongoing outreach to encourage pregnant women to seek early prenatal care. Many are also beginning to integrate preconception and interconception messaging into their services as a new strategy to prevent poor birth outcomes such as infant mortality. Outreach programs, such as Perinatal Care Guidance (PCG), provide assist women to enroll in private or public health insurance and find a medical provider for care throughout their pregnancy, provide follow-up to ensure continued access to care, and assist with issues that arise during the perinatal period.

Several MCAH programs focus on decreasing the incidence of infant mortality within California, including CPSP, AFLP, BIH, RPPC and the Preconception Health and Healthcare Initiative (PHHI). For more information, see the narrative for HSCI-5a.

From January to March 2007 the MCAH Program conducted a survey of local FIMR coordinators to gather information about the structure of current FIMR programs, gaps in the FIMR process, and support and training needs. A report on the survey results was completed in August 2007 and MCAH is working to address these needs.

In September 2007, a survey of the eight BIH-FIMR local jurisdictions that are using the Baby Abstracting System and Information NETwork (BASINET) was conducted. The MCAH Program worked with Go Beyond LLC to implement the suggested improvements to the system. MCAH is evaluating the BASINET pilot, which will end in June 2009.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	payment source from birth certificate	76.6	88.3	82.9

Notes - 2010
Source: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File. Payer source for prenatal care was used. Women with missing prenatal care initiation were subtracted from the denominator when calculating the percent shown. Women with missing payer source included in Total. Tabulations (by place of residence) were done by the MCAH Program.

Narrative:
Health Systems Capacity Indicator 05c (HSCI-5c) compares Medi-Cal and non-Medi-Cal on first trimester prenatal care. Payment source data are obtained from birth certificates. Non-Medi-Cal payment source includes private insurance, self-pay, no charge, other government programs, and medically indigent.

The percent of women entering prenatal care in the first trimester was lower for Medi-Cal births (76.6 percent) than for non-Medi-Cal births (88.3 percent) in 2007. This difference was noted for all race/ethnic groups, with the greatest differences for Whites (20.6 percentage points), Asians/Pacific Islanders (17.9) and American Indians (12.4). The percent of Medi-Cal births and the percent of non-Medi-Cal births that received first trimester care were both down from the previous year (80.6 and 90.5 in 2006, respectively), continuing the slow decline seen over the past five years. In 2003, 82.3 percent of Medi-Cal and 91.2 percent of non-Medi-Cal births had received first trimester prenatal care. Although the non-Medi-Cal population had previously achieved the Healthy People 2010 goal of 90 percent, in 2007 this indicator fell just short.

A common goal of many MCAH programs--including the Adolescent Family Life Program(AFLP), Black Infant Health (BIH), and the Comprehensive Perinatal Services Program (CPSP)--is to identify women in need of prenatal care and connect them to services within the first trimester. Efforts are being made to improve these strategies in order to reach more women earlier in their pregnancies. For example, in San Joaquin County, the health department obtained external funding to fund a "Go Before You Show" public education campaign that encourages women to access early prenatal care. In Los Angeles County, MCAH staff updated and expanded the perinatal resources available through its 211 line and are improving the visibility of this resource, especially in lower income communities. However, despite these successful strategies, numerous barriers prevent women from accessing early prenatal care.

One reason utilization of prenatal care in the first trimester is lower than optimal is that the number of unintended pregnancies remains high in California. Among low-income women (<200 percent of the FPL) surveyed in the 2006 Maternal and Infant Health Assessment (MIHA) Survey, over 50 percent classified their pregnancies as unintended, compared to 21 percent of women whose incomes exceeded 400 percent of the FPL. Only 78 percent of women with an unintended pregnancy reported utilizing prenatal care in the first trimester compared to 91 percent of women with an intended pregnancy. [58]

A new strategy to address unintended pregnancy focuses on the importance of reproductive life planning within the context of preconception health--one of the goals of the Preconception Health Council of California (PHCC), in which representatives from the MCAH and OFP Divisions actively participate. The Council is currently collaborating with the California Family Health Council to integrate preconception health promotion and reproductive life planning messages into Family PACT and Title X- funded clinics, which provide no-cost family planning services to California residents with incomes at or below 200% of the federal poverty level.

In support of this effort and the growing movement to incorporate preconception health promotion into the primary care setting, OFP sponsored a training on preconception care for Family PACT providers and released a Clinical Practice Alert on Preconception Care and Family Planning Services in December 2008.

Since rates of unintended pregnancy are especially high in the African-American community (64% according to 2007 MIHA data, and 82% among clients of the BIH Program according to 2007 MIS data), the BIH Program is collaborating with MCAH's Preconception Health and Healthcare Initiative (PHHI) to incorporate discussion about reproductive life planning and pregnancy spacing into the assessment and case management components of its new model, which will be piloted in 2009.

In addition to identifying women in need of prenatal care at early stages in the pregnancy, MCAH programs are also critical in providing social support services, case management and client follow-up. In the coming years the PHCC will work with the American College of Obstetricians and Gynecologists (ACOG), the March of Dimes California Chapter (MOD) and CPSP on a project whose goal is to maximize the postpartum visit. By setting guidelines for the content of the postpartum visit--including discussion of pregnancy spacing, care for chronic conditions between pregnancies and preparing for subsequent pregnancies through interconception health promotion and timely prenatal care--the project will test another strategy for increasing the rate at which women access prenatal care in the first trimester.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is	2007	payment source from birth certificate	74.7	81.9	78.6

greater than or equal to 80% [Kotelchuck Index])					

Notes - 2010
Source: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File. Payer source for prenatal care was used. Women with missing prenatal care values were subtracted from the denominator when calculating the percent shown. Women with missing payer source included in Total. Tabulations (by place of residence) were done by the MCAH Program.

Narrative:
Health Systems Capacity Indicator 05d (HSCI-5d) compares Medi-Cal and non-Medi-Cal on the percent of women with adequate prenatal care (Kotelchuck Index). Payment source data are obtained from birth certificates. Non-Medi-Cal payment source includes private insurance, self-pay, no charge, other government programs, and medically indigent.

The adequacy of prenatal care is measured, as in HSCI 4, as the percent of women (ages 15 to 44) with a live birth during the year whose observed to expected ratio of prenatal visits is greater than or equal to 80 percent on the Kotelchuck Index. This index also considers the mother's timing of initiation of prenatal care. By this measure, 74.7 percent of Medi-Cal women and 81.9 percent of non-Medi-Cal women had adequate prenatal care in 2007. The percent of Medi-Cal women with adequate prenatal care dropped slightly from the previous year (75.4 percent), while the non-Medi-Cal percent again increased slightly from the previous year (81.5 percent). While California has made much progress, these rates are still considerably lower than the national Healthy People 2010 goal of 90 percent.

In the 1980's, Medi-Cal implemented several strategies to improve prenatal care utilization. Medi-Cal expanded eligibility criteria, improved access through presumptive and continuous eligibility, waived the assets test, and reduced application paperwork. These changes may have encouraged the improvement in prenatal care rates in the 1990s.

Local MCAH programs perform outreach, client education and case-finding functions, including a toll-free telephone information service and targeted activities designed to assist high risk MCAH populations in receiving early and continuous prenatal care. Programs also provide critical social support services, case management and client follow-up. The majority of women served by these programs are low-income and receive their prenatal care through Medi-Cal.

Local Adolescent Family Life Programs use public service announcements, radio talk shows and home visitation to educate clients and stakeholders about the importance of prenatal care.

The Black Infant Health Program aims to increase the number of African-American women receiving prenatal care in the first trimester by educating the community about black infant morbidity and mortality, and forging alliances with prenatal care providers. It also enhances prenatal care through the provision of case management and social support.

The Comprehensive Perinatal Services Program provides statewide support to Medi-Cal obstetrical service providers to enable them to provide comprehensive prenatal care that includes clinical services, nutrition assessment, health education and psychosocial support. Providers receive a financial incentive to initiate prenatal care in the first trimester of pregnancy.

The "Centering Pregnancy" model, which provides prenatal care in a group setting, has been implemented in several local health jurisdictions. The model has been effective in increasing attendance at prenatal care visits, in part because participants benefit from the social support the group model of care offers.

Other state programs that support improvements in adequate prenatal care include the American

Indian Infant Health Initiative in the Department of Health Care Services and the Access for Infants and Mothers program in the Managed Risk Medical Insurance Board. More information about these programs is detailed under HSCI 4.

One reason utilization of prenatal care in the first trimester is lower than optimal is that the number of unintended pregnancies remains high in California. Among low-income women (<200 percent of the FPL) surveyed in the 2006 Maternal and Infant Health Assessment (MIHA) Survey, over 50 percent classified their pregnancies as unintended, compared to 21 percent of women whose incomes exceeded 400 percent of the FPL. Only 78 percent of women with an unintended pregnancy reported utilizing prenatal care in the first trimester compared to 91 percent of women with an intended pregnancy. [59]

Prenatal care is critically important for the health of the fetus and the mother. However, prenatal care should not be viewed as separate from preconception and interconception care, but rather part of a continuum of care that is provided within the context of reproductive life planning so that every pregnancy is intentional and planned for a time when the woman is in the best possible health. Most risk factors, such as chronic medical conditions, tobacco use, alcohol use, and obesity, are present before conception occurs. Since any woman of reproductive age may become pregnant, providing high quality health care that maximizes their health is also likely to improve the health of mother and fetus should a pregnancy occur.

MCAH staff are active members of the Preconception Health Council of California (PHCC), which encourages providers to address risk factors before pregnancy. The PHCC also educates women of childbearing age about preconception health, including reproductive life planning to reduce unintended pregnancy.

Despite these efforts, lack of access to basic health care and exposure to unhealthy environments are significant barriers to improving maternal and fetal health outcomes. Improved access to affordable services may also improve access to family planning services so women can plan, space or avoid pregnancy, which may help women to begin pregnancy in a healthier state overall.

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2007	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2007	250

Notes - 2010
Source: 2007 Medicaid data supplied by California Department of Health Care Services, Medi-Cal (California's Medicaid) Eligibility Branch based on an All County Welfare Directors Letter No. 07-04) specifying the 2007 Federal Poverty Levels (FPLs) for various programs.
http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c07-04.pdf

Notes - 2010
Source: 2007 State Children's Health Insurance Program (SCHIP) Eligibility Levels supplied by Managed Risk Medical Insurance Board (MRMIB), Eligibility, Enrollment & Marketing Division based on Eligibility Levels for the ACCESS To Mothers and Infants (AIM) Program.

The 250% of poverty levels reported by MRMIB represent the upper range levels for each population group. The 250% of poverty levels reported by MRMIB represent the upper range level. For infants 0-1 years of age, the range is 200%-250%.

Narrative:
Health Systems Capacity Indicator 06a (HSCI-6a) compares the income eligibility requirements for Medicaid and the State Children's Health Insurance Program (SCHIP) for infants (ages 0 to 1). In California, the SCHIP program is called Healthy Families (HF).

Infants were eligible for Medi-Cal if the family income was at or below 200 percent of the FPL. Infants were eligible for HF if the family income was between 200 and 250 percent of FPL.

Three counties (San Francisco, Santa Clara, and San Mateo) are able to draw down federal matching funds for children who do not qualify for no-cost Medi-Cal or Healthy Families, as approved in our State Plan. Eligibility for SCHIP in these counties was 250-300% FPL for children aged 0 to 1.

In 2007, infants up to one year old born to women with family incomes between 200 and 300 percent of FPL and who were enrolled in the Access to Infants and Mothers Program (AIM) were eligible for 2 years in the AIM Program, provided the infant was not enrolled in no-cost Medi-Cal or employer-sponsored health insurance.

Given California's current fiscal crisis, there may be changes to the eligibility criteria in the future.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2007	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2007	 250 250

Notes - 2010
Source: 2007 Medicaid data supplied by California Department of Health Care Services, Medi-Cal (California's Medicaid) Eligibility Branch based on an All County Welfare Directors Letter No. 07-04) specifying the 2007 Federal Poverty Levels (FPLs) for various programs.
http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c07-04.pdf

Notes - 2010
Source: 2007 State Children's Health Insurance Program (SCHIP) Eligibility Levels supplied by Managed Risk Medical Insurance Board (MRMIB), Eligibility, Enrollment & Marketing Division based on Eligibility Levels for the ACCESS To Mothers and Infants (AIM) Program.
The 250% of poverty levels reported by MRMIB represent the upper range levels for each

population group. The 250% of poverty levels reported by MRMIB represent the upper range level. Children 1 to 5 years of age have eligibility levels ranging from 133%-250% of FPL; children 6-18 years of age have eligbility levels ranging from 100%-250%.

Narrative:
Health Systems Capacity Indicator 06b (HSCI-6b) compares the income eligibility requirements for Medicaid (Medi-Cal) and SCHIP (Healthy Families) for children from 1 year up to age 19.

Children aged 1-5 years were eligible for Medi-Cal if the family income was at or below 133 percent of FPL; for children age 6-18, the eligibility level was 100 percent of FPL. Children aged 1-5 were eligible for HF with family incomes between 133 and 250 percent of FPL, and children aged 6-18 were eligible for HF if the family income was between 100 and 250 percent of FPL.

Three counties (San Francisco, Santa Clara, and San Mateo) are able to draw down federal matching funds for children who do not qualify for no-cost Medi-Cal or Healthy Families, as approved in our State Plan. Eligibility for SCHIP in these counties was 250-300% FPL for children aged 1-5 and 6-18 years.

Given California's current fiscal crisis, there may be changes to the eligibility criteria in the future.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2007	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2007	300

Notes - 2010
Source: 2007 Medicaid data supplied by California Department of Health Care Services, Medi-Cal (California's Medicaid) Eligibility Branch based on an All County Welfare Directors Letter No. 07-04) specifying the 2007 Federal Poverty Levels (FPLs) for various programs.
http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c07-04.pdf

Notes - 2010
Source: 2007 State Children's Health Insurance Program (SCHIP) Eligibility Levels supplied by Managed Risk Medical Insurance Board (MRMIB), Eligibility, Enrollment & Marketing Division based on Eligibility Levels for the ACCESS To Mothers and Infants (AIM) Program.
Eligibility levels for pregnant women range from 200%-300%.

Narrative:
Health Systems Capacity Indicator 06c (HSCI-6c) compares the income eligibility requirements for Medicaid and SCHIP/HF for pregnant women.

Pregnant women were eligible for Medi-Cal with a family income at or below 200 percent of the FPL. Pregnant women with family income levels between 200 and 300 percent of the FPL were eligible for the AIM Program.

Given California's current fiscal crisis, there may be changes to the eligibility criteria in the future.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
Health Systems Capacity Indicator 09a (HSCI-9a) describes MCH data. There are many sources of MCH data in California, including data from birth and death certificates; hospital discharge data; and several statewide surveys, some of which are described below.

MCAH Division has had access to linked birth and death files since 1965. These data are used for a variety of monitoring, analytic and research endeavors including assessment of fetal and infant mortality rates, sudden infant death syndrome (SIDS), maternal mortality and morbidity, and quality of care indicators. The Perinatal Profiles report provides certain perinatal data and analyses confidentially to hospitals annually and is one of the primary tools for reducing fetal and infant mortality rates and improving quality of care.

MCAH Division also has access to hospital discharge data through the California Office of

Statewide Health Planning and Development (OSHPD). OSHPD has administrative and clinical data from all licensed hospitals in California, including data on population demographics, hospital/clinic characteristics, payer source, births and deliveries, and other conditions, procedures, and injuries. The discharge data are linked annually to birth and death data and are analyzed by MCAH Program analysts.

MCAH Division has access to birth certificate data linked with genetic newborn screening data and birth defects registry data. The Program also has access to Medi-Cal (California's Medicaid) data.

MCAH Division has the capacity to link birth certificate data and WIC eligibility files, as was done in 1999. Because of budgetary constraints, it has not been done since 1999.

MCAH Division's Maternal and Infant Health Assessment (MIHA) survey is an annual population-based survey of women who gave birth in California. The survey is modeled after CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) and is self-administered 10-14 weeks after birth to a stratified, random sample of approximately 3,500 participating women. Strata are by maternal region of residence, race/ethnicity, and education. Surveys are available in English and Spanish. The first year of data collection was completed in 1999. Topics include intendedness of pregnancy, utilization of health care, breastfeeding, and risk behaviors before and during pregnancy, including use of folic acid supplementation and smoking during pregnancy. Birth outcomes are provided through linkage with birth certificate data. The administration of this survey is contracted out to UCSF, and UCSF staff often collaborate with MCAH Division staff on analysis and reporting of survey results.

The California Women's Health Survey (CWHS), conducted under the auspices of the California Office of Women's Health, is an annual, population-based, computer-assisted, random-digit dialed telephone survey in which 200 questions are answered by approximately 4,000 women. The survey is anonymous and is conducted in English and Spanish. Topics include health insurance status, family planning, sexually transmitted infections, pregnancy, mental health, and lifestyle issues such as food/nutrition and exercise. MCAH Division staff sit on the CWHS advisory group, contribute questions to the survey, analyze data and present findings.

The California Health Interview Survey (CHIS) is conducted by the UCLA Center for Health Policy Research in collaboration with CDPH, DHCS, and the Public Health Institute. It is funded by public agencies and private organizations. CHIS is a bi-annual telephone survey of adults, adolescents, and children representative of all parts of the state. Since implementation in 2001, the bi-annual surveys have each covered 42,000-55,000 households, enough to allow for statewide and some local level analysis. Questions included health insurance coverage, alcohol and tobacco use, asthma, diabetes, mental health, oral health, overweight and obesity, and lifestyle issues, including food/nutrition and exercise. MCAH Division staff sit on several CHIS Technical Advisory Groups, helping to develop topic areas and survey questions, and analyzing the data.

The MCAH Division also collects and maintains data on its various programs, including AFLP, BIH, CDAPP, CPSP, FIMR, and SIDS. Data elements vary by program, but generally cover number of clients served, client socio-demographics, and some programs include number of home visits, and use of services. Certain program files can be linked to birth and/or death files.

In order to improve the quality of birth certificate data, trainers from the Office of Vital Records and MCAH RPPC representatives are collaborating on statewide regional birth clerk trainings. Eight trainings were held throughout the state in 2008, and seven additional birth clerk trainings will be held in April through October 2009.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
California Student Survey	3	No
California Health Interview Survey	3	Yes

Notes - 2010

Narrative:
HSCI 9b is data capacity for adolescent tobacco use. The two main sources from which MCAH obtains data on adolescent tobacco use are the California Health Interview Survey (CHIS) and the California Student Tobacco Survey (CSTS).

According to the 2007 CHIS survey, 4.8 percent of California youth age 12-17 years old smoked in the past 30 days; this represents a decrease since 2005, when 6.5 percent reported smoking. The reason for this decrease is unclear, but California youth have a significantly lower smoking prevalence compared to the rest of the United States. CHIS is a random digit dial telephone survey of adults, adolescents, and children from all parts of the state. The survey is conducted every two years. It is the largest state health survey, and is able to provide statewide and local level estimates on a number of health related issues, including adolescent tobacco use.

The 2006 CSTS results show that 6.1 percent of middle school students and 15.4 percent of high school students reported smoking in the past 30 days. CSTS, funded by the CDHS Tobacco Control Section (TCS), is a statewide school-based survey of 6th to 12th graders conducted every other school year.

Other sources of data on adolescent tobacco use include: the California Schools Survey (CSS), which is primarily used for local assessments; the California Tobacco Survey (CTS), a phone survey conducted approximately every three years, which assesses tobacco-related attitudes, beliefs, and media exposure; the Youth Tobacco Purchasing Survey (YTPS); and the Behavioral Risk Factor Surveillance (BRFS) Survey, which includes data on exposure to secondhand smoke.

The County and Statewide Archive of Tobacco Statistics (C-STATS) website (http://www.cstats.info/) provides an archive of California tobacco statistics at the state and county levels. It includes data on many tobacco-related indicators for youth, including smoking prevalence; tobacco use; attitudes and beliefs about smoking, second-hand smoke, and smoking prevention; media exposure; and perceptions of the tobacco industry.

Major motion-picture studios in California include anti-smoking public service announcements on youth-rated digital video disks (DVDs) of motion pictures that include smoking scenes. The portrayal of an emphysema patient is one of four anti-smoking ads Hollywood studios have placed with upcoming movies on DVD that show tobacco use and carry a PG-13 rating or lower. The ads were produced by the state of California from tobacco tax funds and are a timely response as the drop in tobacco consumption has leveled off, especially amongst young people. The Preconception Health and Healthcare Initiative (PHHI) aims to promote healthy behaviors among women who could become pregnant. Supporting young people to refrain from tobacco use long before they may become pregnant is an important part of ensuring preconception health. The Initiative will work with local MCAH programs reaching teens to discuss tobacco use, especially in the context of culturally and age-appropriate reproductive life planning.

On March 18, 2009, a Request for Proposal was released by CDPH to award a contract to an advertising agency to conduct the statewide California Tobacco Control Program Media Campaign in the general market and other ethnic and priority population markets. The applications were due April 16, 2009. The contract will fund tobacco control media activities from September 1, 2009 through August 31, 2012. Funding is approximately $20 million annually, to be available from the Proposition 99 Tobacco Tax and Health Protection Act of 1988.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Performance Reporting

/2007/
California's Title V performance reporting currently includes a total of twenty-eight measures: eighteen national performances measures (NPM) mandated by HRSA and ten additional measures chosen by the state. In FY 2005-2006, the state performance measures (SPM) were reviewed and updated based on the needs and priorities identified in the 2005 Needs Assessment.

The ten SPM in this report, which are based on the 2005 Five Year Needs Assessment, include the following:

SPM 01: The percent of children birth to 21 years enrolled in the CCS program who have a designated medical home;

SPM 02: The ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists;

SPM 03: The percent of women, aged 18-44 years, who reported 14 or more "not good" mental health days in the past 30 days ("frequent mental distress");

SPM 04: The percent of women who reported drinking any alcohol in the first or last trimester of pregnancy;

SPM 05: The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries;

SPM 06: The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System;

SPM 07: The percent of newly referred clients to the CCS program whose cases are opened within 30 days of referral;

SPM 08: The percent of births resulting from an unintended pregnancy;

SPM 09: The percent of 9th grade students who are not within the Healthy Fitness Zone for Body Composition; and

SPM 10: The percent of women, aged 18 years or older, reporting intimate partner physical, sexual or psychological abuse in the past 12 months.

//2007//

The national and state performance measures cover the four levels of the MCH pyramid: Direct Health Care Services, Enabling Services, Population-Based Services, and Infrastructure Building Services. For a discussion of specific programs associated with each performance measure, please refer to Sections IV C (NPMs) and IV D (SPMs). Figures 4a and 4b (Performance Measures Summary Sheet) show where the state's many activities fit on the MCH pyramid.

Data on performance measures are included in two parts of this report - on the data forms and in the narrative. Please refer to the Attachment for information on the development of the annual

objectives for the performance measures.

An attachment is included in this section.

B. State Priorities

The 2005 five-year needs assessment identified ten priorities for maternal, child, and adolescent health in California. The priorities encompass all levels of the MCH health services pyramid and in some cases span pyramid levels.

The ten California Title V priorities and the associated performance measures are:

Priority 1 -Enhance preconception care and work toward eliminating disparities in infant and maternal morbidity and mortality.
> NPM 01 (Screen positive newborns who received timely follow up to definitive diagnosis and clinical management)
> NPM 15 (Smoking in last three months of pregnancy)
> NPM 17 (Very low birth weight infants delivered at facilities for high-risk deliveries and neonates)
> NPM 18 (Prenatal care beginning in first trimester)
> SPM 06 (Neural tube defects among counties participating in the California Birth Defects Monitoring System)

Priority 2 -Promote healthy lifestyle practices among MCAH populations and reduce the rate of overweight children and adolescents.
> NPM 14 (Children ages 2-5 receiving WIC services that have a Body Mass Index at or above the 85th percentile)
> SPM 09 (9th grade students not within the Healthy Fitness Zone for Body Composition)

Priority 3 -Promote responsible sexual behavior in order to decrease the rate of teenage pregnancy and sexually transmitted infections.
> NPM 08 (Births to teenagers aged 15-17)
> SPM 08 (Births resulting from an unintended pregnancy)

Priority 4 -Improve mental health and decrease substance abuse among children, adolescents, and pregnant or parenting women.
> NPM 16 (Suicide deaths among youths15-19)
> SPM 03 ("Not good" mental health days in women)
> SPM 04 (Drinking in first or last trimester of pregnancy)

Priority 5 -Coordinate to develop and implement a system of timely referral between mental health, developmental services, social services, special education services and CCS.
> NPM 02 (CSHCN whose families partner in decision making at all levels and are satisfied with the services they receive)
> NPM 03 (CSHCN who receive coordinated, ongoing, comprehensive care within a medical home)
> NPM 05 (CSHCN whose families report the community-based service systems are organized so they can use them easily)
> SPM 01 (Children enrolled in the CCS program who have a designated medical home)
> SPM 07 (Newly referred clients to the CCS program whose cases are opened within 30 days of referral)

Priority 6 -Improve access to medical and dental services, including the reduction of disparities.
> NPM 01 (Screen positive newborns who received timely follow up to definitive diagnosis and clinical management)
> NPM 04 (Children with special health care needs age 0 to 18 whose families have adequate

private and/or public insurance)
> NPM 07 (19 to 35 month olds who have received full schedule of age appropriate immunizations)
> NPM 09 (Third grade children who have received protective sealants on at least one permanent molar tooth)
> NPM 12 (Newborns who have been screened for hearing before hospital discharge);
> NPM 13 (Children without health insurance)
> NPM 17 (Very low birth weight infants delivered at facilities for high-risk deliveries and neonates)
> NPM 18 (Infants born to pregnant women receiving prenatal care beginning in first trimester)
> SPM 07 (Newly referred clients to the CCS program whose cases are opened within 30 days of referral)

Priority 7 -Expand the number of qualified providers participating in the CCS program, e.g., medical specialists, audiologists, occupational and physical therapists, and nutritionists.
> NPM 03 (CSHCN who receive coordinated, ongoing, comprehensive care within a medical home)
> NPM 04 (CSHCN whose families have adequate private and/or public insurance to pay for the services they need)
> NPM 05 (CSHCN whose families report the community-based service systems are organized so they can use them easily)
> NPM 06 (Youth with special health care needs who received the services necessary to make transition to all aspects of adult life)
> SPM 01 (Children enrolled in the CCS program who have a designated medical home)
> SPM 02 (Ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists)

Priority 8 -Increase the number of family-centered medical homes for CSHCN and the number/percent of CCS children who have a designated medical home.
> NPM 02 (CSHCN whose families partner in decision making at all levels and are satisfied with the services they receive)
> NPM 03 (CSHCN who receive coordinated, ongoing, comprehensive care within a medical home)
> SPM 01 (Children enrolled in the CCS program who have a designated medical home)

Priority 9 -Decrease unintentional and intentional injuries and violence, including family and intimate partner violence.
> NPM 10 (Deaths to children under 14 caused by motor vehicle crashes)
> NPM 16 (Suicide deaths among youths15-19)
> SPM 05 (Deaths to adolescents aged15 -19 caused by motor vehicle injuries)
> SPM 10 (Intimate partner physical, sexual or psychological abuse)

Priority 10 -Increase breastfeeding initiation and duration.
> NPM 11 (Mothers who breastfeed infants at 6 months of age)

Parent and Community Involvement

CDHS recognizes parent and community involvement as critical to the development of responsive, family centered, and community based systems of care. While this has been a longstanding state priority, MCAH/OFP and CMS are making special efforts this year, in accordance with the federal Title V Reviewers' recommendations in August 2004, to strengthen existing partnerships among families, communities and policymakers and to provide more information about those partnerships in this report.

/2009/Drawing on community and statewide stakeholders as well as local health jurisdictions'

input, MCAH continues to build systems of care. Advisory Committees for the PAMR, CPQCC, CMQCC and SIDS Projects provide community input on specific MCAH issues. Regular meetings of local MCAH representatives such as the MCAH Action Team, AFLP Directors and CPSP Coordinators, provide opportunities for local feedback and input. Community partnerships also provide opportunities for systems development and improvement. For example, the MCAH CMQCC Program facilitated information meetings with physician and nurse leaders throughout the state to identify local maternal quality improvement priorities.//2009//

/2010/MCAH continues to convene regular meetings with representatives of MCAH's programs, including AFLP Directors and Regional Representatives; BIH Coordinators; CPSP Coordinators and Executive Committee; and the PAMR, CPQCC, CMQCC and SIDS Project Advisory Committees. MCAH participates in statewide MCAH Action meetings and maintains ongoing communication with MCAH Directors through the MCAH Action listserv.

MCAH communicates with state policymakers about program cost effectiveness, budget impacts, and other issues through CDPH's legislative analysts and the Director's Office, who represent MCAH in legislative hearings related to MCAH Division programs.

The MCAH Division engages parents and community members primarily through the LHJs, but also directly engages program clients as needed. For example, MCAH recently solicited client feedback from AFLP participants in developing nutrition guidelines and updating a teen cookbook.//2010//

Parent and community input has been incorporated into the Title V Five Year Needs Assessment. Counties obtained parent and community input via surveys, focus groups, stakeholder groups, and direct participation in the needs assessment process. Twenty-seven local MCAH health jurisdictions reported collecting survey data from over 2,000 clients, parents and other family members. Sixteen counties reported conducting focus groups.

/2010/Input from the 61 LHJs and other stakeholders is a key component of the 2010-2014 needs assessment. In addition to analyzing core health status indicators, LHJs are using a modified version of the Capacity Assessment for State Title V tool (CAST-5), developed by the Association of Maternal and Child Health Programs and Johns Hopkins University, to assess the capacity of the MCAH "system" to carry out the Ten Essential Public Health Services. LHJ's are required to obtain stakeholder input in completing their capacity assessments, and are strongly encouraged to engage stakeholders in community health planning and establishing health priorities.//2010//

The 17 local BIH agencies have community advisory boards composed of former clients and community leaders as well as health professionals and agency representatives. The advisory boards identify gaps and barriers to services for African Americans and provide input for needs assessment, program planning, and community awareness events. Some community advisory boards, such as The Black Infant Health Leadership Coalition in Fresno and the Black Women's Health Task Force in Pasadena, also partner with local churches and community agencies to provide information and education to providers and the community about racial health disparities.

/2009/ The MCAH Program convened a multi-disciplinary workgroup consisting of BIH Coordinators and staff, MCAH Directors, BIH Community Advisory Committee members, and state MCAH staff. The goal is to identify key components needed for the development of new BIH interventions to address maternal and infant health in the African American community. The workgroup developed a general program concept to be further developed and refined by MCAH, UCSF and the workgroup. //2009//

/2010/The BIH Program Development Workgroup and its 3 subcommittees include current and former BIH clients. Development of the revised BIH program model has involved

nearly 100 BIH staff throughout the state. A larger community engagement effort to address African-American maternal and infant disparities is in development as resources permit.//2010//

The State Early Childhood Comprehensive Systems Project (SECCS) is another example of parental involvement in program planning and implementation. SECCS, funded by HRSA, provides state-level leadership for early childhood health programs to help California's children be emotionally, socially, and physically healthy and ready for kindergarten. The project coordinates a myriad of health-related programs at the state and local levels. Parent input is obtained through focus groups, individual interviews, and inclusion on the Steering Committee. Three members of the SECCS Steering Committee are parents of children with special healthcare needs.

/2009/ Parents are also represented through two organizations on the ECCS Community Communication Toolkit Subcommittee, which is creating a community toolkit to help providers and families navigate the confusing path of finding help when a red flag is raised about a child's development. The Family Resource Center Networks of California (FRCNCA) and Family Voices bring the parents' perspective to this project. //2009//

/2010/The California State Screening Collaborative has engaged the Family Resources Centers Network of California as a Collaborative member, providing family insight into development of statewide screening efforts. MCAH is represented, along with two parents of children with autism, on the California Interagency Autism Planning Group, which has been meeting for 2 years to plan training for educators/providers and high quality, coordinated assessment and educational services for individuals with austism.//2010//

Pediatric Special Care Centers (SCCs) and hospitals that treat CSHCN must meet specific criteria for provision of family-centered care (FCC). During the hospital or SCC review, the following are assessed: the level of parental involvement in treatment decision making; sharing of reports with families; the degree of parent/patient involvement in advisory committees that set policies and procedures; and availability of healthy sibling and parent visiting. As part of the review process of the SCC or hospital, the CMS Branch sends a follow-up report to the facility with FCC recommendations.

The CCS program facilitates FCC services for families of CSHCN. CCS staffing standards allow a parent liaison position in each county CCS program to enable FCC. County CCS programs assist families in accessing authorized services. Many families live long distances from the site of appropriate pediatric specialty and subspecialty care. The program provides reimbursement for travel expenses (gas, bus tickets, taxis), meals for extended stays, and motel rooms for families when there are extended hospital stays.

/2010/ Many CCS county programs have ended their parent liaison contracts due to the state deficit and budget cuts.//2010//

/2009/ Family Voices of California (FVCA) provides monthly conference calls and annual trainings to ensure linkages of families and local Family Resource Centers. FVCA presented "The Right Question", training to assist families to effectively advocate on behalf of their children; a panel of experts presented on "Limited Conservatorship, Special Needs Trusts, Living Options, and Employment."//2009//

/2010/ FVCA Council Agencies work with their local CCS agency to connect families to Family Resource Centers (FRCs). The FCC Work Group reviews county activities, and shares resources.//2010//

CCS presented "CCS, Medi-Cal, Healthy Families, Private Insurance and CCS Eligible Children: How the Funding Streams Covering Children in CCS Work and Interact with Each Other", and "Transition to Adulthood; The State's Vision of Transition and How to Operationalize that Vision."

/2007/ The Children's Regional Integrated Service Systems (CRISS), comprised of fourteen CCS county programs, has an FCC Work Group that meets bimonthly. Among other activities, this Group plans, develops and sponsors an annual conference. The annual conference for fall 2005 was "What Happens at 18? Conservatorship and Other Legal Rights for the CCS Client." Youth and their parents, educators working on transition teams, Regional Center staff, CCS staff, family support agency staff, parent leaders, and public agency staff participated. //2007//

/2008/The Annual Criss Conference for fall 2006, "Negotiating Multiple Transition Hurdles, One at a Time!," featured a youth/family, professional panel presentation focusing on such transitions as moving from the label of delay to disability, active to inactive CCS status, and dependent to independent skills. //2008//

/2009/ "Hot Topics Arising in the Medical Therapy Program: Safe Transport, Complementary Therapies, and Management" was the focus of the 2007 CRISS Annual Conference. CRISS coordinated regional meetings to promote care coordination for children across multiple systems. One regional meeting showcased three successfully implemented county-wide care coordination models for CSHCN in the CRISS region. The 2008 CRISS annual conference will focus on diabetes management for children. //2009//

/2010/ CRISS will co-sponsor a conference with the University Center for Excellence in Developmental Disabilities (UCEDD) and Family Voices on special topics in diabetes management, including linguistic and cultural issues and new treatment modalities.//2010//

/2007/ CHLA, UCLA Child and Family Health Program, LA Partnership for Special Needs Children, CRISS, CCS, and CMS Branch partnered on a conference entitled "Family-Centered Strategies for Effective Transition for Youth with Special Health Care Needs: A training for Providers and Families" in April 2006 in Los Angeles. //2007//

/2009/ FVCA collaborated with advocates across the state to convene a statewide "Health Summit" bringing together families, professionals, advocates, insurers, and legislators to discuss access to affordable and appropriate health care for CSHCN and develop strategies to address these challenges. The 2008 annual conference will focus on Emergency Preparedness for Children with Special Needs.//2009//

/2008/ CHLA, UCLA Child and Family Health Program, LA Partnership for Special Needs Children, CRISS, CCD, and CMS Branch collaborated on a conference entitled, "Care Coordinating Services for CSHCN in the Community" in February 2007. Experts in the field provided information to agency staff, providers, and parents about the system of care for CSHCN, and ways to coordinate services between and among programs and providers. In addition, hands-on breakout sessions were held to address use of parent notebooks, family resource centers, and CMS Net. //2008//

/2008/ The LA Partnership for Special Needs Children (LAPSNC) is expanding to include other entities in Southern California. //2008//

/2009/ LAPSNC is developing an outreach project to strengthen the infrastructure in southern California for organizations providing care to CSHCN. Meetings have been held since 2006 with representatives from the local CCS programs, Regional Centers, and children's hospitals in San Diego, Orange County, and the Inland Empire (Riverside and San Bernardino Counties) to promote interagency collaboration and communication regarding CSHCN. //2009//

/2010/ LAPSNC is increasing parent involvement in meetings and committees, and planning a conference to identify resources in tough economic times.//2010//

/2007/ Participants in the CRISS FCC Work Group have developed a parent notebook with the assistance of families and agencies such as MCHB, the Partnership Health Plan Parent Resource Network, Parents Helping Parents. Planning has begun for trainings on the use of the parent notebook through family resource centers, medical therapy units, and special care centers. //2007//

/2008/ Train-the-trainer on the use of the notebook is currently being planned for 100 participants and will target school nurses, regional centers, hospitals, MTUs, foster parents, family resource center staff, etc. //2008//

/2009/FVCA disseminates state and federal information to families about new resources, conferences, and funding opportunities. FVCA shares information with its network of child advocacy partners on the FVCA website.//2009//

/2007/ The CMS Branch has been directing a Champions for Progress Center Incentive Award and has convened a group of key stakeholders, with past investments in and knowledge of the system of care for CSHCN and their families. This group, which includes family representation, has met monthly for approximately eight months to develop a strategic plan to address the CSHCN Title V performance measures from the National Survey and three new state performance measures. //2007//

/2007/ The project has built on existing coalitions and projects, and past efforts to develop a longterm, strategic plan for serving CSHCN; and it has identified resources within California to carry out the activities defined in the strategic plan. A monitoring and evaluation strategy is being developed to assure continued improvement and progress toward achievement of the performance measures for CSHCN. //2007//

/2008/ The Champions for Progress Center Incentive Award has ended, and a federal MCHB grant has been awarded to USC UCEDD at CHLA in collaboration with CRISS and FVC for a 3-year project to implement integrated community systems of care for CSHCN. The Champions stakeholder group is meeting quarterly to review and comment on implementation progress through June 2008. //2008//

/2009/State CMS and HRSA Grant Project (UCEDD, FVCA, and CRISS)is planning to provide regional conferences around the state to target key stakeholders involved in improving the system of care for CYSHCN and their families. //2009//

/2010/ CMS participation is on hold due to budgetary constraints.//2010//

/2007/ Work is in progress to develop a statewide Youth Advisory Group (ages 14-24 years) to provide guidance on design, implementation and evaluation of transition activities for CMS and other agencies involved in transition issues for adolescence. //2007//

/2008/ The Youth Advisory Group, now named FVCA Kids as Self Advocates (KASA) Youth Panel (plus an adult facilitator), is creating a survey to assess California youth aged 14-24 who have chronic medical issues or disabilities. Their goal is to assess how youth feel about how their medical needs are being met and what they know about the transition from pediatric to adult medical care. The panel has had four meetings, and the draft survey was developed in the last meeting and is now being reviewed. This has brought new experiences, such as decision-making, consensus-building, and critical thinking, to the fourteen panel members. //2008//

/2009/FVCA and KASA will continue to expand their outreach, identify issues and address those issues through distribution of information and participation on committees.

The Preconception Care Council of California (PCCC) was convened by the MCAH Program in partnership with the March of Dimes California Chapter to provide a venue for community

agencies to develop a statewide plan for preconception health in California. //2009//

/2010/CRISS is expanding its activities to eleven rural counties on its northern border, including the county CCS programs and the 7 FRCs.

The Medical Home project for children with epilepsy, convened by CRISS, will be completed May 2009. The local CCS program will continue the collaborative after the close of the project.//2010//

C. National Performance Measures

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

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	99	99.5	100	99.5	100
Annual Indicator	100.0	99.2	100.0	100.0	
Numerator	391	478	566	609	
Denominator	391	482	566	609	
Data Source					Genetic Disease Screening Program, 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
State of California, Department of Public Health, Genetic Disease Screening Program, 2007 Newborn Screening Records.
Newborn screening includes screening for the following six conditions: PKU, congenital hypothyroidism, galactosemia, sickle cell disease, congenital adrenal hyperplasia, and non-PKU inborn errors of metabolism tested by tandem mass spectrometry. In addition, in July 2007 two more conditions were added to the screening: cystic fibrosis and biotidinase deficiency. In 2007, 47% of the screenings included these two newly included conditions.

When looking at trends, it is necessary to keep in mind that data prior to 2005 pertained to only the first four conditions, and that data for 2005 pertained to the first four for the entire year and to the last two for only the last six months of that year.

Notes - 2006
State of California, Department of Public Health, Genetic Disease Screening Program, 2006 Newborn Screening Records
Newborn screening includes screening for the following six conditions: PKU, congenital hypothyroidism, galactosemia, sickle cell disease, congenital adrenal hyperplasia, and non-PKU inborn errors of metabolism tested by tandem mass spectrometry. When looking at trends, it is necessary to keep in mind that data prior to 2005 pertained to only the first four conditions, and that data for 2005 pertained to the first four for the entire year and to the last two for only the last six months of that year.

a. Last Year's Accomplishments
California has effectively achieved universal coverage for newborn screening for genetic, metabolic and hematological disorders, with 100 percent of newborns screened for all conditions for which screening was mandated in 2006. In 2007 the percent of screen positive newborns receiving timely follow-up to definitive diagnosis and clinical management was also 100 percent, the second year in a row.

The Genetic Disease Screening Program (GDSP) conducts two large screening programs--prenatal and neonatal--for the prevention, detection and/or treatment of genetic and congenital disorders that can be prevented or treated prenatally or neonatally. Services include counseling, testing, and educational materials for patients, as well as public information and professional education. Genetic screening is a statutorily mandated service available to all pregnant women (prenatal screening) and newborns (newborn screening).

The expanded Alpha Fetoprotein (AFP) Program is a prenatal screening program for the detection of open neural tube defects (NTDs), abdominal wall defects, Smith-Lemli-Opitz Syndrome (SLOS), and chromosomal anomalies. Women with positive screening tests are referred to State-approved Prenatal Diagnosis Centers under contract with GDSP. Services offered at these Centers include genetic counseling, high-resolution ultrasound, and amniocentesis.

All the conditions for which the NBS program screens, including over 40 metabolic disorders, endocrine disorders, and hemoglobinopathies, are California Children's Services (CCS)-eligible; and GDSP and Children's Medical Services (CMS) have been collaborating to ensure that infants identified with abnormal metabolic screening results from the current and expanded testing receive prompt diagnostic evaluations at one of the CCS-approved Metabolic Special Care Centers (SCC) in the state. The county CCS programs have expedited GDSP referrals, so that infants with suspected metabolic illness can be identified and treated promptly in order to maximize prevention of premature death or serious disabilities. The guidelines for diagnostic follow-up and treatment of the 40 additional metabolic disorders and congenital adrenal hyperplasia are in place. The CMS Branch participated at GDSP meetings in the evaluation and development of further expansion of the program to include cystic fibrosis and biotinidase deficiency disorders. The CMS Branch worked with GDSP on policy and procedures to ensure that infants with abnormal screening results for these disorders will receive expeditious diagnostic evaluations and treatment services as needed.

Both the prenatal and the newborn screening programs were expanded in 2007. Universal screening for both cystic fibrosis and biotidinase deficiency in newborns began July 16, 2007, in accordance with Chapters 47 and 48 Statutes of 2006 (aka the 2006 Budget Act). At the same time, the Expanded AFP triple-marker Prenatal Screening Program began including a fourth marker, the analyte Inhibin (Inh). This fourth marker is used in conjunction with the three markers that were already in use: alpha-fetoprotein (AFP), human chorionic gonadotropin (hCG), and unconjugated estriol (uE3) to improve the risk assessment for Down Syndrome. The detection rate through maternal blood screening for Down Syndrome is expected to increase to about 80%. In addition, the Expanded AFP Program improved the risk calculation for Trisomy 18. This improvement was based on program data analysis and current research on prenatal screening.

The detection rate through maternal blood screening for Trisomy 18 is expected to increase to about 67%. Finally, as of February 10, 2007, the GDSP began to offer second-trimester NTD/SLOS maternal blood screening for women who have had First Trimester Screening, Chorionic Villus Sampling (CVS), or Preimplantation Genetic Diagnosis (PGD). In the past, these women were not offered additional screening following these previous screens and/or diagnostic tests.

The CCS Policy Letter noted in the 2009 narrative was accomplished in 2007 and not 2008. CMS and GDB worked to address issues and updated literature. There is much concern that with budget cuts decreasing the numbers of staff in the CCS local programs and Regional Offices, expedited authorizations necessary for babies screening positive for these endocrine and metabolic disorders may not occur timely, to the detriment of the babies and their families.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Genetic Disease Branch (GDSP) screens for genetic and congenital disorders, including testing, follow-up and early diagnosis of disorders to prevent adverse outcomes or minimize clinical effects.			X	
2. The GDSP ensures quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance with them.				X
3. The GDSP fosters informed participation in its programs through a combination of patient, professional, and public education, and accurate and up-to-date information and counseling.			X	
4. The GDSP and CMS collaborate to ensure that infants identified with abnormal screening results receive prompt diagnostic evaluations at one of the CCS-approved Metabolic Special Care Centers (SCC) in the state.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In February 2009, CMS provided an overview of CCS and responded to issues at a meeting of NBS staff and NBS Area Screening Service Coordinators. Due to NBS staff turnover, it was important to have a learning session.

In March 2009, the California Prenatal Screening Program (PNS) expanded to allow 1st trimester specimens for Integrated Screening and will consist of 4 types of screening tests:

-Patients that submit a blood specimen in the 2nd trimester (15 to 20 weeks): Quad Marker Screening [Alpha Feto-protein (AFP), human chorionic gonadotropin (hCG), unconjugated estriol (uE3), and Inhibin]
-Patients that had Chorionic Villus Sampling (CVS) and submit a blood specimen in the 2nd trimester: NTD/SCD Screening [Risk assessment for Neural Tube Defects (NTDs) and Smith-Lemli-Opitz syndrome (SCD) only]
-Patients that submit a blood specimen in the 1st trimester (10 to 13 weeks 6 days) and 2nd

trimester (15 to 20 weeks): Serum Integrated Screening [Pregnancy Associated Plasma Protein (PAPP-A) and hCG in the first trimester, plus Quad Marker Screening in the second trimester]
-Full Integrated Screening: Nuchal Translucency (NT) Ultrasound when the Crown Rump Length (CRL) is between 45-84 mm, combined with Serum Integrated Screening.

CMS and GDSP will work together to address issues as they arise, and update literature as needed. Despite decreased staff, CCS is attempting to expedite authorizations necessary for babies with positive screening results.

c. Plan for the Coming Year

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

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

GDSP will continue its research studies toward the possibility of screening for additional preventable and treatable genetic and congenital disorders.

GDSP will continue and evaluate the 1st Trimester Prenatal Screening Program.

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

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

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	49.5	50.5	51.5	52.5	52.5
Annual Indicator	47.6	47.6	47.6	46.6	46.6
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	47	47.5	48	48.5	49

Notes - 2008
This measure is the percent of CSHCN age 0 to 18 years whose families partner in decision-making at all levels and are satisfied with the services they receive.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2007
Section Number: Performance Measure #2
Field Name: PM02
Row Name:
Column Name:
Year: 2007
Field Note:
This measure is the percent of CSHCN age 0 to 18 years whose families partner in decision-making at all levels and are satisfied with the services they receive.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2006
The 2006 indicator is pre-populated from 2002 and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families partner in decision-making at all levels and are satisfied with the services they receive.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

a. Last Year's Accomplishments
NPM 02 is one of five measures (see also NPM 03, 04, 05, and 06) taken from the National Survey of CSHCN. Based on the 2005-2006 survey, 46.6 percent of CSHCN age 0 to 18 have families partnering in decision making at all levels and are satisfied with the services they receive.

The most recent National Survey of CSHCN (2005-2006), conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics, identified approximately 750 parents of children with special needs in each state.

Accomplishments related to this measure over the past year include:

1) The Stakeholder Group met May 28, 2008 to begin planning the implementation activities for the strategic plan for CYSHCN. There was poor representation from agencies serving CYSHCN at the meeting, and this factor coupled with state and county CCS program staffing cuts resulted in cancelling further Stakeholder meetings.

2) The Annual CRISS Conference held in 2008 was entitled "Diabetes and Its Challenges: Types I and II, Adolescence and Nutrition."

3) CRISS also convened regional meetings to promote care coordination for children who cross multiple systems and sponsored a regional workshop in September, 2008 entitled "Implementing Innovative Care Coordination Strategies for Children with Special Health Care Needs."

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

5) The CRISS FCC Work Group continued to meet bimonthly, and county member representatives reported on their FCC activities, shared ideas and resources, and coordinated conferences, trainings and activities.

6) The FCC Work Group monitored FCC and transition activities, parent liaison services, and medical home projects.

7) County CCS programs reported on family participation in the CCS program.

8) There has been collaboration among counties and agencies to provide workshops, resource fairs, and conferences for families; these collaborations included parents and families in the planning and development.

9) Family members participated on advisory committees or task forces in many counties, and became involved with in-service training of CCS staff and providers.

10) The Parent Health Liaison (PHL) network provided questionnaires, templates, training manuals, and other resources to assist in collaboration at the local level with CCS agencies.

11) CCS PHL's met monthly via conference calls for technical support, and to track emerging issues and statewide trends, identify solutions, and determine training needs.

12) FVCA provided two statewide PHL conferences based on concerns and issues identified by PHLs: "Transition Issues" and "CSHCN in Foster Care."

13) FVCA served as Family Advisory Group to State CCS to find family members (including youth) to serve on additional committees.

14) "Kids As Self Advocates" (KASA) met once a month via conference call and face-to-face every other month. This group provided input to CMS on committees and documents. State CCS has attended the KASA meetings.

15) FVCA has continued to work on the development of the FVCA Parent Leadership Training Curriculum to prepare families to partner in decision-making.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. CMS will broaden its stakeholder group which includes family partnership to identify state priorities through the 2010 Needs Assessment process.				X
2. Family Voices and CMS are working together to enhance services for families of CYSHCN and involve families as partners in decision-making.		X		
3. The Family-Centered Care (FCC) Work Group of the Children's Regional Integrated Service Systems, comprised of 14 county programs, meets bimonthly to plan annual conferences, workshops, resource fairs, and address issues.				X
4. CCS programs are partnering with Family Resource Centers in their areas.		X		
5. CMS is partnering in the planning of annual educational FCC conferences (Northern and Southern California) for CCS administrators, medical, nurse and social work consultants, parent health liaison/leaders, and therapists.		X		
6. County CCS programs evaluate and report their family participation in their programs.				X
7. The FCC Work Group is providing technical assistance for CCS administrators for hiring or contracting a parent liaison.				X
8. County agencies and families are collaborating to provide workshops, resource fairs, and conferences for families of CSHCN.		X		
9.				
10.				

b. Current Activities

Current activities around this measure include:

1) Due to the state budget deficit and budget cuts, many CCS county programs have ended or are ending their parent liaison contracts. The ramifications of this will be realized in 2009.

2) The FCC Work Group continues to meet bimonthly, monitoring FCC and transition activities, parent liaison services, and medical home projects, and providing resources and support to all counties in attaining parent liaison services.

3) County CCS programs continue to evaluate their programs for family participation in the CCS program.

4) FVCA continues to facilitate PHLs monthly conference calls to discuss local activities, receive technical support, track emerging family issues, identify solutions and statewide trends, and determine training needs.

5) FVCA continues to work with CMS as the Family Advisory Group to enhance services for families of CSHCN.

6) FVCA KASA (Kids As Self Advocates) youth council continues to meet once a month and provide input to CMS.

7) FVCA continues to develop the FVCA Parent Leadership Training Curriculum to prepare families to partner in decision-making.

8) The following additional family-centered & community-based coordinated care activities are continuing into 2009: a) statewide newsletter (CaCSHCNews); b) website for those caring for

CSHCN (www.CSHCN-ca.org); and c) Transition Task Force.

c. Plan for the Coming Year
1) CMS will bring together a broad stakeholder group and focus groups through the Needs Assessment process during 2009.

2) FVCA will continue to support the PHL services and provide trainings to the PHLs to assist families.

3) FVCA will continue to facilitate the PHL's monthly conference calls to discuss local activities, provide technical support, track families' issues, identify statewide trends, and determine training needs.

4) FVCA will continue to meet with CMS as the Family Advisory Group and respond to requests for input on materials and committees.

5) FVCA will continue monthly KASA meetings, both face-to-face and by phone, to ensure their ability to provide input to CMS.

6) FVCA will continue to provide trainings to families and professionals so families can partner in decision-making.

7) FVCA will continue to translate materials into Spanish and Chinese.

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

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	46.5	48	50	51	51
Annual Indicator	44.7	44.7	44.7	42.2	42.2
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	42.5	43	43.5	44	44.5

Notes - 2008
This measure is the percent of CSHCN in the State age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005 - 06.

Notes - 2007
Section Number: Performance Measure #3
Field Name: PM03
Row Name:
Column Name:
Year: 2007
Field Note:

This measure is the percent of CSHCN in the State age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005 - 06.

Notes - 2006
The data reported in 2002 have pre-populated the data for 2006 for this performance measure and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN in the State age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

a. Last Year's Accomplishments
NPM 03 is from the National CSHCN Survey. Based on the 2005-2006 survey, 42.2 percent of the CSHCN in California receive coordinated, ongoing, comprehensive care within a medical home. The most recent National Survey of CSHCN (2005-2006), conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics, identified approximately 750 parents of children with special needs in each state. CCS collaborated with CHLA and the California Epilepsy Foundation on a grant from HRSA, "Improving Access to Care for Children and Youth with Epilepsy in California," also known as "Project Access." The overall goal of the project is to improve access to health and other services related to epilepsy by facilitating the development of state-wide community-based interagency models of comprehensive, family-centered, culturally-effective care and state-wide standards of care, particularly in medical home settings. Other activities include:

1) Collaborated with USC's UCEDD at CHLA, CRISS, and FVCA, on Project Access to increase the number of medical homes for children with epilepsy in Sonoma county.

2) County CCS programs assessed CCS eligible children to determine if they had a documented medical home and explore improvement strategies.

3) The "Hospital Discharge Questionnaire" developed by FVCA and the PHL Network, was provided to families to improve the coordination of care for their child when they come home from the hospital and is available in English, Spanish, and Chinese.

4) Child Health Notebooks to help organize healthcare information and medical records were distributed (also available electronically) in the 14 CRISS counties.

5) FVCA provided trainings for families and professionals on the Medical Home Initiative and distributed binders to help families organize healthcare information and medical records.

6) FVCA provided "resource referral pads" for physicians that list local resources for families.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with USC's UCEDD at CHLA, CRISS, and FVCA, on Project Access to increase the number of medical homes for children with epilepsy in Sonoma County.		X		
2. County CCS programs assess CCS eligible children to determine if they have a documented medical home and explore improvement strategies.				X
3. The "Hospital Discharge Questionnaire" developed by FVCA and the PHL Network, is provided to families to improve the coordination of care for their child when they come home from the hospital.				X
4. Child Health Notebooks to help organize healthcare information and medical records are distributed (also available electronically) in the 14 CRISS counties.				X
5. FVCA provides trainings for families and professionals on the Medical Home Initiative and distributes binders to help families organize healthcare information and medical records.				X
6. FVCA Agencies provide a “resource referral pads” to physicians that list local resources for families.				X
7.				
8.				
9.				
10.				

b. Current Activities

1) Project Access in Sonoma County officially ends in May 2009, but the CCS program intends to continue to convene the local coalition and support the medical home objectives.

2) County CCS programs continue to assess whether CCS eligible children have a documented medical home, and explore improvement strategies.

3) The "Hospital Discharge Questionnaire," developed by FVCA and the PHL Network, is provided to families to improve the coordination of care for their child when they come home from the hospital and is available in English, Spanish, and Chinese.

4) Child Health Notebooks to help organize healthcare information and medical records are distributed in the 14 CRISS counties.

5) FVCA provides trainings for families and professionals on the Medical Home

Initiative and distributes binders to help families organize healthcare information and medical records.

6) FVCA agencies provide "resource referral pads" to physicians listing local resources for families.

7) Work is on hold due to budgetary impact on developing policy for CCS regarding the medical home for CCS clients, authorization of the medical home, including phone consultation and care coordination.

c. Plan for the Coming Year
Plans for the coming year include:

1) The partners in Project Access will continue to collaborate and support the medical home development for children with epilepsy in Sonoma County.

2) Continue evaluation by county CCS programs to determine if children have a medical home and explore improvement strategies.

3) The "Hospital Discharge Questionnaire," developed by FVCA and the PHL Network, will be provided to families to improve the coordination of care for their child when they come home from the hospital and is available in English, Spanish, and Chinese.

4) Child Health Notebooks to help organize healthcare information and medical record will be distributed in the 14 CRISS counties and also made available electronically.

5) FVCA will continue to provide trainings for families and professionals on Medical Home and distribute binders to help families organize healthcare information and medical records.

6) FVCA Agencies will provide "resource referral pads" to physicians, listing local resources for families.

Project Access in Sonoma County officially ends in May 2009, but the CCS program intends to continue to convene the local coalition and support the medical home objectives. Project Access in Sonoma county resulted in the creation of medical homes for children with epilepsy in all three FQHC sites, distribution of parent-friendly materials including a child health notebook, and widespread distribution of standardized seizure action plan and provider information on medical home.

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

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	62.5	64.5	65.5	68.5	65.5
Annual Indicator	59.3	59.3	59.3	59.6	59.6
Numerator					
Denominator					
Data Source					National

					Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	60.3	60.6	61	61.3

Notes - 2008
This measure is the percent of CSHCN age 0 to 18 years whose families have adequate private and/or public insurance to pay for the services they need.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2007
Section Number: Performance Measure #4
Field Name: PM04
Row Name:
Column Name:
Year: 2007
Field Note:

This measure is the percent of CSHCN age 0 to 18 years whose families have adequate private and/or public insurance to pay for the services they need.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2006
The 2006 indicator is pre-populated from 2002 and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families have adequate private and/or public insurance to pay for the services they need.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

a. Last Year's Accomplishments
NPM 04 is from the CSHCN Survey and is related to population-based services. For the 2005-2006 survey, 59.6 percent of families of CSHCN age 0 to 18 years in California had adequate

private and/or public insurance to pay for the services they needed.
The most recent National Survey of CSHCN (2005-2006), conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics, identified approximately 750 parents of children with special needs in each state.

The CMS Branch determines whether CCS eligible children had access to private health coverage utilizing CDHS' Other Health Coverage (OHC) file. When the CMS Branch learned that a child had coverage not shown on the OHC file, it added this information to the file. CHDP programs and providers continued to identify and "deem" certain infants less than one year of age as eligible for ongoing, full-scope, no cost Medi-Cal at the time of a CHDP Health Assessment. The CMS Branch continued to work with HF and the AIM program to facilitate enrollment of eligible infants into HF and those with CCS eligible conditions into the CCS program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The CMS Branch continues to determine whether CCS eligible children have access to private health coverage utilizing CDHS' Other Health Coverage (OHC) file.		X		
2. CHDP programs and providers are identifying and "deeming" certain infants less than one year of age as eligible for ongoing, full scope, no cost Medi-Cal at the time of a CHDP Health Assessment.		X		
3. The CMS Branch continues to work with HF and the AIM program to facilitate enrollment of eligible infants into HF and those with CCS eligible conditions into the CCS program.		X		
4. The CMS Branch will continue to implement the CHDP Gateway and identify CCS eligible children through the Gateway process.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1) The CMS Branch continues to work with HF and the AIM program to facilitate enrollment of eligible infants into HF and those with CCS eligible conditions into the CCS program.

2) The CMS Branch continues to update the OHC file as health coverage information is obtained.

3) The CMS Branch continues to implement the CHDP Gateway and identify CCS eligible children through the Gateway process.

4) As resources become available, develop strategies to refer children enrolled in CCS to all sources of available insurance, including Healthy Families, county Healthy Kids programs, Kaiser Permanente (KP) Care for Kids, and Medicaid waiver programs as appropriate.

5) As resources become available, link state and local CCS programs and other agencies serving CSHCN with funded outreach programs and projects promoting insurance coverage for children (e.g., Governor's coverage initiatives, other campaigns).

6) As resources become available, review existing Medicaid waivers and consider opportunities for expansion to include additional youth, e.g., for Medi-Cal "deeming" for additional youth with special health care needs (YSHCN).

c. Plan for the Coming Year
CMS will continue to participate in health care financing discussions at various levels of state government.

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

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	68	69	70	71	85.5
Annual Indicator	65.9	65.9	65.9	85.3	85.3
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	86	86.5	87	87	87

Notes - 2008
This measure is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2007
Section Number: Performance Measure #5
Field Name: PM05
Row Name:
Column Name:
Year: 2007
Field Note:

This measure is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2006
The 2006 indicator is pre-populated from 2002 and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

a. Last Year's Accomplishments
NPM 05 is a National CSHCN Survey measure and is the percent of CSHCN age 0 to 18 years whose families report that community-based service systems are organized so they can use them easily. For California in 2005-2006, the result was 85.3 percent.

The most recent National Survey of CSHCN (2005-2006), conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics, identified approximately 750 parents of children with special needs in each state.

1) CRISS Medical Eligibility Work Group met quarterly with CCS medical consultants, hospital and pediatric representatives to improve consistency in inter-county interpretation of CCS law and regulation.

2) CHDP, HCPCFC, and CCS programs reported on a performance measure evaluating effective care coordination.

3) The LA Partnership for Special Needs Children (LAPSNC) focused on increasing parent involvement by inviting representatives from the Family Resources Centers (FRC) to meetings, and joining committees.

4) FVCA Council Agencies worked with their local CCS agency to provide trainings to CCS employees, and connect families to Family Resource Centers for community resources, support and information.

5) The FCC Work Group met bimonthly to review county FCC activities, share resources, and plan conferences, trainings, and activities.

6) The CMS Branch, in partnership with Medi-Cal, submitted the Pediatric Palliative Care Waiver application to the federal Centers for Medicare and Medicaid Services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. CRISS Medical Eligibility Work Group meets quarterly with CCS medical consultants, hospital and pediatric representatives, to improve consistency in inter-county interpretation of CCS law, regulation.				X
2. CHDP, HCPCFC, and CCS programs report on a performance measure evaluating effective care coordination.				X
3. The LA Partnership for Special Needs Children (LAPSNC) focuses on increasing parent involvement by inviting representatives from the Family Resources Centers (FRC) to meetings, and joining committees.				X
4. FVCA Council Agencies work with their local CCS agency to provide trainings to CCS employees, and connect families to Family Resource Centers for community resources, support and information.				X
5. The FCC Work Group meet bimonthly to review county FCC activities, share resources, and plan conferences, trainings, and activities.				X
6. The CMS Branch and the Medi-Cal program collaborate on the implementation of a pediatric Palliative Care program.				X
7.				
8.				
9.				
10.				

b. Current Activities
Current activities include:

1) CRISS Medical Eligibility Work Group, CCS medical consultants, hospital and pediatric representatives, meet quarterly to improve consistency in inter-county interpretation of CCS law, regulation and policy regarding medical eligibility and benefits in 14-county in CRISS region.

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

3) The LA Partnership for Special Needs Children (LAPSNC) focus on increasing parent involvement by inviting representatives from the Family Resources Centers (FRC) to meetings, and joining committees.

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

5) The FCC Work Group meets bimonthly to review county FCC activities, share resources, and plan conferences, trainings, and activities.

6) The CMS Branch and the Medi-Cal program collaborate on the implementation of a Pediatric Palliative Care program.

c. Plan for the Coming Year
Plans for the coming year include:

1) CRISS Medical Eligibility Work Group, CCS medical consultants, hospital and pediatric representatives, will continue to meet quarterly to improve consistency in inter-county

interpretation of CCS law, regulation and policy regarding medical eligibility and benefits in 14-county in CRISS region.

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

3) The LA Partnership for Special Needs Children (LAPSNC) will continue to focus on increasing parent involvement by inviting representatives from the Family Resources Centers (FRC) to meetings, and joining committees.

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

5) The CMS Branch and the Medi-Cal program will collaborate on the implementation of a Pediatric Palliative Care program.

6) LAPSNC is planning a conference related to identifying resources in challenging economic times for CSHCN and their families.

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

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			5.8	5.8	37.5
Annual Indicator	5.8	5.8	5.8	37.1	37.1
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	37.5	38	38	38.5	38.5

Notes - 2008
This measure is the percent of youth with special health care needs in California who receive the services necessary to make transitions to all aspects of adult life.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be

considered baseline data.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2007
Section Number: Performance Measure #6
Field Name: PM06
Row Name:
Column Name:
Year: 2007
Field Note:
This measure is the percent of youth with special health care needs in California who receive the services necessary to make transitions to all aspects of adult life.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2006
The data reported in 2002 have pre-populated the data for 2006 for this performance measure.

This measure is the percent of youth with special health care needs in the country who receive the services necessary to make transitions to all aspects of adult life.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.
Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

a. Last Year's Accomplishments
NPM 06 is a National CSHCN Survey measure and is the percentage of youth who received the services necessary to make transitions to all aspects of adult life. For California in 2005-2006, the result was 37.1 percent.

The most recent National Survey of CSHCN (2005-2006), conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics, identified approximately 750 parents of children with special needs in each state.

1) CCS social work consultants met quarterly and discuss transition issues.

2) The CMS Branch convened the Transition Task force to improve systems of care for CSHCN.

3) CMS staff collaborated with KASA via conference calls on issues surrounding transition. One particular topic was a "Transition Toolkit" designed for youth with disabilities. The toolkit, which is still in the draft stage, is a project with the California Health Incentives Improvement Project. CMS staff continues to present updates on transition at the Family Voices of California

conferences.

4) As staffing allowed, the CMS Branch staff collaborated with the Statewide Workgroup on the Transition of Care for CSHCN drafted Transition Planning recommendations with various templates for county CCS programs to use with their staff and families.

5) On January 7, 2008 FVCA held their 2nd Bi-Annual Parent Health Liaison Conference "Transition Issues" PHL Conference at the Sierra Health Foundation in Sacramento. The purpose of the conference was to: 1) Provide training to Parent Health Liaisons and FVCA Council members on Transition Issues identified by PHLs and 2) Learn about the state's (CMS) vision of transition and how to operationalize that vision.

6) CMS staff met quarterly with FVCA council members and PHL to develop strategies to improve transition for CSHCN to adult health care providers.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Counties continue to be involved in the implementation and evaluation of transition strategies.				X
2. The CMS Branch continues to meet with the Transition Workgroup to develop statewide guidelines and procedures for transition of care for CSHCN.				X
3. CMS social work consultants continue to meet on transition issues.		X		
4. State CMS staff will continue to instruct CCS-approved SCCs and those newly applying for approval on the importance and methods of integrating transition planning into patient care beginning at age 14 years.		X		
5. CMS staff will continue to meet quarterly with FVCA council members and PHL to develop strategies to improve transition for CSHCN to adult health care providers.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Current activities include:

1) CMS social work consultants continue to meet on transition issues.

2) State CMS staff continues to instruct CCS-approved SCCs and those newly applying for approval on the importance and methods of integrating transition planning into patient care beginning at age 14 years.

3) CMS continues to collaborate with Counties, Family Voices, and the KASA group on transition issues for CSHCN.

4) As staffing allows, the CMS Branch continues to meet with the Transition Workgroup to develop statewide guidelines and procedures for transition of care for CSHCN.

5) CMS staff continues to meet quarterly with FVCA council members and PHL to develop strategies to improve transition for CSHCN to adult health care providers.

c. Plan for the Coming Year

1) Some Transition Task Forces hosted by their county Developmental Disabilities Council will be hosting transition fairs and other activities to support this population.

2) CMS staff will continue to meet quarterly with FVCA council members and PHL to develop strategies to improve transition for CSHCN to adult health care providers.

3) The Statewide Youth Advisory Council, under the auspices of Family Voices of California, will be creating a transition activity calendar and developing a survey on adult health care providers and identifying needs of young adults with disabilities.

4) As staffing allows, the CMS Branch will continue to meet with the Transition Workgroup to develop statewide guidelines and procedures for transition of care for CSHCN.

5) CMS will disseminate the "Transition Toolkit."

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

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	75.8	78	82	78.4	78.9
Annual Indicator	81.3	77.9	80.3	79.4	80.6
Numerator	417804	410274	433605	432828	433234
Denominator	513904	526667	539981	545123	537511
Data Source					National Immunization Survey, 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	79.4	79.9	80.4	80.9	80.9

Notes - 2008

Source of percent immunized: Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Local Area US, National Immunization Survey, Q1/2008-Q4/2008. Available at: http://www.cdc.gov/vaccines/stats-surv/nis/tables/08/tab03_antigen_state.xls. Last accessed on September 1, 2009. Data for the 4:3:1:3:3 immunization series used.

Denominator: The number of two-year olds in the given year is from the California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007. Numerators are estimates derived by multiplying the percent of immunized children by the denominator.

Notes - 2007
Source of percent immunized: Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Immunization Action Plan Area, US, National Immunization Survey, 2007. Available at: http://www2a.cdc.gov/nip/coverage/nis/nis_iap.asp?fmt=v&rpt=tab03_antigen_state&qtr=Q1/2007-Q4/2007. Last accessed on October 10, 2008. Data for the 4:3:1:3:3 immunization series used.

Denominator: The number of two-year olds in the given year is from the California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007. Numerators are estimates derived by multiplying the percent of immunized children by the denominator.

Notes - 2006
Source of percent immunized: Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Immunization Action Plan Area, US, National Immunization Survey, 2006. Available at: http://www.cdc.gov/vaccines/stats-surv/nis/tables/06/tab03_antigen_state.xls Last accessed on January 3, 2008. Data for the 4:3:1:3:3 immunization series used.
Denominator: The number of two-year olds in the given year is from the California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007. Numerators are estimates derived by multiplying the percent of immunized children by the denominator.

a. Last Year's Accomplishments
NPM 07, the percentage of 19 to 35 month olds in California who completed the full schedule of age-appropriate immunizations, was 79.4 percent in 2007, down from 80.3 percent in 2006. This is similar to the national rate of 80.1 percent.

The current immunization rate is comparable to the Healthy People 2010 objective of 80 percent. (The standard for calculating age-appropriate immunizations changed in 2003 from the 4-3-1-3 schedule used in previous years to the 4-3-1-3-3 schedule. The data points for 2003-2007 are therefore not comparable to the data reported for previous years.)

The 4-3-1-3-3 schedule consists of four or more doses of diphtheria and tetanus toxoid and pertussis vaccine/diphtheria and tetanus toxoid (DPT/DT); three or more doses of poliovirus vaccine; one or more doses of measles-containing vaccine (MCV); three or more doses of Haemophilus influenza type b vaccine (Hib); and three or more doses of Hepatitis B vaccine (Hep B).

To promote childhood immunization, the CHDP program assures access to vaccines that are required for school entry and has issued provider information notices that contain updated information on the vaccines covered by the CHDP program. CHDP also maintains access to vaccines that are indicated in some high risk children, reimbursing medical providers for vaccine purchase when these vaccines are not supplied by the federal Vaccines for Children (VFC) program.

Efforts to improve immunization rates have been made through CHDP, Medi-Cal, Healthy Families, Healthy Start, the Health Insurance Plan of California (HIPC), the Access for Infants and Mothers Program (AIM), and the Immunization (IZ) Branch.

During the past year, the CMS Branch collaborated with the IZ Branch by 1) adjusting the reimbursement rates to equal Medi-Cal's for purchased vaccines Hepatitis A, Hepatitis B, HiB, and Pneumococcal Polysaccharide; 2) removing "high risk factor" as a requirement for inactivated influenza vaccine for children 6 months to 21 years; 3) increasing CHDP vaccine reimbursement rates for MMR, varicella, and IPV vaccines; and 4) adding Pentacel,™ Kinrix,™ and Rotarix™ vaccines as CHDP benefits as VFC vaccines.

Due to increasing parent resistance to childhood vaccines, the CMS Branch took a proactive stance to assist CHDP providers with resources and methods to promote vaccines and address parental fears. The program informed providers about educational events and resources, including: 1) about a Public Health Café web-based presentation "Talking About Vaccine Safety with Parents and Patients" sponsored by the California Immunization Coalition; 2) a 2-hour CDC webcast, "Immunization Update 2008"; 3) launch of the "Vaccinate Your Baby" campaign by Every Child By Two (ECBT), American Academy of Pediatrics and spokesperson/actress Amanda Peet; and 4) important website resources http://www.chop.edu/consumer/index.jsp and http://immunizeca.org.

California has also been working to improve regional immunization registries, creating a state hub to link all the regions, and unifying the statewide system for identifying pockets of need and developing adequate interventions. There are nine regional immunization registries, covering 57 of 58 California counties. Efforts are underway to improve the electronic exchange of information on patients moving between regions and jurisdictions and also to allow schools, childcare centers, Medi-Cal, WIC, and Cal-WORKS to link into regional registries. It is anticipated that by 2009, 8 of the 9 regional registries representing 95% of the CA population will be connected and immunization information will be securely and rapidly transferred throughout the state.

The IZ Branch holds collaborative coordination meetings three-times a year with the CMS Branch; Medi-Cal and Medi-Cal Managed Care; and Healthy Families. This is a collaborative effort to inform all involved agencies about ACIP/VFC decisions and to streamline the process for providing new immunizations as benefits under CHDP and Medi-Cal.

Local health jurisdictions continued to support IZ efforts on many levels, with activities that included trainings to providers and policy makers, professional and public outreach, participation in Coalitions with key partners, establishment of new clinic sites, referrals linking families to IZ services, provision of technical assistance and evaluation of local IZ data to determine follow-up strategies to increase rates.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCAH, OFP and CMS advocate for eligible children to join Medi-Cal or HF, both of which cover immunization.		X		
2. Healthy Start (HS), the Health Insurance Plan of California (HIPC), and Access for Infants and Mothers (AIM) provide health care access, including immunizations, for children.			X	
3. Health promotion for adequate immunizations is also done through the CHDP Gateway and AFLP, BIH, and CPSP.				X
4. Nine regional immunization registries, covering 53 of 58 California counties, provide the foundation for a centralized system of maintaining immunization records.				X
5. Based on data from the regional immunization registries, pockets of need are identified, and interventions are developed.				X
6. Efforts are underway to improve the electronic exchange of			X	

information for patients moving between regions, and to allow schools, childcare centers, Medi-Cal, WIC, and Cal-WORKS to link into regional registries.				
7. MCAH staff participate in a variety of ongoing activities, including serving on local Immunization Coalitions, participating in health fairs, providing trainings to providers, making referrals, evaluating data & establishing IZ clinic sites			X	
8.				
9.				
10.				

b. Current Activities
The CMS Branch and Medi-Cal Program are encouraging providers to deliver needed services, particularly immunizations, during the CHDP Gateway/pre-enrollment period.

MCAH, OFP and CMS advocate for families to enroll in Medi-Cal or HF. With more children having access to primary and preventive care, the number of children receiving immunizations should increase. Local MCAH Divisions, including AFLP and BIH, continue to assess the immunization status of adolescent and women clients and their children on a periodic schedule, and promote the importance of maintaining up-to-date immunizations by assisting program clients to access ongoing preventive care.

The CMS and IZ Branches, Medi-Cal, and Medi-Cal Managed Care are meeting three times per year (following ACIP-VFC National Meetings) to discuss results of the National Meetings and streamline and communicate our processes wherever possible.

The CMS Branch has posted a CHDP Provider Information Notice making the CHDP providers aware of the Immunization Branch's Virtual Town Hall Webcast, "Vaccines: Wading through the Confusion," which is available until June 30, 2009, as a podcast and an archived webcast.

c. Plan for the Coming Year
The CMS and IZ Branches will work together to make providers aware of vaccine shortages and other immunization-related issues of importance. Through the CMS Branch and the CHDP Executive Committee, local CHDP programs will be kept informed on all immunization issues.

The CMS Branch will continue to collaborate with the IZ Branch in its work on California's statewide immunization registry.

The MCAH Division and OFP will be working with the IZ Branch in its roll-out of the new adolescent immunizations over the next couple years.

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

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	21.9	20	20.1	20	19.7
Annual Indicator	20.6	20.3	20.0	19.9	19.1
Numerator	16263	16740	17208	17582	17008

Denominator	790821	822674	858626	882026	888169
Data Source					CA Birth Statistical Master File, 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	19.4	19.1	18.8	18.5	18.2

Notes - 2008
Numerator: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File. Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations were done by the MCAH Program.

Data for 2008 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 26.5; 2001 = 23.8; 2002 = 22.4; 2003 = 21.2; 2004 = 20.6; 2005 = 20.3

Notes - 2007
Numerator: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File. Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations were done by the MCAH Program.

Data for 2006-2007 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 26.5; 2001 = 23.8; 2002 = 22.4; 2003 = 21.2; 2004 = 20.6; 2005 = 20.3

Notes - 2006
Numerator: State of California, Department of Public Health, Center for Health Statistics, 2006 California Birth Statistical Master File. Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations were done by the MCAH Program.

Data for 2006 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 26.5; 2001 = 23.8; 2002 = 22.4; 2003 = 21.2; 2004 = 20.6; 2005 = 20.3

a. Last Year's Accomplishments
Reducing the adolescent birth rate is one of California's highest health priorities. Between 1987 and 1994, the birth rate among 15-17 year olds increased from 34 to 45 births per 1,000 women. Since 1994, the rate has fallen steadily, down to 26.5 in 2000, down further to 20.0 in 2006, and 19.9 in 2007. California has made good progress in this area, and has surpassed the HP 2010 target of 43 births per 1,000 women aged 15-17.

Racial and ethnic differences in the adolescent birth rate persist. In 2007, Asians had the lowest birth rate for women 15-17 years old (5.1 births per 1,000 women), followed by Whites (5.4 per 1.000). Rates for Multiple Race (13.0), American Indian (13.2), Pacific Islander (16.8), and African American (19.9) teens were higher. Hispanic adolescents had a birth rate of 34.4 per 1,000 women, more than five times higher than the rates for Asians and Whites.

The MCAH Division and OFP support several teen pregnancy prevention programs. AFLP utilizes a case management and mentoring model to assess and address the risks and resources of adolescent clients and their children related to pregnancy prevention, birth outcomes, child health and safety, access to health insurance, appropriate utilization of health care, and to enhance the psychosocial and economic well-being of the adolescent family.

OFP programs include the Family Planning, Access, Care, and Treatment Program (Family PACT); the Community Challenge Grant (CCG) Program; and the Domestic Violence Program (DV). California's 2009 Budget Act eliminated the Teen Smart Outreach (TSO) Program, the Male Involvement Program (MIP); and the Information and Education Program (I&E).

In addition to the CDPH teen pregnancy prevention programs, DSS operates the Cal Learn program, and CDE funds 140 school districts and county offices of education to operate the California School Age Families Education (Cal-SAFE) program. Cal Learn assists pregnant/parenting teens to attend and graduate from high school, and provides case management services according to AFLP standards. Cal-SAFE is designed to increase the availability of support services necessary for enrolled expectant/parenting students to improve academic achievement and parenting skills.

The MCAH Division staff actively participated on the Preconception Health Council of California (PHCC), a partnership between the MCAH Division and the March of Dimes California Chapter (MOD). Formed in 2006, the Council is a state-wide collaborative composed of stakeholders and decision-makers in the development of preconception care services. It provides information, tools and resources to local communities focusing on the importance of achieving optimal health for all women before pregnancy, reproductive life planning, and pregnancy spacing.

The Adolescent Sexual Health Workgroup (ASHWG), a product of national stakeholder meetings, is comprised of program managers from the MCAH Division, OFP, the STD Control Branch, the Office of AIDS, the California Department of Education, and private partners. The ASHWG Data Integration Subcommittee achieved agreement among its state agency partners on generating STD, HIV, and birth data with the same age, racial/ethnicity, and gender categories. State-level tables have been generated for 2000-2004 and are posted on the MCAH website, as well as the website or the California Adolescent Health Collaborative, an MCAH contractor. The Subcommittee is still working to resolve confidentiality issues regarding small cell sizes for syphilis, gonorrhea, and AIDS data in age and race/ethnic categories, and to address dissemination issues in making county level data available to LHJs. MCAH participated in AMCHP's national conference to highlight the newly developed data integration tables that identified disparities among ethnic populations.

ASHWG also developed Core Competencies for adolescent sexual and reproductive health. These cover basic knowledge, attributes, abilities and skills and are intended to apply to all staff and professionals who interact with youth. The Core Competencies are intended as an interdisciplinary guide that can be used in multiple ways, including recruiting and hiring staff, staff development and training, self assessment performance appraisal, curriculum development, and quality assurance in program implementation. Feedback from potential users and national experts has been incorporated, and the Core Competencies have been finalized and made available online.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. AFLP provides case management services to pregnant and/or parenting teens to improve birth outcomes and prevent additional pregnancies.		X		
2. The Family PACT Program provides reproductive health services, education, and counseling to 300,000 adolescents annually, including comprehensive clinical exams and access to contraception.	X			
3. The Community Challenge Grant Program funds 116 community agencies and serves approximately 167,000 teens annually.		X		
4. Cal-SAFE, operating in 140 school districts, enables expectant/parenting adolescents to improve academic achievement and parenting skills, and provides quality child care/developmental programs for their children.			X	
5. MCAH, OFP, Office of AIDS, and the Sexually Transmitted Disease offices collaborate with key stakeholders at the state level, to better coordinate efforts in HIV, STD, and teen pregnancy prevention.			X	
6. MCAH, OFP and key stakeholders collaborate on data integration to generate STD, HIV, and birth data for 2000-2004.				X
7. MCAH, OFP and key stakeholders collaborate on Core Competencies, a document intended as an interdisciplinary guide for staff and professionals who work on adolescent sexual health issues.				X
8.				
9.				
10.				

b. Current Activities

OFP contracts with the UCSF Bixby Center for Reproductive Health Research & Policy to provide program monitoring and evaluation services for Family PACT and CCG.

AFLP, Family PACT, and CCG continue teen pregnancy prevention efforts. However, in response to the budget deficit facing California, proposed budget reductions could result in less program evaluation, education, and outreach for teen pregnancy prevention programs.

In FY 2008-09, state general funds for AFLP were decreased by 10%. To minimize the impact, MCAH made adjustments in other programs to fully fund the program.

ASHWG provider Core Competencies for adolescent sexual/reproductive health were finalized and disseminated via the internet. MCAH will develop a mechanism to determine their implementation and application. Lastly, ASHWG will be assessing its role in promoting youth development.

The Preconception Health and Healthcare Initiative (PHHI) launched a website (www.everywomancalifornia.org) to provide information for people working in preconception health.

Through collaboration between the PHCC and AFLP, a new reproductive life planning tool for teens is being piloted in Sacramento County and will be available for use.

The MCAH Epidemiology, Assessment and Program Development Branch completed a Teen

Birth Rate Resource, which includes detailed maps and tables of teen birth rates by race/ethnicity at sub-county levels, for targeting of teen pregnancy prevention efforts.

c. Plan for the Coming Year

In spite of the considerable success in the reduction of teen birth rates in recent years, teen pregnancy prevention will continue to be a major issue for California, given the demographics of California's youth population.

ASHWG will continue to promote integration among HIV, STD, and teen pregnancy prevention programs in CDPH and CDE. The ASHWG Data Integration Subcommittee will work on further refinement of the standard data tables, including addressing the issues of confidentiality and small cell size.

The Core Competencies for providers of adolescent sexual and reproductive health have been finalized and disseminated, and now ASHWG is deliberating about next steps for the core competencies (i.e., curriculum).

Continued collaboration between PHHI, AFLP and Family PACT will offer further opportunities for integration of culturally appropriate tools and resources into existing programs helping teens to take charge of their reproductive lives.

PHHI continues will enhance and promote its new website, which will also feature links to resources such as reproductive life planning toolkits and other materials relevant to teens.

The MCAH Epidemiology, Assessment and Program Development Branch will work to post the Teen Birth Rate Resource as an interactive website maintained by OSHPD to facilitate use of this resource by stakeholders.

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

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	20.2	31	27.6	27.6	28.1
Annual Indicator	27.6	27.6	27.6	27.6	27.6
Numerator	132808	130064	129152	128373	129671
Denominator	481280	471246	467943	465121	469824
Data Source					Dental Health Foundation, 2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	28.6	29.1	29.6	30.1	30.1

Notes - 2008
Data source for percent of third grade children with sealants: Dental Health Foundation, California Smile Survey, "Mommy It Hurts to Chew," February 2006. Accessed 10/02/08 at http://www.dentalhealthfoundation.org/images/lib_PDF/dhf_2006_report.pdf. As of 09/01/09, the website for Dental Health Foundation is not accessible so a review for a more current data source could not be obtained at this time.

*Based on weighted results from a completed survey of a representative sample of elementary schools in California conducted during 2004-05. Dental sealant information is based on one-minute, non-invasive oral health screening of all third graders in selected schools using protocols from the Association of State and Terroitorial Dental Directors at http://www.dentalhealthfoundation.org/index.php?option=com_content&task=view&id=43&Itemid=60. Accessed 10/02/08.

Denominator source: California Department of Education. Accessed 09/01/09 at http://dq.cde.ca.gov/dataquest/StateEnr.asp?cChoice=StEnrGrd&cYear=2008-09&cLevel=State&cTopic=Enrollment&myTimeFrame=S&submit1=Submit

Notes - 2007
Data source for percent of third grade children with sealants: Dental Health Foundation, California Smile Survey, "Mommy It Hurts to Chew," February 2006. Accessed 10/02/08 at http://www.dentalhealthfoundation.org/images/lib_PDF/dhf_2006_report.pdf. *Based on weighted results from a completed survey of a representative sample of elementary schools in California conducted during 2004-05. Dental sealant information is based on one-minute, non-invasive oral health screening of all third graders in selected schools using protocols from the Association of State and Terroitorial Dental Directors at http://www.dentalhealthfoundation.org/index.php?option=com_content&task=view&id=43&Itemid=60. Accessed 10/02/08.

Denominator source: California Department of Education. Accessed 10/02/08 at http://dq.cde.ca.gov/dataquest/StateEnr.asp?cChoice=StEnrGrd&cYear=2007-08&cLevel=State&cTopic=Enrollment&myTimeFrame=S&submit1=Submit. Numerators are estimates derived by multiplying the percent of children with a sealant by the denominator.

Notes - 2006
Data source for percent of third grade children with sealants came from the Dental Health Foundation, California Smile Survey, "Mommy It Hurts to Chew" February 2006, at http://www.dentalhealthfoundation.org/images/lib_PDF/dhf_2006_report.pdf. Denominator source came from the California Department of Education, at http://data1.cde.ca.gov/dataquest/StateEnr.asp?cChoice=StEnrGrd&cYear=2006-07&cLevel.
*Based on weighted results from a completed survey of a representative sample of elementary schools in California, 2006. Dental sealant
information is based on one-minute, non-invasive oral health screening of all third graders in selected schools using protocols from the Association of State and Terroitorial Dental Directors at http://www.dentalhealthfoundation.org/index.php?option=com_content&task=view&id=43&Itemid=60, Access Date: 4-18-08

a. Last Year's Accomplishments
Children's access to preventive dental services is assessed in relation to the percent of third grade children who have received protective sealants on at least one permanent molar tooth. The percent with sealants in California is estimated to be 27.6 percent in 2007. The Healthy People 2010 objective is 50 percent.

The estimate for this performance measure is from the Oral Health Needs Assessment (OHNA), a survey of a representative sample of elementary schools in California during the 2004-2005

school year. Dental sealant information is based on a one-minute, non-invasive oral health screening of all third graders in selected schools. The CA Office of Oral Health (OOH) partnered with the MCAH Division and the Dental Health Foundation to conduct the OHNA.

The CA Office of Oral Health (OOH) oversees the California Children's Dental Disease Prevention Program (CDDPP), which serves more than 300,000 preschool and elementary school children annually. The CDDPP includes the screening/application of dental sealants to children in grades 2-5 as well as other oral health activities. Last year, 46,223 sealants were placed on 14,318 children enrolled in this program.

In partnership with CDDPP and the UCSF School of Dentistry, Sierra Health Foundation's BRIGHTSMILES Program awarded up to $1 million in grants over a 3 year period to 5 new and 5 existing CDDPP school-based oral health preventive service programs. These programs continue to follow the CDDPP model of screening, preventive treatment and education for more than 9000 children per year. Last year 1849 students received sealants through the BRIGHTSMILES program.

CHDP provided dental screenings for 1,683,900 children in FY 2007-08. The CHDP program encourages providers to provide fluoride varnish in children ages 0-6 years.

To meet the growing demand for technical assistance at both the state and local levels, the MCAH Division contracted with UCSF School of Dentistry for a dental hygienist to serve as the MCAH Oral Health Policy Consultant. MCAH, CMS, Medi-Cal and OOH are members of the CA Oral Health Access Council (OHAC). The OHAC is a diverse panel of oral health stakeholders that are working together to improve the oral health status of the state's traditionally underserved populations. MCAH, CMS, Medi-Cal and OOH are also members of the Oral Health DHCS/CDPH Work Group. The Work Group assists in the coordination of state oral health activities and serves as a clearinghouse for member organizations. In addition, MCAH, OOH and Medi-Cal are members of the CHDP Dental Subcommittee, whose goal is to increase access to dental care for the CHDP eligible population.

California law effective 2007 requires that children receive a dental check-up by May 31 of their first year in public school (kindergarten or first grade) or within 12 months prior to school entry. This new requirement will increase identification of children who need further dental examination and treatment, and also identify barriers to receiving dental care. The OOH shall conduct an evaluation of data provided by local county offices of education and submit a report to the Legislature by January 1, 2010.

The CA Dental Association Foundation has ended its Pediatric Oral Health ACCESS Program to enhance general dentists' skills and comfort levels to treat young children. An estimated 320 dentists completed the training.

The Dental Health Foundation was awarded a HRSA "Targeted State MCH Oral Health Service Systems" four-year grant. The program provides screening, health education, fluoride varnish and dental referral resources to WIC families. MCAH joined the project advisory committee to provide technical assistance. Alameda and Humboldt began pilot sites.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Medi-Cal and HF provide access to a comprehensive package of primary and preventive services, including dental care, for California's low-income children.		X		
2. CHDP provides dental screenings for over 1.8 million children		X		

a year and is developing an Oral Health for Infants and Toddlers Provider Training Manual for county programs.				
3. The CMS Branch is undertaking activities to encourage orthodontists and dentists to accept more CCS children into their practices, including more rapid reimbursement.		X		
4. The CDDPP provides dental sealants screening/application to more than 300,000 school children and oral health education in the classroom. CDDPP includes a parent education component.		X		
5. MCAH Division, with key State stakeholders (e.g. Medi-Cal, State First 5 Commission, CMS and AAP), develops and promotes policy strategies that will improve the oral health of its targeted population.				X
6. The MCAH Division has contracted with UCSF School of Dentistry for a dental hygienist to serve as the Branch's oral health policy consultant to provide technical assistance at the state and local levels.				X
7. Children are required to receive a dental check-up within 12 months of their enrollment into kindergarten or first grade, whichever is their first year of public school.				X
8. MCAH local jurisdictions are working with medical, dental and education providers in community dental health advisory boards to promote preventive oral health practices and provide fluoride varnish applications.				X
9. Sierra Health Foundation, in partnership with CDDPP and UCSF, is awarding $1 million in grants over 3 years to new and existing CDDPP school-based oral health preventive service programs.				X
10. The Dental Health Foundation was awarded a HRSA "Targeted State MCH Oral Health Service Systems" four-year grant to link WIC families with oral health resources and services.				X

b. Current Activities

MCAH continues to meet with key State stakeholders (e.g., Medi-Cal, First 5, CMS and AAP) to develop and promote policy strategies to improve the oral health of its targeted population. The MCAH Oral Health Program webpage was redesigned and updated with resources and information for both providers and the public.

Thirteen LHJs have a dental coordinator on staff. Other jurisdictions rely on their local Children's Dental Disease Prevention Program (CDDPP) and/or CHDP coordinators to integrate oral health outreach programs and fluoride varnish clinics. MCAH case management programs, such as CPSP, BIH, and AFLP, enroll women and their families into Medi-Cal and Healthy Families and provide them with necessary dental referrals. However, dental providers are difficult to find in many locations because few will accept public insurance or treat low-income pregnant women.

The CDA has formed a sealant work group to promote the use of sealants by its membership.

The HRSA "Targeted State MCH Oral Health Service Systems" grant added three more WIC sites across the state.

As a member of the advisory committee, MCAH participated in the Perinatal Oral Health Consensus Conference in February 2009 to review literature and consider recommendations. Development of state clinical oral health guidelines for providers who treat clients during pregnancy and early childhood is underway.

A brochure entitled, "Fluoride Varnish--Helping Smiles Stay Strong" is nearly complete.

c. Plan for the Coming Year

State and county programs will continue to promote oral health, but the state will not be able to fully address NPM 09 until appropriate funds are allocated for sealant promotion, placement, and continuous surveillance of prevalence. A number of cuts to optional Medi-Cal benefits, including the elimination of most adult dental coverage, will take effect July 1, 2009, which is likely to have a devastating effect on access to dental care, not only for adults, but also for children. Not only are children are much more likely to use dental services if their parents also have access, but many rural dental clinics rely upon the reimbursement they receive for adult dental services to remain open and may not be able to continue providing dental services to other eligible enrollees absent this revenue stream.

As a result of the low prevalence of sealant use demonstrated by the Oral Health Needs Assessment, the California Dental Association is planning an educational initiative for dentists to encourage more widespread use of sealants.

CHDP providers will be notified when the new sealant brochure is available for downloading on the Denti-Cal website.

Given that dental decay is the most common chronic childhood disease, the MCAH Division has identified increasing access to dental services as one of its priorities. MCAH will encourage jurisdictions to strengthen strategies to increase the number of children receiving preventive dental services. MCAH is also developing oral health indicators to measure results of local health jurisdictions' oral health activities.

The Oral Health Policy consultant will continue to provide technical assistance to local jurisdictions, including presentations, resources and links to grant funding. Oral health educational materials (in English and Spanish) that address early childhood dental decay prevention for mothers and young children will be distributed through the MCAH Division and OFP programs. Other health programs within and outside the state have also requested CDPH materials.

Collaborating with other state and external partnerships, MCAH Division staff will be participating in a number of activities over the coming year, including:

1) Enumerating CDPH programs providing health services to children and families that do and do not have an identifiable oral health component.

2) Prioritizing programs needing new or revised oral health content and developing new or revised content for them with consultation from the expert advisory panel.

3) Assisting local MCAH jurisdictions to include measures of oral health status and resources in local needs assessments, include oral health activities in local work plans, develop oral health-related outcomes measures, and integrate oral health with other local MCAH jurisdictions.

4) Creating and disseminating a set of state perinatal clinical oral health guidelines for providers engaged in the care of pregnant women and their children.

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

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	2.6	2.9	3	3.1	3
Annual Indicator	3.1	3.2	2.6	2.3	2.3
Numerator	250	257	218	191	
Denominator	7951488	7930829	8228513	8200066	
Data Source					CA Death Statistical Master File 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2.9	2.9	2.8	2.7	2.6

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2007 California Death Statistical Master File (The ICD-10 codes for fatal MV traffic injuries are: V29-V79(.4-.9), V81-V82(.1), V83-V86(.0-.3), V12-V14,V20-V28(.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V892). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2007 should be not compared to data reported in previous years due to changes in methodology used for calculating this indicator. The methodology was updated for consistency between fatal and nonfatal injury reporting. The rate now includes only motor vehicle traffic incidents and excludes motor vehicle non-traffic incidents. Rates for prior years using these updated inclusion criteria: 2000 = 2.6; 2001 = 2.7; 2002 = 2.6; 2003 = 3.2; 2004 = 2.7; 2005 = 2.8; 2006 =2.4.

Notes - 2006
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2006 California Death Statistical Master File (ICD-10 Group Cause of Death Codes 296-306). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 2.9; 2001 = 3.1; 2002 = 2.8; 2003 = 3.5; 2004 = 3.0; 2005 = 3.1

a. Last Year's Accomplishments

California motor vehicle death rates for children aged 0-14 declined from 5.4 deaths per 100,000 in 1990 to 2.9 in 2000. After a couple years or increase between 2000-2003, the motor vehicle death rate for children 0-14 has been generally decreasing, with 2007 representing the lowest rate at 2.3 deaths per 100,000. Although the 2007 rate reflects a change in methodology used to calculate this indicator, this downward trend persists after adjustment of prior year rates. (See 2007 Notes.)

Rates for Hispanic and African American children, at 2.9 and 2.8 per 100,000, respectively, were nearly twice as high as those for Whites (1.5 per 100,000) and Asians (1.4 per 100,000). (Other race/ethnic groups had too few deaths due to motor vehicle accidents to be included in the comparison.)

The Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University is a resource center on child and adolescent injury prevention. Under a contract with MCAH Division, CIPPP provided technical assistance to local health jurisdictions, and provided regular reviews of the current injury prevention literature.

MCAH Division provides funding to local health jurisdictions in support of local efforts to promote maternal and child health, and jurisdictions may use this funding for child injury prevention, among other projects. Counties are expected to continue to address childhood injury prevention issues. With their Title V allotments, 41 LHJs are participating in infrastructure building activities, and 33 LHJs include enabling services or public education. Counties also received grants from the California Office of Traffic Safety (OTS), which have enabled them to expand childhood injury prevention programs.

Many local health jurisdictions participate in Safe Kids coalitions. Safe Kids is a worldwide network of local groups whose mission is to prevent accidental childhood injury. They bring together health and safety experts, educators, foundations, corporate sponsors, governments and volunteers to educate and protect families. Safe Kids Coalitions identify and target the injury problems most prevalent in their local areas. They plan and implement strategies to address those problems by: 1) calling attention to the problem through media and public awareness activities; 2) advocating for engineering improvements and enhanced safety legislation and enforcement; 3) providing educational programs for children and families; and 4) distributing lifesaving safety devices to families in need.

To raise funds to support child injury and abuse prevention programs, the State sells personalized auto license plates, called "Kid's Plates." Kid's Plates feature a heart, hand, star, or plus sign. The proceeds fund child injury prevention efforts, including bicycle safety, motor vehicle occupant protection, and pedestrian safety, as well as other child injury and abuse prevention programs. The Kid's Plates Program provides a wide range of technical assistance to help foster effective regional and local injury prevention efforts and funds grants for training and equipment. CIPPP is the Kid's Plate program administrator for the Epidemiology and Prevention for Injury Control (EPIC) Branch. CIPPP also provides technical assistance to local health jurisdictions in developing, implementing and evaluating injury prevention programs. Last year, technical assistance was provided to eleven local MCAH jurisdictions and county First 5 organizations via teleconferencing.

Other activities California has undertaken to reduce motor vehicle deaths among children include: increased enforcement of drinking and driving laws; passenger restraint laws; graduated driver licensing; public education campaigns addressing the risks of drinking while driving; and vehicle safety improvements. Additional discussion of California's activities and successes in this area is included in the narratives for Health Status Indicators 3b and 3c.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Local MCAH funded programs participating in the SAFE KIDS Coalitions implement traffic safety training, child passenger safety checks and safety seat distribution, and bicycle helmet education programs.			X	
2. AFLP, BIH, and CPSP provide educational materials on use of car seats and child injury prevention.			X	
3. To raise funds to support child injury and abuse prevention programs, the State sells special car license plates, called Kid's Plates.		X		
4. The Epidemiology and Prevention for Injury Control (EPIC) Branch maintains an up-to-date list of locally operated child passenger safety seat programs for use by traffic courts, community agencies, hospitals and clinics.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Local health jurisdictions participate in Safe Kids Coalitions, child passenger safety checks, child passenger safety seat distribution and training, and bicycle helmet educational programs. Humboldt County MCAH conducted a Gift of Safety campaign designed to raise awareness about childhood injury prevention through radio advertisement, encouraging the purchase of safety equipment during the holiday season 2008. San Diego County MCAH developed a low literacy curriculum covering health and safety information from pregnancy through age 3 years, which is tailored for use during homes visits. AFLP, CPSP, and BIH provide educational materials on use of car seats and child injury prevention instruction.

MCAH Division collaborates with the CDPH EPIC Branch on child injury prevention activities. EPIC's Vehicle Occupant Safety Program (VOSP) works to strengthen and expand California's child passenger safety infrastructure. VOSP promotes resource sharing and capacity building among California's state and local Child Passenger Safety agencies and provides professional development opportunities, technical assistance and training resources. An updated statewide list of current locally operated child passenger safety seat programs is available online at http://www.dhs.ca.gov/ps/cdic/epic.

MCAH Division continues to work with Safe Kids California Advisory Committee, the Statewide Coalition on Traffic Safety, and the Child Death Review Council.

c. Plan for the Coming Year

The current activities of the MCAH Division, CIPPP and local health jurisdictions will be continued. Fifteen LHJs have identified childhood injury prevention as a local objective in their MCAH scope of work.

MCAH Division will continue to work on the Statewide Coalition on Traffic Safety (SCOTS). SCOTS is a task force containing representatives from more than 20 state and national agencies including the CDPH MCAH Division and EPIC Branch, the California Highway Patrol (CHP), the

California OTS, the California Alcohol and Beverage Control, the California Department of Education (CDE), and the California Department of Transportation (Caltrans). As an active partner in the SCOTS coalition, the MCAH Division has assisted in motor vehicle related injury control efforts for children by establishing common statewide goals and priorities; strengthening injury prevention and control partnerships; sharing data, knowledge and resources; avoiding redundant activities; and leveraging existing resources, including funds, people and leadership attention, toward common objectives.

The California OTS is funding, as a part of a national campaign, the "Next Generation" Click It or Ticket campaign through mini-grants during the 2008-2009 fiscal year with the goal of increasing seatbelt use statewide to 95% in 2009. Collaboration of community agencies will enhance the success of this public health campaign.

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

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			69.6	71	71.5
Annual Indicator	69.1	70.2	69.4	61.6	61.6
Numerator	361762	369404	377112	260565	
Denominator	523322	526361	543134	423075	
Data Source					MIHA, 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	72	72.5	73	73.5	73.5

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Source: 2007 Maternal and Infant Health Assessment Survey (MIHA), MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported any breastfeeding at 3 months of age. Denominator: The number of women who delivered a live birth that reported whether or not they breastfed at 3 months of age. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year and exclude mothers who could not answer the question because they responded to the survey before 3 months post-partum.

Data for 2007 should not be compared to prior years due to changes in the MIHA survey. The MIHA breastfeeding question changed to breastfeeding at 3 months, compared to breastfeeding at 2 months in 2006 and prior years.

Notes - 2006

Source: 2006 Maternal and Infant Health Assessment Survey (MIHA), MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported any breastfeeding at 2 months of age. Denominator: The number of women who delivered a live birth that reported whether or not they breastfed at 2 months of age. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year.

a. Last Year's Accomplishments

Performance Measure 11 was revised in 2006 from the percentage of mothers who breastfeed their infants at hospital discharge to the percentage of mothers who breastfeed their infants at six months of age. Data on breastfeeding at age six months are currently not available for California. The closest currently available data are for breastfeeding at three months of age; these were first collected in 2007. Prior to 2007, the closest available data were for breastfeeding at two months of age. Data for this measure cannot be compared across years. In 2007, 61.6 percent of mothers breastfed their infants at 3 months of age.

MCAH Division programs such as AFLP, BIH, and CDAPP continued to promote exclusive breastfeeding among their constituencies.

The MCAH Division provided technical assistance to hospital staff at labor and delivery hospitals using the hospital breastfeeding toolkit to improve hospital lactation policies, including the use of quality assurance indicators.

MCAH Division staff provided technical assistance to other partners, such as Medi-Cal, the United States Breastfeeding subcommittee, and the California Obesity conference. MCAH staff participates on the Office of Women's Health Breastfeeding Supportive Workplaces Committee. In December, 2007, this Committee met with the Labor Commissioner, who has trained her staff on enforcing California's Workplace Lactation Accommodation Law. Dialogue continues with the Commissioner.

Through the Women's Health Action Learning Collaborative in Los Angeles County, the MCAH and the Nutrition Network Worksite Program developed a breastfeeding and weight educational handout.

MCAH cosponsored the California Breastfeeding Awareness Walk on October 15, 2008.

The MCAH breastfeeding website was expanded to include new resources: African American Breastfeeding; Emergency Preparedness: Infant and Young Child Care and Feeding; Employed/Working Mothers' Breastfeeding Resources; Medications and Breastfeeding; and Family Planning and Contraception during Breastfeeding.

MCAH staff surveyed women utilizing the CDPH Complex lactation rooms in 2005, 2007 and 2008 and provided recommendations to the Director of Public Health.

The majority of the MCAH Local Health Jurisdictions reported that they support breastfeeding via their Title V allocation funding. Examples of their provider-related activities include: Amador County developed and updated Breastfeeding Resource flier for medical and community based organizations serving young families. Butte County conducted 2-day Lactation Education Conference (150 attendees). Humboldt, Imperial, and Siskiyou produced a breastfeeding bag for hospital distribution in OB units. Kings County sponsored a Certified Lactation Counselor course and distributed a breastfeeding resource list to provider's offices, WIC, etc. They assisted in the review and adoption of the March of Dimes "Comenzado Bien" Program to make it breastfeeding friendly and worked with a group home for pregnant and parenting teens to encourage "baby friendly" policies. They also presented Breastfeeding friendly business awards to local businesses. Santa Barbara County developed M.O.U.s with physicians to enable WIC lactation consultants to assist their clients with lactation consultation.

Counties also provide breastfeeding programs and services targeted to women. Colusa County addresses low breastfeeding rates by considering every pregnant woman/mom as at risk population. To address barriers including those to breastfeeding, a new home visiting program for families with children 0-3 years old started July 2008. The El Dorado County Breastfeeding Coalition distributed tote bags containing breastfeeding information and managed the Express Stop program, providing free use of hospital grade electric breast pump at work sites for working mothers. Humboldt County created a "License to Breastfeed" card for distribution at fairs and events. Imperial County updated a Breastfeeding Resources Guide and distributed it to all moms leaving the hospital breastfeeding.

Additionally, some LHJs held community events. Lassen County held a breastfeeding awareness walk. Marin County developed a public awareness project around breastfeeding in public utilizing life-sized cutouts of women breastfeeding that was launched in September 2008. Plumas County crafted an information article for newspapers on Workplace Lactation Law.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. AFLP promotes breastfeeding among adolescent mothers, an age group that is less likely to breastfeed.		X		
2. The CDAPP promotes breastfeeding as beneficial for both mother and child in reducing the risk for diabetes.		X		
3. BIH collaborates with local breastfeeding coalitions to promote breastfeeding in several counties.		X		
4. MCAH is participating on the CDPH Obesity Prevention Group; breastfeeding promotion is one of the interventions for childhood obesity prevention.				X
5. MCAH staff help promote local breastfeeding coalitions, including working with a team from the University of California at Davis (UCD) to organize CA Breastfeeding Coalition meetings.				X
6. MCAH disseminated Breastfeeding: Investing in California's Future, 2007 by the Breastfeeding Promotion Advisory Committee.				X
7. The MCAH is providing toolkits, training and technical assistance to staff at labor and delivery hospitals to improve hospital lactation policies.		X		
8. MCAH maintains two breastfeeding pages which include breastfeeding data and reports, model hospital breastfeeding policies, information on advocacy groups, workplace lactation support and emergency preparedness.				X
9.				
10.				

b. Current Activities

MCAH continues to mail annual hospital breastfeeding rates, resources, and an offer of technical support via the Regional Perinatal Program to all labor and delivery hospital CEOs and Directors of Nursing.

The MCAH nutritionist continues as the alternate for the Association of State and Territorial Public Health Nutrition Directors on the US Breastfeeding Promotion Committee. She is an active member of the Workplace and Marketing workgroups.

MCAH continues to share information with its programs during World Breastfeeding Week held August 1-8 every year. MCAH emails all county and CBO affiliates encouraging their participation in the celebration.

Lactation technical assistance, material development and trainings will continue for MCAH Division programs, especially CPSP, AFLP, RPPC, CDAPP and BIH.

In response to California Senate Bill 22, WIC and MCAH are finalizing a web based curriculum for hospital administrators to move them toward the model hospital breastfeeding policies.

MCAH has been assisting in the revision of the nutrition sections of Caring for Our Children: National Health and Safety Standards: Guidelines for Out-of-Home Child Care Programs, with special attention to breastfeeding.

MCAH participated on a workgroup to develop a maternal health Medi-Cal Dashboard. Exclusive breastfeeding of term births at hospital discharge was chosen as a key postnatal measure.

CDAPP is updating the breastfeeding chapter of the Sweet Success Guidelines for Care.

c. Plan for the Coming Year

MCAH will continue to promulgate previous initiatives, including refining and expanding the Birth and Beyond California Project to provide technical assistance and training to hospitals in areas of California with the lowest exclusive breastfeeding rates. Hospital administrators in the Central Valley, Orange County and Los Angeles County are educated about the ways they can improve their policies and procedures. Staff and trainer education is provided free of charge, and networking opportunities are offered.

MCAH will continue to be involved with strategic planning of the CDC-funded California obesity prevention initiative entitled Nutrition, Physical Activity and Obesity Prevention Program. MCAH is part of the breastfeeding strategic planning for this grant. A temporary Breastfeeding Roundtable is being formed to replace the previous Breastfeeding Promotion Advisory Committee. This provisional group will help author the first draft of the California breastfeeding strategic plan. In the Fall of 2009, an official Breastfeeding Roundtable will be formed and begin bi-annual meetings.

MCAH will continue working with the Nutrition, Physical Activity and Obesity Prevention Program and WIC to develop one or more policies to support breastfeeding among CDPH staff, develop educational materials to support these policies, and improve signage for existing lactation rooms.

MCAH will continue to monitor hospital exclusive and any breastfeeding rates and post them on their website when feasible and accurate. In addition, MCAH continues to refine the Maternal Infant Health Assessment (MIHA) breastfeeding questions to obtain more useful data for targeting hospital interventions.

MCAH will continue to improve the CDPH and MCAH breastfeeding web pages to make them more useful to the consumer and local MCAH programs.

MCAH is in the discussion stage with CDC to negotiate a collaborative project to determine whether the level of implementation of any or all of the "Ten Steps to Successful Breastfeeding" of the Baby Friendly Hospital Initiative, measured by the CDC National Survey of Maternity Practices in Infant Nutrition and Care (mPINC) Hospital Survey, affects the percentage of women who initiate breastfeeding exclusively in California birthing hospitals. In addition, this study will assess regional differences in implementation of policies that promote and support breastfeeding throughout California hospitals. If this data linkage is implemented, the data will be used to

identify and target polices to positively impact these populations with poor rates of initiation of exclusive breastfeeding.

MCAH is the lead for updating the chapter on Normal Infant Feeding, which promotes breastfeeding, in the California Daily Food Guide.

CPSP's "Steps to Take" breastfeeding pages are being updated with materials developed by WIC and the National Breastfeeding Campaign to encourage labor and delivery options that promote, protect and support breastfeeding families.

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

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	70	70	75	75	85
Annual Indicator	68.6	75.0	75.7	73.3	73.3
Numerator	374096	411162	425638	415867	
Denominator	545329	548216	562157	567527	
Data Source					Office of Vital Records birth certificate data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	95	95	95	95	95

Notes - 2008
Manual indicator is reported for 2008 based on 2007 results. 2008 data will be available in February 2010.

Notes - 2007
Section Number: Performance Measure #12
Field Name: PM12
Row Name:
Column Name:
Year: 2007
Field Note:

Measure based on hospitals carrying out universal newborn hearing screening in California. This measure is the percent of newborns who have been screened for hearing before hospital discharge.
Source: Numerator and denominator data are from the State of California, Department of Public Health, Office of Vital Records, birth certificate data. Numerator: Number of newborns who have

been screened for hearing before discharge for FY 2007.
Denominator: Number of live births by occurrence in California in FY 2007.

Notes - 2006
Measure based on hospitals carrying out universal newborn hearing screening in California. This measure is the percent of newborns who have been screened for hearing before hospital discharge.
Source: Numerator and denominator data are from the State of California, Department of Public Health, Office of Vital Records, birth certificate data. Numerator: Number of newborns who have been screened for hearing before discharge for FY 2006.
Denominator: Number of live births by occurrence in California in FY 2006.

a. Last Year's Accomplishments
NPM 12 is the percent of newborns who have been screened for hearing loss before hospital discharge. California began implementing legislation effective January 2008 that expanded the Newborn Hearing Screening Program (NHSP) to all general acute care hospitals with licensed perinatal services. As of December 2008, there were 224 hospitals certified to participate in the NHSP, including 48 new expansion hospitals. The number of infants who received hearing screening prior to hospital discharge in this report is based on NHSP program data that was reported from the hospitals to the Hearing Coordination Centers (HCC). This does not include any estimate of screening that may be occurring in non-certified hospitals that do not report to the NHSP.

Based on information reported by the individual Hearing Coordination Centers (HCCs) for Calendar Year (CY) 2007, 415,867 infants, or 73.3 percent of all California newborns, received newborn hearing screening prior to hospital discharge. This decrease of 2 percent from CY 2006 is most likely due to a loss of aggregate screening data reports when a change in HCC contractors occurred. Since DHCS has no statewide data management capabilities, the HCCs receive monthly aggregate data reports from the hospitals for infants who pass screening and the state program only receives aggregate data reports from HCCs on a quarterly basis. This impacts the program's ability to accurately report the number of infants who receive screening, those who need follow-up, those identified with hearing loss, and those who have entered early intervention services.

Accomplishments in the past year include:

1) The CMS Branch evaluated and selected 3 HCC contractors through a competitive process to perform the expanded scope of work requiring all general acute care hospitals with licensed perinatal services to participate in the NHSP.

2) The CMS Branch revised the NHSP inpatient and outpatient screening provider standards to accommodate the program expansion.

3) California continued the NHSP Quality Improvement learning collaborative initiated with the help of the National Initiative for Children's Healthcare Quality (NICHQ) to reduce loss to follow-up.

4) The California NHSP presented at four breakout sessions at the national Early Hearing Detection and Intervention Conference in New Orleans in February 2008.

5) Representatives from the California NHSP presented aspects of the program at the International Newborn Hearing Screening Conference in Como, Italy in June 2008.

6) The CMS Branch selected a contractor, through a competitive process, to provide a statewide data management service for use by hospitals, HCCs, and the state program.

7) The CMS Branch collaborated with the Department of Developmental Services (DDS) to obtain Individualized Family Service Plan (IFSP) dates on infants in the NHSP on a quarterly basis.

8) The CMS Branch provided technical assistance and consultation support to HCCs.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The CMS Branch will work with the California Department of Education to support the implementation of the parent support activities in the grant from MCHB.		X		
2. Activities to implement a statewide data management service for the NHSP will continue.				X
3. Technical assistance and consultation support will continue for all HCCs.		X		
4. The CMS Branch will ensure that all general acute hospitals with licensed perinatal services will participate in the NHSP expansion.			X	
5. The CMS Branch continues to work with Medi-Cal and its fiscal intermediary to address issues affecting access to outpatient hearing screening and audiology services.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Current activities include:

1) Amendments to HCC contracts to implement a 10% budget cut due to California's fiscal crisis.

2) Expansion activities have been delayed. The new timeline is for all 90 expansion hospitals to be certified by December 31, 2009.

3) The California NHSP presented two breakout sessions and one poster presentation at the national Early Hearing Detection and Intervention Conference (EHDI) in Dallas in March 2009.

4) Dr. Morrow (NHSP program medical consultant) was one of 11 nominees for the Antonia Brancia Maxon Award for EHDI Excellence for 2009.

5) The CMS Branch justified the need for the data management service contract and received approval to move forward with contract execution (expected by July 1, 2009).

6) The CMS Branch continues to collaborate with DDS to obtain IFSP dates on infants in the NHSP on a quarterly basis.

7) The CMS Branch continues facilitation of the Quality Improvement learning collaborative.

8) The CMS Branch is working with the California Department of Education to implement a Memorandum of Understanding to share information between the HCCs and the MCHB-funded parent support contractors.

9) The CMS Branch is working with the Speech Language Pathology and Audiology licensing board regarding quality of care issues and standards of audiologic practice.

10) The CMS Branch continues to work with Medi-Cal and its fiscal intermediary to address issues affecting access to outpatient hearing, screening and audiology services.

c. Plan for the Coming Year
Plans for the coming year include:

1) All general acute care hospitals with licensed perinatal services will be certified and participate in the NHSP.

2) The CMS Branch will continue to collaborate in the implementation of the parent support grant from MCHB.

3) The statewide data management service for the NHSP will be implemented after contract execution.

4) The CMS Branch will continue participation and facilitation of the NHSP Quality Improvement learning collaborative.

5) The CMS Branch will produce new issues of the Audiology Bulletin to address additional areas of interest to pediatric audiologists.

6) Technical assistance and consultation support will continue for all HCCs.

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

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	15.5	12.9	13	13.5	13.3
Annual Indicator	13.1	13.6	13.9	11.2	11.2
Numerator	1323850	1443896	1458592	1185414	
Denominator	10105720	10616890	10493468	10584055	
Data Source					Current Population Survey, 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**

Annual Performance Objective	13.1	12.9	12.7	12.7	12.5

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Source: Estimated percent of uninsured children (age 0-18) is from the Kaiser Family Foundation analysis of the March 2008 release of the Current Population Survey. Denominator (estimate of the number of children 18 years of age and younger): State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. The numerator was derived by multiplying the percent uninsured by the denominator.

Notes - 2006
Source: Estimated percent of uninsured children (age 0-18) is from the Kaiser Family Foundation analysis of the March 2007 release of the Current Population Survey. Denominator (estimate of the number of children 18 years of age and younger): State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. The numerator was derived by multiplying the percent uninsured by the denominator.

a. Last Year's Accomplishments
The percent of uninsured children in California has decreased nearly 30 percent since 2000, when 15.7 percent of those aged 0-18 lacked health insurance. After slight increases in 2005-06, the percent without insurance declined significantly in 2007 to 11.2 percent. Despite this success, over 1.1 million children still lack coverage. The Healthy People 2010 objective is zero percent uninsured.

Data for NPM 13 are based on the U.S. Current Population Survey. Estimates derived from the 2007 California Health Interview Survey (CHIS), which utilizes a different survey methodology, produce slightly lower numbers [60]. According to the 2007 CHIS, 1.1 million California children age 0 to 18 (10.2 percent) lacked health insurance coverage all or part of the year in 2007. [78]

Insurance coverage rates depend largely on three sources of coverage: job-based insurance, Medi-Cal and Healthy Families (HF). According to the 2007 CHIS, just over half of children aged 0-18 were covered by job-based health insurance, and less than a third were enrolled in California's Medi-Cal and HF programs[78]. Of California's uninsured children, 385,000 (56%) were eligible for enrollment in Medi-Cal or HF. Another 155,000 uninsured children were eligible for one of the 14 county-based Healthy Kids programs in 2007, but not enrolled. The remaining 143,000 uninsured children were not eligible for these public programs due to family income, or because they lived in counties without a Healthy Kids expansion program. [63] California's number of uninsured children could be reduced 80 percent if all children eligible for public insurance programs were enrolled. In an effort to decrease the number of uninsured children, a comprehensive outreach and education campaign has been undertaken to increase enrollment in Medi-Cal and HF. Efforts to reduce administrative barriers include a shortened joint application for both Medi-Cal and HF, elimination of quarterly status reports under Medi-Cal, and on-line enrollment. Health-e-APP, a web-based HF application, became available in 2003 and has improved speed, accuracy, and consumer satisfaction with the application process.

Through the CHDP Gateway, any child under 19 years with family income at or below 200 percent FPL (and not already in the MEDS system) is "presumed eligible" for Medi-Cal or HF and given a temporary Medi-Cal Benefits Identification Card. This provides access to no-cost, full-scope fee-for-service Medi-Cal benefits for up to 60 days. From July 2003 through December 2008, 3.9 million children were pre-enrolled in the Gateway, and 77 percent requested a joint application for Medi-Cal and HF. From June 2004 through December 2008, 285,027 infants were automatically enrolled in Medi-Cal, with 69,903 infants automatically enrolled as the result of a Gateway transaction in FY 2007-08.

A significant share of California's uninsured but eligible children are served by the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Senate Bill (SB) 437, enacted in October 2006, created the WIC Gateway. This allows parents and caretakers of infant and child WIC applicants to submit a simple electronic application to simultaneously obtain presumptive eligibility for Medi-Cal or HF and apply for enrollment to either as well. By targeting locations already serving many of these uninsured children--such as WIC agencies--and simplifying the enrollment process, the WIC Gateway has the potential to enroll tens of thousands of uninsured children into Medi-Cal and HF.

Many counties have created Children's Health Initiatives (CHI) to locally fund insurance programs for children ineligible for Medi-Cal (Medicaid) or Healthy Families (SCHIP) coverage. In 2001, one county covered 1,335 children, and by 2007, 23 counties covered 86,000 children. The California Children's Health Initiatives (CCHI) is a collaboration of 32 local CHI's dedicated to ensuring that all California children have access to quality health coverage. Together, the CHI's emphasize streamlined enrollment into HF, Medi-Cal and Healthy Kids insurance programs, and share a goal of creating and maintaining a sustainable health care program for all children in California. Local MCAH programs assist families to enroll in available insurance programs, with 38 counties cumulatively reporting 46,353 referrals to Medi-Cal; 14,003 to HF; 776 to Access for Infants and Mothers (AIM); 333 to Healthy Kids; and 40,654 referrals to other insurance.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCAH Division programs encourage and facilitate enrollment in Medi-Cal and HF and CHI via education and assistance efforts.			X	
2. The CMS Branch works to maximize the effectiveness of the Gateway for enrolling eligible children in Medi-Cal or HF.				X
3. CHDP provides information and materials in multiple languages for the Gateway.				X
4. CDPH and MRMIB continue to implement and support improvements in the process of eligibility determination and enrollment for Medi-Cal and HF.		X		
5. DHCS and the WIC Program will conduct a feasibility study report over the next year to determine the viability of the WIC Gateway (established through legislation in 2006) and guide its development and implementation.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCAH Division programs, including AFLP, BIH, and CPSP, encourage and facilitate enrollment in Medi-Cal and HF and CHI. Efforts are ongoing and include public awareness media campaigns and other community education efforts. For example, Humboldt County implemented local systems changes to assure that infants born to mothers on Medi-Cal are immediately enrolled in Medi-Cal and to better track children accessing health care through the CHDP Gateway.

CDPH, DHCS and MRMIB, in collaboration with stakeholders, are responsible for designing, promulgating and implementing the WIC gateway to streamline and expedite health insurance enrollment for children served at local WIC agencies.

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

State funding for Certified Application Assistants (CAA) was terminated as of July 2003 due to the state budget crisis. Some CAAs continue working on a county-funded or volunteer basis, and the State continues to provide CAA trainings. CAAs work with families in clinics, community centers, schools, and homes, helping them navigate the complex eligibility structures of Medi-Cal and HF.

c. Plan for the Coming Year

MCAH Division programs, including AFLP, BIH, and CPSP, will continue to encourage and facilitate enrollment in Medi-Cal, HF and CHI.

DHCS and MRMIB will continue to implement and support improvements in the process of eligibility determination and enrollment for Medi-Cal and HF.

MCAH local health jurisdictions will continue to provide referrals to health insurance plans for MCAH families and provide supportive activities to ensure continuous access to recommended health care services. LHJs are required to determine high risk populations, target outreach, provide case finding and care coordination to women, children and adolescents who are not linked to a source of care. Other high risk groups targeted are children with special health care needs, low income pregnant women, and women of childbearing age who are at risk for adverse perinatal outcomes.

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

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			33.7	33.6	33.6
Annual Indicator	33.8	33.7	33.2	33.6	33.3
Numerator	114071	111876	112867	104896	100447
Denominator	337488	331975	339961	312190	301643
Data Source					PedNSS, 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	33.5	33.5	33.4	33.4	33.4

Notes - 2008

Data Source: CDC, Pediatric Nutrition Surveillance System (PedNSS) Annual Reports for Calendar Year 2008. Table 12C, 2008 Pediatric Nutrition Surveillance, Summary of Trends in

Growth and Anemia Indicators, Children Aged < 5 years.

Overall percent computed by summing percent of children age 24-59 months in the 85th-<95th percentile for Body Mass Index (BMI) plus the percent greater than or equal to the 95th percentile for BMI. The numerator was calculated by multiplying the denominator by this overall percent. Data available at:
http://www.dhcs.ca.gov/services/chdp/Documents/PedNSS/2008/12C.pdf. Last accessed on September 1, 2009.

In California, PedNSS data are collected from the Child Health and Disability Prevention (CHDP) Program health assessment screening appointments. The CHDP program targets low-income, high-risk children, birth through 19 years of age. CHDP data are collected in medical offices/clinics and recorded on the CHDP Confidential Screening/Billing Report form (PM 160). This form is submitted for payment and program reporting as well as serving as California's data source. These data are transmitted to the CDC for inclusion in the national PedNSS.

Notes - 2007
Data Source: CDC, Pediatric Nutrition Surveillance System (PedNSS) Annual Reports for Calendar Year 2007. Table 16C, Growth Indicators by Race/Ethnicity and Age, 2007 Pediatric Nutrition Surveillance, California, Children Aged < 5 Years. Overall percent computed by summing percent of children age 24-59 months in the 85th-<95th percentile for Body Mass Index (BMI) plus the percent greater than or equal to the 95th percentile for BMI. The numerator was calculated by multiplying the denominator by this overall percent. Data available at:
http://www.dhcs.ca.gov/services/chdp/Documents/PedNSS/2007/16C.pdf. Last accessed on October 2, 2008.

In California, PedNSS data are collected from the Child Health and Disability Prevention (CHDP) Program health assessment screening appointments. The CHDP program targets low-income, high-risk children, birth through 19 years of age. CHDP data are collected in medical offices/clinics and recorded on the CHDP Confidential
Screening/Billing Report form (PM 160). This form is submitted for payment and program reporting as well as serving as California's data source. These data are transmitted to the CDC for inclusion in the national PedNSS.

Notes - 2006
Data Source: CDC, Pediatric Nutrition Surveillance System (PedNSS) Annual Reports for Calendar Year 2006. Table 16C, Growth Indicators by Race/Ethnicity and Age, 2006 Pediatric Nutrition Surveillance, California, Children Aged < 5 Years. Overall percent computed by summing percent of children age 24-59 months in the 85th-<95th percentile for Body Mass Index (BMI) plus the percent greater than or equal to the 95th percentile for BMI. The numerator was calculated by multiplying the denominator by this overall percent. Data available at:
http://www.dhcs.ca.gov/services/chdp/Documents/PedNSS/2006/16C.pdf. Last accessed on January 3, 2008.

In California, PedNSS data are collected from the Child Health and Disability Prevention (CHDP) Program health assessment screening appointments. The CHDP program targets low-income, high-risk children, birth through 19 years of age. CHDP data are collected in medical offices/clinics and recorded on the CHDP Confidential
Screening/Billing Report form (PM 160). This form is submitted for payment and program reporting as well as serving as California's data source. These data are transmitted to the CDC for inclusion in the national PedNSS.

a. Last Year's Accomplishments
The 2007 Pediatric Nutrition Surveillance System (PedNSS) revealed that 33.6 percent of children, ages 2 to 5 years, who received WIC services, had a BMI at or above the 85th percentile. This is similar to the findings of 33.7 and 33.8 percent in 2005 and 2004, respectively,

and slightly higher than the 2006 level of 33.2 percent. The increase was in the percent of 2- to 5-year-olds at or above the 95th percentile (17.4 percent in 2007). The percent between the 85th and 95th percentiles remained constant in 2007 at 16.2%. Although there is no HP 2010 target for this age group, this is notably higher than the HP 2010 target of 5 percent of 6- to 19-year-olds at or above the 95th percentile.

Prevalence rates differ by race/ethnicity. For 2007, Pacific Islander children were most likely to have a BMI at or above the 85th percentile (46.8 percent), followed by American Indians/Alaska Natives (39.3 percent), Hispanics (35.5 percent), Whites (28.9 percent), African Americans (28.5 percent), Asians (25.7 percent) and Filipinos (25.6 percent). Prevalence increased most among Pacific Islanders (43.8 percent in 2006), but also for Hispanic (34.8 percent in 2006) and African American (27.9 in 2006) children.

The MCAH Division continues to promote early intervention to reduce childhood obesity, promoting optimal preconception weight and euglycemia pre-pregnancy, optimal prenatal weight gain and glycemic control in pregnancy, and breastfeeding. These concepts were included in the strategic plan for addressing obesity in California.

The MCAH Division has been meeting with the California Nutrition Network Program to collaborate on nutrition and physical activity efforts between programs, especially targeting preconception and African Americans.

All of the local health jurisdictions reported working on obesity efforts for 2007-08. In addition to supporting breastfeeding, examples of other county activities include: provider education for reducing the weight of women of childbearing age and the weight gained in pregnancy; evaluation of local childhood and women's obesity data and sharing with health care and public health workers through mapping and reports; county nutrition plans; school health, including walk-to-school programs; community nutrition and physical activity classes, including those utilizing the National Office of Women's Health BodyWorks curriculum for parents of tweens; Healthy Eating and Living Collaboratives; media strategies; and collaboration with CHDP and CCS. Kern County, for example, is targeting women of childbearing age with elevated BMI through analyzing data sets on obesity and providing the information to providers and the public.

CHDP collaborated with Kaiser Permanente to co-brand a poster with evidence-based messages regarding childhood obesity. This poster was disseminated to local CHDP programs, CHDP providers and health plans for use as a provider prompt to deliver evidence-based counseling when obtaining Body Mass Index percentile during the CHDP health screen. The poster is used in a counseling module that is made available for free to CHDP provider offices in an attempt to promote brief focused counseling in the healthcare setting.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Data collection from CHDP nutrition assessments for the Pediatric Nutrition Surveillance System (PedNSS) continues.		X		
2. CHDP program benefits include cholesterol and fasting blood glucose screening tests for children at risk for obesity, the complications of obesity and at risk for cardiovascular disease.			X	
3. State and local CHDP nutritionists develop and implement nutrition education, provide consultation and training to CHDP providers, and coordinate follow-up and referrals to related programs.				X
4. MCAH develops and/or provides nutrition education materials and initiatives, nutrition assessment materials, technical				X

assistance and consultation, and funding opportunities to MCAH programs and colleagues.				
5. BIH and CPSP promote optimal weight gain in pregnancy and breastfeeding in an effort to reduce the risk of obesity.		X		
6. BIH and AFLP promote physical activity and proper nutrition by encouraging healthy eating through discussions on how to cut fat, lower calories and move more.		X		
7. CDAPP promotes breastfeeding, optimal nutrition, optimal pregestational weight, optimal pregnancy weight gain, and glycemic control during pregnancy.		X		
8. The MCAH Division partners with other state programs and agencies to dialogue with advocates, experts and local MCAH directors to prevent overweight among infants and pre-school aged children.				X
9. MCAH and CMS collaborate with the California Nutrition Network for Healthy, Active Families to promote healthy eating and a physically active lifestyle among low income Californians.				X
10. MCAH Offers MCAH LHJs a “Here is Where Healthy Starts” award for policies/programs in place to support good nutrition, physical activity, safety and breastfeeding.				X

b. Current Activities

MCAH 's main approaches to preventing overweight among children 2-5 years focus on modifying risk factors before pregnancy, in utero, and in infancy. The Preconception Health Council of California (PHCC) is working on web-based fact sheets, links to resources, and best practices related to preconception health, such as healthy weight, healthy food choices and physical activity.

The CMS Branch continues to collect data from nutrition assessments by CHDP providers for infants, children, and adolescents. State and local CHDP nutritionists develop and implement nutrition education, provide consultation and training to CHDP providers, and coordinate follow-up and referrals.

MCAH and CMS collaborate with multiple partners to promote healthy lifestyles to reduce the prevalence of obesity. MCAH and CMS are on the planning committee for the 2009 Childhood Obesity Conference, which will build upon the past four conferences by promoting collaboration, showcasing evidence-based prevention interventions, accelerating the obesity prevention movement, and featuring community efforts.

MCAH is also on the planning committee for the 2009 Weight of the Nation, a national forum to highlight progress in the prevention and control of obesity through policy and environmental strategies.

MCAH and CMS continue strategic planning of the CDC-funded California Nutrition, Physical Activity and Obesity Prevention Program.

MCAH is also currently updating CDAPP nutrition and physical activity guidelines.

c. Plan for the Coming Year

The MCAH Division will collaborate with other state programs and agencies to dialogue with advocates, experts and local MCAH directors to prevent overweight among our youngest, most vulnerable children.

The MCAH Division and CMS Branch will continue to participate on the Obesity Prevention Group

(OPG), chaired by Coordinating Office for Obesity Prevention, which aims to integrate obesity prevention into CDPH programs, and develop an action plan and obesity-related proposals for funding opportunities.

MCAH is updating a cookbook for teens. Options for substituting seasonal fruits and vegetables and recommendations for physical activity will be included. In addition, MCAH will review and update the Adolescent Nutrition and Physical Activity Guidelines for AFLP.

The PHCC will market new ACOG and MOD provider guidelines for the post-partum visit, which will include guidance to providers for the interconception management of women who developed gestational diabetes during their prior pregnancy. This will be done by March 2010.

The MCAH Division will continue to provide nutrition, physical activity, breastfeeding resources and intervention ideas to MCAH health jurisdiction directors.

MCAH is leading the revision of the Pregnancy and Infant Feeding chapters of the California Food Guide.

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

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			3.4	3.7	3.6
Annual Indicator	3.4	3.8	3.0	2.6	2.6
Numerator	18154	20218	16544	14706	
Denominator	530756	532721	555604	556252	
Data Source					MIHA, 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3.5	3.4	3.3	3.2	3.1

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Source: 2007 Maternal and Infant Health Assessment Survey, MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported any smoking in the third trimester of pregnancy. Denominator: The number of women who delivered a live birth that reported whether or not they smoked during pregnancy. Numerator and deonominator are weighted to the representative number of resident women in the state who delivered a live birth that year.

Notes - 2006

Source: 2006 Maternal and Infant Health Assessment Survey, MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported any smoking in the third trimester of pregnancy. Denominator: The number of women who delivered a live birth that reported whether or not they smoked during pregnancy. Numerator and deonominator are weighed to the representative number of resident women in the state who delivered a live birth that year.

a. Last Year's Accomplishments

Smoking during pregnancy dropped again in 2007, with 2.6 percent of women who gave birth reporting they smoked during the last trimester of pregnancy. Smoking during pregnancy has declined by over 50 percent since 1999, when 5.7 percent of women reported smoking during the last three months of pregnancy. This trend is consistent with the continual decline in smoking among all women in California over the past two decades. [Data on smoking during pregnancy are from the California Maternal and Infant Health Assessment (MIHA) and include women aged 15 years and older.]

Smoking prevalence during the last trimester of pregnancy differs by racial and ethnic group. For 2007, women falling within the Other category were most likely to smoke during the last trimester (18.3 percent), followed by White women (5.6 percent) and African American women (5.4 percent). Latinas (1.0 percent) and Asians (0.3 percent) were least likely to report smoking during the last trimester. While both White and African American women had shown significant declines in 2006 compared to the prior year, both groups showed slight increases in 2007. The Healthy People 2010 target is that 99 percent of pregnant women report not having smoked in the 30 days prior to the time they are asked the question.

Efforts to reduce and prevent smoking are incorporated into MCAH Division programs serving pregnant women. AFLP assists pregnant teens by providing smoking exposure assessment and cessation assistance. To assist African American women, BIH employs a community-based strategy to modify high-risk behaviors including smoking, alcohol use, and drug use, while promoting healthy behaviors and improving access to healthcare services. For women accessing prenatal care through Medi-Cal, CPSP includes smoking cessation as one goal for improving maternal health and birth outcomes.

The decline of smoking in California over the last 20 years is largely attributable to the state's comprehensive tobacco control program, which has included a statewide media campaign, a cessation help line (with tailored counseling for teens and pregnant women), approximately 100 local programs across the state based in local health departments and community based organizations, and the energetic efforts of four ethnic networks. These efforts reduced California's overall cigarette consumption at twice the rate of the nation from 1988 to 2002; played an instrumental part in making almost all indoor workplaces smoke free, including restaurants and bars; and made tobacco less accessible and less socially desirable among youth and adults.

Smoking cessation is part of preconception care. It is one of the key components of the MCAH Division's Preconception Health and Healthcare Initiative (PHHI) and is critical to the work of the Preconception Health Council of California (PHCC). The PHCC provides information, tools and resources to local communities focusing on the importance of achieving optimal health before pregnancy, including refraining from tobacco use.

The Los Angeles Collaborative to Promote Preconception/Interconception Care embarked on a multi-phased two-year action plan "Healthy Births through Healthy Communities: A Commitment to Action" to implement systematic improvements for accessible perinatal healthcare and resources. The LA County Collaborative is comprised of the LA County MCAH programs, LA Best Babies Network (LABBN) and the March of Dimes Los Angeles Division. The Collaborative has gained key commitments from healthcare leaders and community based organizations and is promoting understanding of the importance of, and need for, preconception/interconception care. The Collaborative held a successful train-the-trainers event for135 public health providers in

March 2008 on the ABCDEs of preconception care, which included a focus on smoking cessation for women of childbearing age.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. AFLP assess clients for smoking habits and exposure to second hand smoke and discuss the risks of smoking for the mother and baby during pregnancy and after birth.		X		
2. BIH clients receive education about smoking and health; the BIH Scope of Work includes smoking cessation to reduce low birth weights.		X		
3. CPSP guidelines assist providers and practitioners with health education, nutrition, and psychosocial intervention guidelines; handouts are also available, in English and Spanish, to educate women about smoking cessation.		X		
4. The California Preconception Health and Health Care Initiative has developed a provider/patient resource packet to assist health care providers; one topic covered is smoking during pregnancy.				X
5. Four statewide Priority Population Partnerships addressing the African American, American Indian, Asian/Pacific Islander, and Hispanic/Latino populations conduct culturally specific educational and advocacy campaigns.		X		
6. The California Smokers' Helpline of the California Tobacco Control Program provides tailored counseling services for teens, adults, and pregnant women in English, Spanish, Korean, Mandarin, Cantonese, and Vietnamese.		X		
7. The Preconception Health Council of California (PHCC) was developed under the leadership of MCAH and the CA Chapter of MOD and is composed of organizations committed to creating and providing preconception care education and services.				X
8. The Los Angeles Collaborative to Promote Preconception/Interconception Care is implementing systematic improvement for accessible perinatal healthcare and resources over the next 2 years.				X
9. The MCAH and OFP websites includes links to the CDPH California Tobacco Control Section's tobacco prevention efforts.				X
10. California Diabetes Program has received CDC funding to train healthcare professionals on the detrimental effects of tobacco use, including second hand smoke on diabetic pregnant women and their unborn children.				X

b. Current Activities

AFLP clients are assessed for smoking habits and exposure to second hand smoke at entry and annually. Case managers discuss the risks of smoking to the mother and baby during pregnancy and after birth.

BIH clients receive education about smoking and health. The BIH program provides referrals for treatment services for pregnant and/or parenting African American clients who currently use tobacco products.

CPSP guidelines, "Steps to Take," assist providers and practitioners with health education,

nutrition, and psychosocial intervention guidelines. "Camera ready" handouts are available for CPSP to educate women about smoking cessation.

The CDPH Tobacco Control Section supports statewide, regional, county, and community smoking cessation projects, and promotes health and better quality of life by advocating social norms that create a tobacco-free environment.

The California Smokers' Helpline provides intensive tobacco cessation counseling for teens, adults, and pregnant women. Perinatal Services Coordinators from local MCAH programs have consulted with experts at the Helpline on educational outreach materials.

The PHCC website features fact sheets encouraging women and their partners to stop smoking if they may have a baby in the future. The website also has tools and resources for providers, such as successful models for integrating smoking cessation counseling into practice, and links to the California Smokers' Helpline and other smoking cessation programs.

c. Plan for the Coming Year

The California Smokers' Helpline will continue to provide intensive tobacco cessation counseling via the telephone, and access to materials through its website. The California Tobacco Control Section will continue its seven statewide Priority Population Partnerships addressing the issue of tobacco control with California's African Americans, American Indians, Asian/Pacific Islanders, Hispanics/Latinos, labor union members, people of low socio-economic status, and the lesbian, gay, bisexual and transgender community.

The California Diabetes Program has received special funding from the CDC to present a proactive project to healthcare providers and diabetic educators. Through their "Do You cAARd?" presentation and campaign, they provide compelling information about how tobacco use, including second hand smoke, increases insulin resistance and increases diabetes-related complications. The campaign includes a gold TAKE CHARGE card to be handed out to encourage use of the California Smokers Helpline.

AFLP, BIH, and CPSP will continue their activities related to smoking assessment, education, and cessation support for pregnant women. Local health jurisdictions will continue their smoking cessation activities, including outreach, education, referrals, data collection, and data analysis.

The LA Preconception Health Collaborative will be collaborating with the Tobacco Control Program and the Service Planning Area (SPA) 6, South Los Angeles Area Health Officer to launch a smoking cessation project that will target the African American population. LA MCAH will support the project by identifying high risk areas, likely at the zip code level, and recruiting eligible African American mothers from other programs (e.g., BIH, HBLC, and LAMB project).

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

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	4.6	4.8	5.6	4.7	4.7
Annual Indicator	5.7	4.9	5.2	4.1	4.1
Numerator	153	135	150	122	
Denominator	2689492	2762949	2865987	2955147	

Data Source					CA Death Statistical Master File, 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	4.6	4.6	4.5	4.4	4.3

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2007 California Death Statistical Master File (ICD-10 Group Cause of Death Codes 331-337). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006-2007 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 5.2; 2001 = 4.9; 2002 = 4.7; 2003 = 5.0; 2004 = 5.7; 2005 = 4.9

Notes - 2006
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2006 California Death Statistical Master File (ICD-10 Group Cause of Death Codes 331-337). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 5.2; 2001 = 4.9; 2002 = 4.7; 2003 = 5.0; 2004 = 5.7; 2005 = 4.9

a. Last Year's Accomplishments
The rate of suicide deaths among California youth declined between 1990 and 1998, from 9.2 to 6.3 per 100,000 youth. Between 1999 and 2006, the rate fluctuated around 5.0. Last year brought a further reduction, with the rate decreasing from 5.2 per 100,000 in 2006 down to 4.1 per 100,00 in 2007. The 2007 rate was the lowest observed over the past five years, and is substantially lower than the Annual Performance Objective. This is also below the all ages HP 2010 target of 5 per 100,000.

In California and across the country there is increasing recognition of the importance of promoting mental health and of early detection and treatment of mental health problems. MCAH Division programs play an important role in identifying mental health needs, intervening before mental health problems become debilitating, and facilitating access to integrated, comprehensive

treatment.

The following MCAH Division programs include a mental health component: CPSP, BIH, AFLP, DV, CDAPP, Preconception Health and Healthcare Initiative (PHHI) and local MCAH programs. All include assessment and/or referral, and some include treatment as well.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. AFLP case managers refer adolescent clients with suicide risk and other mental health problems to needed mental health services.		X		
2. AFLP case management strategies include both youth development and risk reduction activities and services.		X		
3. MCAH Division works with the Adolescent Health Collaborative and other key partners to promote best practices in mental health and suicide prevention. This includes particular attention to the foster youth population.				X
4. Local MCAH Programs work with local collaboratives which address Adolescent Health issues including youth development, drug abuse prevention and intervention, and mental health issues including suicide prevention.				X
5. Local MCAH Programs screen clients for signs of depression.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

California continues to receive funding through the Mental Health Services Act (MHSA) of 2004, which imposes a one percent tax on annual incomes in excess of $1 million. The funds, which total about $750 million a year, are distributed by the Department of Mental Health to counties. Distribution of the funds has improved the availability of county mental health services. Services planned and/or implemented to date have focused on the needs of teens and families, and have improved the ability of local MCAH staff to match client needs to available resources.

Teen clients receiving CPSP services receive a psychosocial assessment during each trimester of prenatal care and once during the postpartum period. Perinatal depression and risk of suicide ideation is one of the most common complications of the perinatal period. Some local AFLP programs also utilize the Edinburgh depression scale to screen teen clients for risk of depression. Increased psycho-social screening is identifying more perinatal adolescent risk factors. Despite the increased funding for services, many LHJs are reporting difficulty in client's access to mental health services.

Los Angeles County MCAH programs have identified adolescent well being as a local objective that includes teen suicide prevention. Interventions include a multidisciplinary collaborative planning process, website, and best practices workshop.

c. Plan for the Coming Year

The MCAH Division will continue to look for opportunities to incorporate positive youth development into its programs and coordinate with others in the State to increase the assets of our youth. MCAH will continue to work with California Adolescent Health Collaborative (CAHC) and others to promote best practices in mental health and to investigate best practices in suicide prevention.

The MCAH Division will work to maintain and improve appropriate linkages between the Department of Alcohol and Drug Programs (ADP), the Department of Mental Health (DMH), the Department of Rehabilitation, the Department of Social Services (DSS), Medi-Cal, Office of Emergency Services (domestic violence), CDPH and DHCS to address systemic barriers and create pathways to service delivery. MCAH will also continue to promote providers' screening, assessment, education, and referral to treatment and services for adolescent clients at risk of alcohol use, drug abuse, domestic violence, depression, and stress. Many of the LHJs have implemented the 4 P's Plus Program by training local providers to screen and provide brief interventions for clients at risk for tobacco, alcohol and other drug use.

MCAH will continue to support and promote the incorporation of mental health and behavioral issues into LHJ activities as they work toward improving the health and well-being of the MCAH population within their boundaries. As a result of MHSA funding, it is anticipated that services for adolescent clients with mental health or behavioral health issues will expand, and that access to care will be improved.

MCAH has a contract with the CAHC, which has reviewed adolescent health indicators, including suicide rates, and will develop a statewide profile that identifies "hot spots" (jurisdictions with poor health indicators) and "cold spots" (jurisdictions with good health indicators and effective adolescent health programs). CAHC will develop a tool for LHJs to use in assessing local community support for positive youth outcomes.

In 2008, CAHC sponsored "Epidemic of Suicide of Adolescents and Young Adults" Workshop in Sacramento on August 4th with more than 100 participants. The CAHC website includes research information about adolescent suicide. Select LHJs will receive technical assistance from the CAHC to do additional qualitative work in identified hot spots and consider best practice programs which have shown effectiveness in similar health jurisdictions.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	69.6	68.5	68.2	67.2	67.5
Annual Indicator	68.0	67.1	66.9	67.3	67.3
Numerator	4360	4546	4471	4577	
Denominator	6411	6770	6679	6800	
Data Source					CA Birth Statistical Master File 2007; CCS, 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	67.8	68.1	68.4	68.4	68.7

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Source: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File and California Children Services, Approved Hospitals for NICUs as of December 2008. Tabulations, by place of occurrence, were done by the MCAH Program.

Notes - 2006
Source: State of California, Department of Public Health, Center for Health Statistics, 2006 California Birth Statistical Master File and California Children Services, Approved Hospitals for NICUs as of Jan. 30, 2006. Tabulations, by place of occurrence, were done by the MCAH Program.

a. Last Year's Accomplishments
NPM 17, the percent of Very Low Birth Weight (VLBW) infants delivered at facilities for high-risk deliveries and neonates, has fluctuated around 67 percent since 2000. The lowest point was in 2001 and the highest point was 68.7 in 2002. In 2007, 67.3 percent of VLBW infants were delivered at such facilities, which is far short of the Healthy People 2010 objective of 90 percent.

There is some variation by race/ethnicity in the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates. In 2007, Asians and Whites had the lowest percentages of these VLBW deliveries at NICU facilities at 64.97 and 65.6, respectively. American Indians had the highest percent (83.3), followed by African-Americans (72.3), Pacific Islanders (70.06) and Hispanics (67.1).

The California figures are based on data from hospitals designated by the CCS program as Regional, Community or Intermediate NICUs. There are currently 114 CMS-approved NICUs in California, however, not all facilities providing care for VLBW infants seek certification by CCS.

The fourteen Regional Perinatal Programs of California (RPPC) provide planning and coordination to ensure that all high-risk patients are matched with the appropriate level of care. The RPPC develops communication networks, disseminates education materials, assists hospitals with data collection for quality improvement, and provides hospital linkages to California's Perinatal Transport Systems (CPeTS).

The MCAH Division has two data projects which monitor perinatal outcomes: the Improved Perinatal Outcome Data Reports (IPODR) (http://www.cdph.ca.gov/data/indicators/Pages/InfantPerinatalOutcomesDataReport.aspx) and the California Perinatal Profiles (http://perinatalprofiles.berkeley.edu/). The IPODR website includes an annual county profile report based on California Birth/Death Vital Statistics and Hospital Discharge Data aggregated at the zip code level. The California Perinatal Profiles website provides both public (state and regional) and confidential (hospital specific) data to aid quality improvement in maternity hospitals in California.

Efforts continue to improve data collected from birth certificates. In 2007-2008 the Office of Vital Records (OVR) invited MCAH to work through RPPC Representatives to collaboratively plan and present a statewide series of eight regional trainings for birth clerks. The interactive presentations included discussions of difficulties gathering data, and awards for improved data collection were presented to birth clerks.

The March of Dimes is collaborating with RPPC and local MCAH agencies to implement the Preterm Labor Assessment Toolkit in 30 California hospitals. The toolkit assists practitioners in triaging women with suspected preterm labor, and emphasizes maternal transport when it is the safest option.

Funding for emergency preparedness efforts was cut in September 2007. The importance of perinatal emergency preparedness continues to be an active topic. RPPC Region 4 has selected emergency preparedness as its quality improvement topic for this year, and RPPC Regions 2 & 3 included emergency preparedness in their "Hot Topics" annual meeting.

The CMS Branch began collaborating with CPQCC on developing a plan to monitor outcomes of infants/children in the newly restructured High Risk Infant Follow-up program. This monitoring capability, coupled with perinatal/neonatal CPQCC data elements, will enable the Branch to assess outcomes in association with perinatal/neonatal care.

MCAH continues to collaborate with CPQCC and CPeTS to develop an electronic data system, which allows tracking of transfers, comparisons of maternal versus neonatal transports, and monitoring of outcomes. CPQCC developed and implemented a web-based perinatal transport data collection system to identify data elements to guide perinatal transport quality improvement. Presently there are 150 participating hospitals. Data collected in 2007 using the web-based Perinatal Transport Data Collection Form totaled 4245 forms. Based on feedback, the data collection form was revised for 2008. Changes to the form were presented in conjunction with CPQCC data collection training at seven regional meetings across the state, attended by 237 representatives from 145 hospitals during February 2008.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The fourteen Regional Perinatal Programs of CA (RPPC) provide regional planning and coordination and ensure that the needs of high-risk patients are matched with the appropriate level of care.				X
2. The CA Perinatal Transport Systems (CPeTS) assist in the referral of high-risk pregnant women and newborn infants by providing bed availability status for regional CCS approved NICUs, updated daily, on the CPeTS website.		X		
3. RPPC and CPeTS assist hospitals with data collection and quality improvement activities.				X
4. MCAH and the Emergency Preparedness Office (EPO) are collaborating to develop a Perinatal Disaster Preparedness Plan.				X
5. RPPC will work with EPO and Licensing and Certification in proposing revisions for emergency situations to some sections of Title 22 regulations.				X
6. The CPQCC reports on neonatal care for hospital/NICU members of CPQCC, providing CCS a useful and uniform reporting scheme for comparative assessment of hospitals on level of care for neonates.				X
7. The Improved Perinatal Outcome Data Reports (IPODR), which include county profiles and other reports, provide information on which to base health planning and allocation decisions, and evaluation of these decisions.				X
8. The California Perinatal Profiles website provides both public (state and regional) and confidential (hospital specific) data to				X

aid continuous quality improvement to all maternity hospitals.				
9. RPPC will convene a group to produce a Birth Clerk-Birth Certificate Tool Kit for hospitals to address the educational training needs of birth clerks due to the high turnover rate.				X
10. RPPC and CMS continue to host trainings through 2007 on a toolkit to assist hospitals with transfer/transport agreements, policy development, outreach education, and review of outcome data.				X

b. Current Activities

The RPPC and CPeTS continue their work matching high-risk patients with the appropriate level of care. The RPPCs review birth outcomes data, including IPODR and Perinatal Profiles data, with hospitals in their region to identify areas for improvement.

The CPQCC continues to collaborate with CMS to retrieve, analyze and develop NICU data. All CCS approved NICUs are required to submit data annually. The number of CPQCC member hospitals in 2008 was 127. The 2007 dataset includes 11,270 Big Babies >1500 grams, and 6,836 Small Babies <1500 gram. There were 7,430 acute transports.

In 2008, PQIP completed its first multi-hospital quality improvement collaborative using the IHI model. This addressed the prevention of Healthcare Associated Infections (HAI) in 19 of the 66 CCS Community level NICUs in California, aiming to decrease catheter associated blood stream infection (CABSI) rates by 25-50% in all patients with central lines in place, between baseline assessment (9/1/07-2/29/08) and intervention (3/1/08-12/31/08). This successful collaborative was an extension of the 2007-08 Nosocomial Infection Demonstration Project, which included 20 of 21 CCS Regional NICUs. These combined projects resulted in one-third of all CPQCC member NICUs participating in efforts to decrease nosocomial infection.

RPPC leadership was instrumental in submitting an National Quality Forum (NQF) Perinatal Measure for Infants under 1500g Delivered at Appropriate Site, which was accepted in October 2008.

c. Plan for the Coming Year

The RPPC and CPeTS will continue their work in the areas of 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 activities surrounding these patient transfers.

The CMS Branch and CPQCC will continue to respond to CPQCC membership questions, and review data element selection in an effort to decrease any unnecessary data collection by hospitals. CMS will continue to analyze CPQCC data reports for CCS-approved NICUs, addressing outliers and concerns about quality of care.

The CPQCC databases have expanded over the last several years to include: 1) Vermont Oxford Network (VON) Minimal Small Baby <1500 grams; 2) CPQCC High-Acuity, Big Baby Database; 3) All --California Neonatal Transport Database; 4) All-California, Rapid--Cycle Maternal/Infant Database, which includes Census, Birth Certificate and OSHPD Hospital Discharge data linked to CPQCC outcomes and isscheduled for first release in 2009; and 5) as of February 2009, the on-line High-Risk Infant Follow-up (HRIF) dataset for CCS, following eligible infants 0-3 years of age.

RPPC, with OVR, will provide seven Birth Clerk trainings to explain some of the medical terms on the certificate to improve reporting; provide gestational dating wheels for determining last menstrual period; and provide newly developed informational sheets from the California Birth Defects Monitoring Program which include pictures and family resources.

CDAPP and CPSP will continue to strengthen ongoing collaboration between CPSP providers and CDAPP Sweet Success affiliates to ensure that CPSP clients with diabetes or who develop gestational diabetes have access to expert care in diabetes management

CPQCC will launch its next collaborative project, the Neonatal Nutrition Quality Initiative, at the upcoming annual CAN meeting in 2009 in San Diego, and we look forward to even broader participation from the membership.

MCAH and CMS continue participation on the CPQCC Executive Committee and the Perinatal Quality Improvement Panel (PQIP). PQIP is an executive subcommittee of CPQCC that oversees data analysis and quality improvement efforts and develops and distributes toolkits on quality improvement topics. The PQIP subcommittee will continue to review and update its toolkits, which include:

- Antenatal Corticosteroid Therapy
- Care and Management of the Late Preterm Infant
- Delivery Room Management of the Very Low Birth Weight (VLBW) Infant
- Hospital Acquired Infection Prevention (Revised March 2008)
- Improving Initial Lung Function: Surfactant and Other Means
- Nutritional Support of the Very Low Birth Weight Infant (Revised December 2008)
- Postnatal Steroid Administration
- Prevention of Perinatal Group B Streptococcus Disease (Revised August 2008)
- Prevention of Perinatal HIV (Revised September 2008)
- Severe Hyperbilirubinemina Prevention

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	88.4	89.4	87.1	86.7	86.9
Annual Indicator	87.1	86.6	85.9	82.9	82.4
Numerator	466463	470955	478973	459175	445108
Denominator	535633	544118	557642	554107	539978
Data Source					CA Birth Statistical Master File, 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	87.1	87.3	87.5	87.5	87.5

Notes - 2008

Source: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

Notes - 2007
Source: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

Notes - 2006
Source: State of California, Department of Public Health, Center for Health Statistics, 2006 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

a. Last Year's Accomplishments
NPM 18 increased about one percentage point a year between 1998 and 2003. Since then, however, NPM 18 has been decreasing each year, from 87.3 in 2003 to 82.9 in 2007. The Healthy People 2010 objective is 90 percent.

The rate decreased slightly across all racial/ethnic groups in 2007. Only White and Asian women met the statewide annual objective for 2007. White and Asian women were more likely to receive prenatal care in the first trimester (87.1 percent and 87.2 percent, respectively) than women who were Hispanic (80.3 percent), African American (79.0 percent), American Indian (68.9 percent), or Pacific Islander (68.2 percent).

In the 1980s, in order to improve prenatal care utilization, California expanded Medi-Cal eligibility criteria, improved access to Medi-Cal through presumptive and continuous eligibility, waived the assets test, and reduced application paperwork.

To improve preconception health and encourage planned pregnancies and early prenatal care, MCAH in 2006 convened the Preconception Health Council of California (PHCC), a partnership between MCAH, OFP and the March of Dimes California Chapter. PHCC has played a pivotal role in relaying the message of the importance of intended pregnancy, pregnancy spacing and preconception care to local communities. The PHCC develops and provides information, tools and resources to local communities, focusing on the importance of achieving optimal health before pregnancy. MCAH and the PHCC sponsored a Preconception Health Education Day in 2008 at the semiannual meeting of the local MCAH Directors.

CPSP, AFLP, BIH, WIC, and the American Indian Infant Health Initiative (AIIHI) supported improvements in prenatal care through direct and indirect delivery of services and support. The programs provide case management services and linkages to medical care for their target populations.

CPSP provides perinatal support services to approximately 165,000 women a year, and reimbursement to the 1500 active CPSP providers is more than $88 million/year. CPSP providers receive a bonus for providing prenatal care in the first trimester.

Community Health Workers from the BIH program provided assessment, education and linkage to services for pregnant African American women.

MCAH and OFP programs provided ethnically diverse staff for recruiting clients into care, and local MCAH jurisdictions employed a variety of methods to target diverse populations. MCAH Division programs throughout the state provided local toll free lines for residents to obtain referral

to low cost health insurance and prenatal care. In addition, each jurisdiction delivered outreach in a way appropriate to their population's needs.

Los Angeles County developed, updated and expanded perinatal resources in its "211" phone number service, which provides information accessible through a single number that residents can call. They are improving visibility of this resource for women, especially those with low incomes.

Local Health Jurisdictions collaborated with schools to incorporate prenatal care essentials into curricula for local schools, nursing schools and medical residency programs.

About 40 percent of all births in California are unintended. [64] California's Family PACT Program provided no-cost family planning services to all California residents with incomes at or below 200 percent of the federal poverty level, and, insofar as these services help to reduce the rate of unintended pregnancy, they also contribute indirectly to more timely prenatal care, since women with planned pregnancies seek care earlier.

The Access for Infants and Mothers (AIM) Program provided low-cost coverage for over 7000 pregnant women with incomes from 200-300% of Federal Poverty Level.

Despite these accomplishments and efforts to increase the number of women who receive prenatal care in the first trimester, some obstacles remain. These include delays due to lack of awareness of Medi-Cal's Presumptive Eligibility Program, delays due to the Medi-Cal enrollment process, increases in the number of uninsured due to the economic downturn, and high rates of unintended pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The CPSP provides Medi-Cal eligible women with prenatal care, health education, and support services.		X		
2. The BIH program identifies pregnant and parenting African American women who are at risk for poor birth outcomes and provides them assistance in accessing and maintaining health care and other support services.		X		
3. The AFLP provides case management services to pregnant adolescents at risk of poor birth outcomes; services include nutritional and prenatal counseling and referrals for prenatal and other medical services.		X		
4. The AIIHI serves prenatal and parenting American Indian women with direct health care services and case management services.		X		
5. The MCAH Division and OFP work to provide ethnically diverse staff for recruiting clients into care, and local MCH jurisdictions employ a variety of methods to target diverse populations.		X		
6. The Family PACT Program provides no-cost family planning services to low-income residents; these services help reduce the rate of unintended pregnancy, and contribute indirectly to increased utilization of prenatal care.	X			
7. The PHCC plays a pivotal role in relaying the message of the importance of intended pregnancy, pregnancy spacing and preconception care to local communities.			X	

8. Local Health Jurisdictions collaborate with schools to assure the incorporation of prenatal care essentials into curricula for local schools, nursing schools and medical residency programs.				X
9. The AIM program provides low-cost health coverage to pregnant women who don't have adequate coverage and whose incomes are too high for Medi-Cal.		X		
10.				

b. Current Activities
AFLP, WIC, BIH, and AIIHI continue to provide case management services and linkages to medical care for target populations.

CPSP continues to provide comprehensive perinatal services, including routine obstetric care, nutrition, health education, and psychosocial services, to its clients. Providers receive a bonus for each woman receiving three assessments and the initial pregnancy office visit within 4 weeks of entry into care. CPSP providers are eligible for payment of one additional obstetrical visit to ensure continuity of care for each CPSP patient.

PHCC is developing clinical guidelines to optimize the post partum visit as a first step in providing interconception care, especially for women who have had a poor pregnancy outcome. PHCC is launching a comprehensive preconception health website, with low literacy fact sheets for consumers and provider resources such as toolkits, best practices, and web links.

PHCC and the MCAH Division are organizing a full-day training for MCAH Directors from LHJs.

California's Family PACT Program continues to provide no-cost family planning services to all California residents with incomes at or below 200 percent of the FPL.

The AIM program continues to provide low-cost health coverage to pregnant women with inadequate coverage and whose incomes are too high for Medi-Cal.

LHJs will continue to collaborate with schools to incorporate prenatal care essentials into curricula for local schools, nursing schools and medical residency programs.

c. Plan for the Coming Year
MCAH will continue to work with local jurisdictions to improve outreach to women of childbearing age and pregnant women and provide linkages to early prenatal care.

CPSP, AFLP, WIC, BIH, and AIIHI will continue to provide case management services and linkages to medical care for their target populations.

CPSP plans to expand provider trainings to include web-based provider overview training; research the feasibility of mandating potential CPSP providers to attend state sponsored CPSP training prior to becoming an approved provider; and provide local data on CPSP billing patterns to evaluate local CPSP programs.

Perinatal services coordinators in the local jurisdictions will also continue provider recruitment, and will monitor and strengthen the utilization of CPSP's scope of benefits by training providers and practitioners in documentation, program services, and developing materials and evaluative reports on the efficacy of services.

MCAH and its local jurisdictions undertake these activities to ensure the availability and effectiveness of CPSP services, even in this era of budget constraints, and to achieve improvements in first trimester entry into prenatal care.

The PHCC plans to work with CPSP to maximize the postpartum visit by providing information and counseling to clients about healthy behaviors between pregnancies, including optimal pregnancy spacing, and assisting providers to address high risk prenatal adolescents that could impact subsequent pregnancies.

The MCAH Division is working to consolidate data on beneficiaries, paid claims, birth outcomes, and hospital discharge to develop baseline data on the efficacy of CPSP services.

AIM will continue to provide low-cost health insurance to pregnant women with incomes between 200 and 300% of Federal Poverty Level.

D. State Performance Measures

State Performance Measure 1: *The percent of children birth to 21 years enrolled in the CCS program who have a designated medical home.*

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			50	70	84.2
Annual Indicator		57.9	76.4	84.2	89.0
Numerator		92903	123748	146423	152893
Denominator		160499	162023	173850	171885
Data Source					CMS Net and LA County
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	89.5	89.5	89.5	89.5	89.5

Notes - 2008
This measure is the percent of children birth to 21 years enrolled in the CCS program who have a designated medical home.

The data are from CMS Net data for 57 counties and data from Los Angeles County CCS program for FY 2008-09.

Notes - 2007
This measure is the percent of children birth to 21 years enrolled in the CCS program who have a designated medical home.

The data are from CMS Net data for 56 counties and data from local county CCS programs for the remaining 2 counties for FY 2007-08.

Notes - 2006
This measure is the percent of children birth to 21 years enrolled in the CCS program who have a designated medical home.

The data are from CMS Net data for 56 counties and data from local county CCS programs for the remaining 2 counties for FY 2006-07.

a. Last Year's Accomplishments

SPM 01, the percent of children birth to 21 years enrolled in the CCS program who have a designated medical home, for 2008 is 88.9 percent. There has been an increase of 5.5 percent since 2007. There has been an increase of 16.5 percent since 2006. It is believed that improvement for this indicator is due to better recording of a medical home. However, the definition of medical home continues to be used interchangeably with primary care physician (PCP).

SPM 01 was a new California State Performance Measure in 2006. There is a medical home National Performance Measure, NPM 03: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. NPM 03 is from the CSHCN Survey for California and is a different population than the CCS program.

County CCS programs assessed whether CCS eligible children had a documented primary care physician/medical home and worked at improving this documentation, however, they have no way to distinguish a PCP from a true medical home.

The Healthy People 2010 Objective is that every child with special health care needs will receive comprehensive care in a medical home, and though this is probably not attainable in this timeframe, the CCS program does have a goal to eventually reach this objective. The CMS stakeholder group for developing the strategic plan for the Title V 2005 Needs Assessment identified having a medical home for children enrolled in the CCS program as one of the top three state priorities. The work to increase the number of Family Centered Care (FCC) medical homes for CSHCN as well as policy development on medical home and the medical home initiative for CSHCN are on hold due to staffing cuts and budget issues. The goal to complete the data definition for the "medical home" field to reflect where the child receives comprehensive and coordinated, ongoing medical care requires work, including having physicians identify whether they are a true medical home and having the local programs assist with identifying true medical homes.

CCS has been collaborating with Children's Hospital Los Angeles (CHLA) and the CA Epilepsy Foundation on a grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in CA. One of the goals of the project is to improve access to health and other services and support related to epilepsy by facilitating development of medical homes for medical care for children and youth (0-18) with epilepsy in CA, especially those residing in medically underserved areas. Family Voices of California (FVCA) provided trainings for families and professionals on the Medical Home and distributed binders to help families organize healthcare information and medical records. FVCA developed a "resource referral pads" to physicians that list local resources for families.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to collaborate with CHLA on the grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in California.		X		
2. Evaluation by county CCS programs to determine if children have a medical home and explore improvement strategies.				X
3. FVCA provides trainings for families and professionals on the Medical Home Initiative and distributes binders to help families organize healthcare information and medical records.				X
4. FVCA Agencies provide “resource referral pads” to physicians that list local resources for families.				X
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
1. Collaboration continues with CHLA on the grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in CA.

2. Due to budget cuts, work is on hold for utilizing the Federal MCHB grant awarded to the USC's UCEDD at CHLA for collaboration with CRISS, CMS Branch, and FVCA to implement the strategies around increasing the number of FCC medical homes for CSHCN and the number/percent of CCS children who have a designated medical home.

3. Due to budget cuts, work is on hold for developing a policy letter for CCS regarding the medical home for CCS clients, particularly authorization of the medical home and ramifications of this authorization.

4. Continue evaluation by county CCS programs to determine if children have a medical home and explore improvement strategies.

5. FVCA continues to provide trainings for families and professionals on the Medical Home Initiative and distributes binders to help families organize healthcare information and medical records.

6. FVCA agencies continue to provide "resource referral pads" to physicians, which list local resources for families.

c. Plan for the Coming Year
Plans for the coming year include:

1. Continue to collaborate and support the medical home project for children with epilepsy after the grant ends in 2009.

2. Continue evaluation by county CCS programs to determine if children in the CCS program have a medical home and how to improve performance regarding effective case management.

3. FVCA will continue to provide trainings for families and professionals on the Medical Home and distribute binders to help families organize healthcare information and medical records.

4. FVCA Agencies will provide "resource referral pads" to physicians, listing local resources for families.

State Performance Measure 2: *The ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists.*

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

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Performance Objective			0	0	0
Annual Indicator		0.0	0.0	0.0	0.0
Numerator		137	130	137	151
Denominator		67267	57865	56034	55198
Data Source					CCS Program
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	0	0	0	0	0

Notes - 2008
This measure is the ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists.

The data is from CCS program listing of approved providers at Cardiac Special Care Centers and CCS ICD 9 codes for cardiac and cardiac related diagnoses for FY 2008-09.

There was an error in the number of children birth through 14 years for 2006-07 and the corrected number is 57865, with the resultant ratio of 1:445.

For 2008-09, the ratio is 1:366 due to an increase in the number of cardiologists and a decrease in the number of CCS clients due to closure of some inactive cases with cardiac diagnoses. The increase in cardiologists is primarily in one area of Northern CA due to very aggressive recruiting, and there continues to be significant deficits of pediatric cardiologists in all other areas.

The indicator is 1:350 for 2009-2012.

Notes - 2007
This measure is the ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists.

The data is from CCS program listing of approved providers at Cardiac Special Care Centers and CCS ICD 9 codes for cardiac and cardiac related diagnoses for FY 2007-08.

There was an error in the number of children birth through 14 years for 2006-07 and the corrected number is 57865, with the resultant ratio of 1:445.

For 2007-08, the ratio is 1:409 due to a small increase in the number of cardiologists and a decrease in the number of CCS clients due to closure of some inactive cases with cardiac diagnoses.

The indicator is 1:400 for 2008-2012.

Notes - 2006
This measure is the ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists.

The data is from CCS program listing of approved providers at Cardiac Special Care Centers and CCS ICD 9 codes for cardiac and cardiac related diagnoses for FY 2006-07.

There was an error in the number of children birth through 14 years and the corrected number is 57865, with the resultant ratio of 1:445.

a. Last Year's Accomplishments
SPM 02, the ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists, for FY

2008-09 is 1:366. This is the fourth year for this measure and there is a 10% increase in the number of cardiologists and a 1% decrease in the number of children seen by these cardiologists from FY 2007-08 (1:409). SPM 02 addresses provider capacity for the subspecialty of pediatric cardiologists. There are concerns over the shortage of pediatric subspecialty providers throughout the state, particularly for CSHCN with complex medical conditions. This measure was selected because children with diagnoses related to congenital heart disease make up the largest group of children enrolled in CCS, and because of the shortage of pediatric cardiologists throughout the state. This may be a result of an insufficient pool of pediatric cardiologists in the country, and difficulty recruiting this subspecialty to California due to the high cost of living, lower salaries, and lower reimbursement. The increase in pediatric cardiologists for 2008-09 was localized to Northern California and particularly to aggressive recruitment at Stanford. All other areas of the state and especially Southern California have a continued insufficient pool of pediatric cardiologists. One fallout from not having sufficient numbers of pediatric cardiologists is that with the increase in obesity, pediatric cardiologists are not able to evaluate all the children who may be having cardiovascular disease due to their obesity.

The CCS program (for the past 3-4 years) has been intentionally closing cases where the children/youth no longer need follow-up by specialists. This case closure may have resulted in a lower number of active cases in CMS Net with the ICD-9 cardiac related diagnoses.

The ratio for this measure was obtained by determining the number of active cases in CMS Net with a select number of cardiac ICD-9 codes (390.0 through 429.9, 440.0 through 448.9, 745.0 through 747.9, 780.2, 785.0 through 785.3, and 786.50 through 786.51). This number of active cases (22079) was the result of extrapolating for LA County. The assumption is that CCS cases represent approximately 40 percent of pediatric cardiologists' caseloads. Pediatric cardiologists care for 55,198 children birth through 14 years of age in California. As the number of pediatric cardiologists at all the CCS Hospitals is 151, the ratio is one pediatric cardiologist per 366 children birth through 14 years of age. This is a low estimate because some pediatric cardiologists continue to see their youth past 14 years of age.

Work has been ongoing to improve the SCC directories so that there is a better assessment of the number of pediatric cardiologists at the SCCs. Due to staffing shortages the CMS Branch has not been able to devote time to working with pediatric cardiologists in the state on ways to increase their numbers.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintain and strengthen the provider network for CSHCN through the CMS Cardiac Technical Advisory Committee (TAC).				X
2. mprove CCS program capacity to serve older teens and YSHCN who are transitioning to adult services.				X
3. Annually update the directory of core team members at the Pediatric Cardiac SCCs to evaluate the availability of pediatric subspecialty physicians in the state available to CSHCN.				X
4. CCS Transition Workgroup and other partners evaluate and implement strategies to address provider capacity and provide a guide for the transition process.				X
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
1. Maintain the CMS Cardiac Technical Advisory Committee (TAC) to consult by telephone on cardiac issues as needed. Staffing does not allow for face to face committee meetings.

2. Improve CCS program capacity to serve older teens and YSHCN who are transitioning to adult services. Evaluate the CCS provider network for Cardiologists to care for teens in transition to adult care.

3. Update the directory of core team members at the Pediatric Cardiac SCCs to evaluate the availability of pediatric subspecialty physicians in the state available to CSHCN as staffing allows.

4. CCS will coordinate with Transition Workgroup and other partners electronically to evaluate and implement strategies to address provider capacity. The Transition Workgroup has developed a Transition Toolkit which will be disseminated this year. CCS no longer has staff to attend the Transition Workgroup meetings.

c. Plan for the Coming Year
1. Maintain the CMS Cardiac Technical Advisory Committee (TAC) to consult by telephone on cardiac issues as needed. Staffing does not allow for face to face committee meetings.

2. Improve CCS program capacity to serve older teens and YSHCN who are transitioning to adult services. Evaluate the CCS provider network for Cardiologists to care for teens in transition to adult care.

3. Update the directory of core team members at the Pediatric Cardiac SCCs to evaluate the availability of pediatric subspecialty physicians in the state available to CSHCN as staffing allows.

4. CCS will coordinate with Transition Workgroup and other partners electronically to evaluate and implement strategies to address provider capacity. The Transition Workgroup will disseminate the Transition Toolkit this year. CCS no longer has staff to attend the Transition Workgroup meetings.

State Performance Measure 3: *The percent of women, aged 18-44 years, who reported 14 or more "not good" mental health days in the past 30 days ("frequent mental distress").*

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			13.6	12.8	12.7
Annual Indicator	13.7	12.9	13.4	13.4	13.4
Numerator	941842	877547	918931	918149	
Denominator	6858643	6822505	6870676	6865507	
Data Source					CA Women's Health Survey, 2007
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance	12.6	12.5	12.4	12.4	12.4

Objective					

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Source: California Department of Public Health, California Women's Health Survey (CWHS), 2007. Numerator: Number of women, 18-44 years of age, who reported 14 or more not good mental health days in the past 30 days. Denominator: Number of women, 18-44 years of age, reporting the number of not good mental health days. Numerator and denominator were weighted using the California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050, May 2004.

Notes - 2006
Source: California Department of Public Health, California Women's Health Survey (CWHS), 2006. Numerator: Number of women, 18-44 years of age, who reported 14 or more not good mental health days in the past 30 days. Denominator: Number of women, 18-44 years of age, reporting the number of not good mental health days. Numerator and denominator were weighted using the California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050, May 2004.

a. Last Year's Accomplishments
SPM 03, the percent of women aged 18-44 years who reported 14 or more "not good" mental health days in the past 30 days, became a new California State Performance Measure in 2006. SPM 03 was 13.4 percent in 2007, the same as the previous year. Since 2000, this measure has fluctuated between 12.9 and 15.7 percent.

In California and across the country there is increasing recognition of the importance of mental health promotion and early detection and treatment of mental health problems. MCAH Division and OFP play an important role in identifying mental health needs, intervening before mental health problems become debilitating, and facilitating access to integrated, comprehensive treatment.

MCAH Division and OFP staff continued to actively participate on the Preconception Health Council of California (PHCC), a partnership between MCAH, OFP and the March of Dimes California Chapter. The PHCC is a state-wide collaborative that provides information, tools and resources to local communities, focusing on the importance of achieving optimal health, including mental health, before pregnancy. The PHCC developed a website with an emotional wellness component to help women of childbearing age achieve optimal mental health, improving their well-being and ensuring a better outcome for their babies if they become pregnant.

The MCAH Division continues to be a key collaborator in the University of California, Berkeley's Bright Beginnings grant, funded by HRSA. The project improves the California MCAH workforce's capacity to address maternal mental health issues in a timely and effective manner through continuing education courses. The Bright Beginnings project convened a conference on maternal mental health for primary care providers in Northern California in Fall 2008. The conference examined women's experiences dealing with mental health issues in pregnancy and post partum, explored what is being done in California to integrate mental health and primary care services, and identified successful ways to address barriers and select among promising practices.

Maternal mental health was one of the selected measures discussed in the MCAH Division publication, "Preconception Health: Selected Measures, California, 2005." This was distributed during the Second National Summit on Preconception Health and Health Care on October 29-31, 2007 at Oakland, CA.

Preliminary findings from the Preconception Hospitalization Study showed that mental disorders

(ICD 9-CM codes 295-301.9) were the most frequent diagnoses for the cohort of women who had births in 2003 and had been hospitalized for selected chronic conditions during 2000-2002. Collaboration between the Black Infant Health (BIH) program and California's Office of AIDS funded training for effective techniques in HIV education and counseling for BIH providers. The California Training Center developed a training curriculum and provided training to the BIH Coordinators, their MCAH Directors and BIH staff who provide direct client services.

The California Diabetes and Pregnancy Program (CDAPP) provides various types of psychosocial information for providers on the CDPH website. Topics include depression and diabetes; domestic violence; screening for perinatal depression; and stress checks. The Sweet Success provider trainings include instruction on how to use the Edinburgh Postpartum Depression Scale.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCAH Division and OFP programs -- including CPSP, BIH, AFLP, DV, CDAPP, and local MCAH programs--include mental health assessment and/or referral, as well as treatment in some cases.		X		
2. Local MCAH staff improved the ability to match client needs to resources due to increased resource availability and program capacity with new California Mental Health Services Act funding.		X		
3. BIH, in collaboration with the Office of AIDS, trains BIH Coordinators, staff, and MCAH directors in perinatal HIV/AIDS prevention, including education and counseling to overcome client emotional barriers to testing.		X		
4. MCAH and OFP reported results from the California Women's Health Survey and California's Maternal and Infant Health Assessment survey at meetings and on CDPH websites, covering postpartum depression and mental health issues.				X
5. MCAH informs the research and program communities by analyzing and presenting data on mental health from the California Women's Health Survey (CWHS) and from the Maternal and Infant Health Assessment survey.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

To address the issue of underlying depression in women, the following MCAH and OFP programs include a mental health component: CPSP, BIH, AFLP, DV, CDAPP, PHHI and local MCAH programs. All include assessment and/or referral, and some include treatment. Programs address general depression, as well as postpartum depression in the populations they serve.

MCAH reviews and reports results from the California Women's Health Survey and the California's Maternal and Infant Health Assessment survey at meetings and on CDPH websites, covering postpartum depression and other mental health issues.

The UCB Bright Beginnings project is currently planning a conference on maternal mental health for primary care providers, which will be held in Southern California in Fall 2009. The conference

will utilize the same successful format as the previous conference, and will examine other mental health issues women face in pregnancy and the postpartum period.

c. Plan for the Coming Year
In the coming year MCAH plans to:

- Establish and maintain appropriate linkages between the Department of Alcohol and Drug Programs (ADP), the Department of Mental Health (DMH), the Department of Rehabilitation, the Department of Social Services (DSS), Medi-Cal, Office of Emergency Services (domestic violence), CDPH and DHCS to address systemic barriers and create pathways to service delivery.

- Build capacity of the provider network that delivers comprehensive perinatal services, addressing psychosocial assessment and reassessment each trimester and post-partum, development of a care plan, efficacious referrals, and client follow-up.

- Collaborate with DMH, DSS, Office of Emergency Services, and Medi-Cal to enhance the Domestic Violence Program in the areas of prevention and treatment of domestic violence, as well as improving mental health in preconception/pregnant/parenting women.

- Continue to support and promote the incorporation of mental health and behavioral issues into LHJ activities as they work toward improving the health and well-being of the MCAH population within their boundaries. MHSA funding will expand access and services for clients with mental health or behavioral health issues, including women at risk for postpartum depression. Behavioral health services for adolescents have also increased within the LHJs and will continue to do so. The MCAH and OFP Divisions will continue to support locally implemented activities designed to improve the overall well-being of the MCAH population.

- Continue collaboration between BIH and Office of AIDS for HIV/AIDS prevention, with funding from CDC, to address the increasing risk of HIV/AIDS in this population. The California Training Center will develop a training curriculum and provide training to the BIH Coordinators, their MCAH Directors and BIH staff who provide direct services to the client. The training will include effective techniques in HIV education, sexual history and risk, and group facilitation skills.

- Monitor the new website of the MCAH Division's Preconception Health and Healthcare Initiative (PHHI), which features links to information, tools and resources related to mental health and well-being for women of childbearing age.

- Convene the UCB Bright Beginnings project conference on maternal mental health for primary care providers in Southern California in Fall 2009.

- Request that CDAPP providers expand screening to the postpartum period. CDAPP will also revise the Sweet Success guidelines with the most current information on use of the Edinburgh Postpartum Depression Scale.

State Performance Measure 4: *The percent of women who reported drinking any alcohol in the first or last trimester of pregnancy.*

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

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			16.4	17.1	16.9

Annual Indicator	16.5	17.3	15.8	15.0	15
Numerator	87461	92534	87117	82872	
Denominator	530470	534314	552433	552073	
Data Source					MIHA, 2007
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	16.7	16.5	16.3	16	15.7

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Source: 2007 Maternal and Infant Health Assessment Survey, MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported drinking any alcohol in the first or third trimester of pregnancy. Denominator: The number of women who delivered a live birth that reported whether or not they consumed alcohol during pregnancy. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year.

Notes - 2006
Source: 2006 Maternal and Infant Health Assessment Survey, MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported drinking any alcohol in the first or third trimester of pregnancy. Denominator: The number of women who delivered a live birth that reported whether or not they consumed alcohol during pregnancy. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year.

a. Last Year's Accomplishments
SPM 04 was added as a State Performance Measure in 2006.

The percent of women who gave birth that reported drinking any alcohol in the first or last trimester of pregnancy declined again in 2007, reaching 15.0 percent. This was down from 15.8 percent in 2006, and represents the lowest level since these data have been reported. The related Healthy People 2010 target is that 94 percent of pregnant women report no drinking in the 30 days prior to the time the question is asked. [Data for SPM 04 are from the California Maternal and Infant Health Assessment (MIHA) and include women aged 15 years and older.]

Mothers who reported drinking during the first or last trimester of pregnancy differed by racial and ethnic group. White women (27.8 percent) and those reporting Other race (34.5 percent) were most likely to drink any alcohol, followed by African American (11.7 percent) and Latina (9.2 percent) women. Asian/Pacific Islander women (6.4 percent) were least likely to report drinking in the first or last trimester of pregnancy.

An estimated 4,460 to 6,050 babies with Fetal Alcohol Spectrum Disorder (FASD) are born each year in California. [65, 66] FASD describes the range of effects that can occur in an individual whose mother used alcohol during pregnancy. These effects may include physical, cognitive, behavioral and/or learning difficulties with lifelong implications. Nationally, FASD is the most common form of preventable brain injury in infants. The MCAH Division seeks to improve birth outcomes for women at risk of alcohol use or abuse, including screening and referral for treatment services. Community-based prevention programs, including AFLP, BIH, CPSP, DV, and CDAPP educate clients about FASD, identify mothers at high risk, and refer them for alcohol treatment services.

Over the past couple years, the MCAH Division has taken a leading role in promoting preconception health and healthcare, of which reduction of alcohol use by women of reproductive age is a key feature. The MCAH Division's PHHI and representatives from MCAH Division

actively participate in the Preconception Health Council of California (PHCC), a partnership between the MCAH, OFP and the March of Dimes California Chapter (MOD). Formed in 2006, the Council is a statewide collaborative that provides information, tools and resources to local communities pertaining to the importance of achieving optimal health for women before pregnancy, including the reduction of alcohol use, as a means to improving poor birth outcomes like FASD.

Developed by Dr. Ira Chasnoff, the 4 P's Plus is a nationally-recognized screening tool that helps medical staff identify women who may be at risk and who need additional evaluations by certified alcohol and drug counselors. Many California MCAH local health jurisdictions are active in FASD prevention, and over 20 use Dr. Chasnoff's 4 P's Plus screening tools. Several counties also use county-specific strategies, coalitions and programs designed to address the issue of perinatal substance use and FASD. Strategies include incorporating substance use avoidance education into preconception care, school-based clinics, school curricula and community education opportunities.

Mendocino County's MCAH Program participated in the Partnership for Healthy Babies collaborative and developed a media outreach campaign, using movie slides and posters, in collaboration with three local family wineries with the licensed tagline "We Don't Want You To Drink During Pregnancy." Counties have partnered with medical care providers and developed assessment tools that incorporate provisions for referral to locally available treatment and guidance facilities.

One of the selected measures discussed in the MCAH publication "Preconception Health: Selected Measures, California, 2005" was alcohol consumption. The publication was distributed during the Second National Summit on Preconception Health and Health Care on October 29-31, 2007 at Oakland, CA and is available on the MCAH website.

The PHCC developed educational materials with a module that alerts women to the risks of having an unintended pregnancy while engaging in alcohol use.

Alameda County's Perinatal Substance Abuse Task Force developed a strategic plan: Children's Screening, Assessment, Referral and Treatment (SART). The aim is to improve pediatric care for substance-exposed children.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Community-based prevention and support programs, including AFLP, BIH, CPSP, DV, and CDAPP, educate clients about the dangers of alcohol use during pregnancy and refer high-risk women for alcohol treatment services.		X		
2. The MCAH Division and the CMS Branch collaborate on the March of Dimes Alcohol and Pregnancy Campaign to increase knowledge and awareness about consequences of substance use during pregnancy.				X
3. The MCAH Division participates in the Statewide FASD Task Force, which meets quarterly and consists of representatives from state agencies and local communities.				X
4. Local MCAH jurisdictions conduct prenatal substance abuse screening programs, with many using the 4-Ps Plus model.				X
5. Fresno County uses federal Healthy Start funds to identify and provide support services to women at high risk for alcohol use during pregnancy.		X		

6. Butte County received funds from their local First 5 to receive training directly from Dr. Chasnoff and to organize the First Chance Coalition for Alcohol and Drug Free Babies.				X
7. Plans are in place to update the preconception provider/patient resource packet funded by the March of Dimes. Alcohol use is one of the covered topics.				X
8.				
9.				
10.				

b. Current Activities
MCAH participates in the FASD Task Force, which meets quarterly and consists of representatives from state and local agencies. On March 13, 2009, the Task Force held a Strategic Planning Meeting to review its 2005-2010 Strategic Plan, re-examine its focus, and identify action steps for completing specified objectives.

With a contract from MCAH, Dr. Ira Chasnoff's comprehensive report on perinatal substance use screening data, with specific findings on the use of the 4 P's Plus tool, was completed and released in October 2008.

A preconception health website containing valuable information on topics that include perinatal substance use prevention was recently launched.

Alameda County is implementing their Pediatric System of Care Strategic Plan to improve care of substance-exposed children at risk for social/emotional, developmental, behavioral, psychological, and physical problems.

In partnership with the Department of Alcohol and Drug Programs (ADP), MCAH wrote a letter to manufacturers of at-home pregnancy kits, requesting them to include warning inserts on alcohol consumption and its consequences (FASD). Six of 35 manufacturers have consented to the request.

In April 2009, ADP reconvened the Alcohol and Other Drug (AOD) Workgroup of the State Interagency Team (SIT) to address FASD prevention. This workgroup includes representatives from the Departments of Public Health (MCAH), Mental Health, Social Services, Education, Developmental Services, and ADP.

c. Plan for the Coming Year
The MCAH Division and local health jurisdictions will expand current efforts to reduce and eliminate the consumption of alcohol during pregnancy.

Local health jurisdictions will work on developing and strengthening coalitions with public and private agencies, healthcare providers, and public representatives at the local level to determine how best to identify women at risk and how to develop appropriate referral sources. Barriers will be identified and addressed. Many California counties are working to develop and implement coordinated, integrated systems of care to address issues of perinatal substance abuse based on various evidence based models. Many local health jurisdictions are focusing on alcohol use during pregnancy in their educational presentations to healthcare providers and other interest groups. For example, Santa Cruz County Public Health Nurses provide home-based support, education, and professional assistance for families with premature and/or substance exposed babies, or moms with mental health issues. The program is intended to provide for the infant's optimal cognitive, emotional, and physical development, and ensure comfort and competency of family members in parenting and caregiving roles.

The MCAH Division will continue to participate in the Statewide FASD Task Force. Activities of the 2005-2010 Strategic Plan include efforts to improve data collection, improve public awareness, sustain an effective statewide task force, and establish a public policy agenda.

MCAH will also participate in the SIT AOD Workgroup to work with partner agencies on ways to increase FASD awareness and address prevention. The broad representation and common interest of this collaborative provides an opportune venue for MCAH to highlight the Chasnoff report recommendations as a reference for developing the Workgroup's priorities and activities.

The PHCC will guide the planned revision and reprinting of the preconception provider/patient resource packet, including the section on alcohol use.

The MCAH Division's PHHI plans to augment its new website that will connect people working in preconception health and will feature links to tools and resources related to alcohol use among women of reproductive age.

State Performance Measure 5: *The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries.*

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	20.7	19.5	18.2	16.6	16.4
Annual Indicator	18.4	17.1	16.9	13.5	13.5
Numerator	494	474	485	399	
Denominator	2689492	2778214	2865987	2955147	
Data Source					CA Death Statistical Master File 2007
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	16.2	16	15.8	15.8	15.6

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2007 Death Statistical Master File The ICD-10 codes for fatal MV traffic injuries are: V29-V79(.4-.9), V81-V82(.1), V83-V86(.0-.3), V12-V14,V20-V28(.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V892. Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2007 should be not compared to data reported in previous years due to changes in methodology used for calculating this indicator. The methodology was updated for consistency between fatal and nonfatal injury reporting. The rate now includes only motor vehicle traffic incidents, and exludes motor vehicle non-traffic indicents. Rates for prior years using these updated inclusion criteria: 2000 = 12.6; 2001 = 17.0; 2002 = 20.0; 2003 = 19.4; 2004 = 18.1; 2005 = 16.6; 2006 =16.5.

Notes - 2006

Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2006 Death Statistical Master File (ICD-10 Group Cause of Death Codes 296-306). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 12.9; 2001 = 17.3; 2002 = 20.2; 2003 = 19.9; 2004 = 18.5; 2005 = 17.2

a. Last Year's Accomplishments

The rate of motor vehicle deaths among 15-19 year olds declined significantly between 1990 and 2000, falling from 27.3 to 12.9 per 100,000. After large increases in 2001 and 2002, the rate has declined in each subsequent year. 2007 marked the steepest of these decreases, with the rate dropping from a revised rate of 16.5 per 100,000 in 2006 to 13.5 in 2007. (Denominators are based on the number of adolescents, not the number of miles driven. See 2007 notes for clarification of changes in methodology used to calculate rates.) While there has been much improvement in this indicator, the rate is still higher than the HP 2010 target of 9.2 per 100,000 in the overall population.

The highest rates of adolescent motor vehicle deaths were to Hispanics (15.0 per 100,000), and Whites (14.0 per 100,000). Asian and African American adolescents experienced death rates from motor vehicle injuries at a rate lower than the state average. Other race/ethnic groups had too few motor vehicle deaths to be included in the comparison.

Motor vehicle injuries are the leading cause of death in California's teen population. Alcohol use by young drivers is especially dangerous. In 2002, 24 percent of drivers ages 15 to 20 who were killed in motor vehicle crashes were intoxicated. [67] During the last decade, the California Highway Patrol has increased enforcement of driving under the influence/drunk driving (DUI) laws and has undertaken extensive education and public awareness programs. These include: "Sober Graduation," a program targeting high school seniors; the "Designated Driver Program;" and the "El Protector" program established in response to the high number of fatal accidents and DUI arrests involving Hispanic youth.

The Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University is a resource center on child and adolescent injury prevention. Under a contract with MCAH, CIPPP has provided technical assistance to local health jurisdictions in developing, implementing and evaluating injury prevention programs, and provided regular reviews of current injury prevention literature.

MCAH Division provides funding to 61 local health jurisdictions to promote local maternal, child and adolescent health improvement programs. Injury prevention is an important component of local programs. The primary injury reduction focus for each jurisdiction varies depending upon the hazards identified for that community. MCAH allocated funding for local childhood injury prevention in five counties in three-year cycles. Counties are expected to address injury prevention issues with their general funding allotment.

To raise funds in support of child injury and abuse prevention programs, the State sells personalized auto license plates, called "Kid's Plates," which features a heart, hand, star, or plus sign. The proceeds fund child injury and abuse prevention programs. The Kid's Plates Program provides a wide range of technical assistance to help foster effective regional and local injury prevention efforts and fund grants for training and equipment. CIPPP is the Kid's Plate Program administrator for CDPH's Epidemiology and Prevention for Injury Control (EPIC) Branch.

MCAH Division collaborated with EPIC to coordinate activities that address joint areas of interest,

including the Statewide Coalition on Traffic Safety, the Statewide Strategic Highway Safety Plan (SHSP), and various child passenger safety programs. MCAH Division also worked with EPIC and other agencies to promote adolescent injury prevention through MCAH programs.

The MCAH Division has served as a member of the UC Berkeley Center for Traffic Safety's Teen Traffic Safety Task Force, which has been working to develop a document summarizing proven and promising practices to reduce teen traffic injuries. This document will be disseminated to MCAH stakeholders.

Other activities California has undertaken to reduce motor vehicle deaths among children include: passenger restraint laws; graduated driver licensing (GDL); and vehicle safety improvements. Additional information on California's activities and successes in reducing motor vehicle deaths among adolescents is presented in the discussion of Health Status Indicator 3c.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The MCAH Division will stop funding of local childhood injury prevention programs in five counties this year since most local health agencies have successfully implemented injury prevention programs for their area.				X
2. The MCAH Division-supported bi-monthly injury prevention teleconferences have been discontinued. Technical assistance for local health jurisdictions remains available as needed.				X
3. Funds administered by CHDS and EPIC that are raised by sales of special car license plates, called Kid's Plates, support child injury and abuse prevention programs, including motor vehicle and pedestrian safety.		X		
4. The MCAH Division collaborates with EPIC, the CDHS Childhood Lead Poisoning Prevention Branch, and other related agencies to ensure the incorporation of childhood injury prevention modalities within MCAH programs.		X		
5. The MCAH Division participates in the Statewide Coalition on Traffic Safety, which focuses on seat belt use and prevention of speeding and driving under the influence.				X
6. The MCAH Division aids in developing California's Statewide Strategic Highway Safety Plan spearheaded by the Dept. of Transportation to identify key safety needs and to provide a structure for data-driven decision-making.				X
7. Local health jurisdictions participate with key agencies to promote and implement traffic safety training, use of bicycle helmets, swimming pool and playground equipment safety, and use of seat belts and child restraints.		X		
8. Local health jurisdictions are using the Child Death Review data to identify trends and raise awareness about deaths due to motor vehicle injuries.				X
9. Local health jurisdictions conduct home safety evaluations when performing client home visits, and provide guidance on corrective actions when perilous situations are identified.	X			
10.				

b. Current Activities

LHJs undertake various activities to promote adolescent injury prevention, including participation in Safe Kids Coalitions, traffic safety education, bicycle helmet distribution and education, and education on appropriate use of seat belts. Humboldt County, for example, implemented a Youth Safe Driving Program, conducting focus groups on driving attitudes and behavior, launching DUI prevention and seat belt campaigns, and convening a Youth Safe Driving Subcommittee. With a California OTS grant, this subcommittee conducted media outreach, seat belt observations at local high schools, a safe driving poster contest and safe driving classes.

In other LHJs, staff conduct home safety evaluations when performing home visits, and provide guidance for corrective actions if needed. Sutter County educated a high school community about teen drinking and driving using the program "Every 15 Minutes." Counties also use Child Death Review data to identify trends and raise awareness.

California's continues its GDL program, which includes 2 of the 3 recommended elements demonstrated to save lives in recent research reported by AAA. [79]

MCAH programs are working with local law enforcement agencies on the "Next Generation" Click it or Ticket program for 2008-09. Consistent public health messages will strengthen the impact of this campaign for the MCAH population.

MCAH also continues to collaborate with EPIC and other agencies to coordinate activities that address joint areas of interest.

c. Plan for the Coming Year

Current activities of the MCAH Division, the EPIC Branch, CIPPP and local health jurisdictions will be continued.

MCAH Division will continue its collaborative work with the SCOTS and SHSP coalitions. As an active partner in these efforts, MCAH assists in motor vehicle related injury control efforts by establishing common statewide goals and priorities; strengthening injury prevention and control partnerships; sharing data, knowledge and resources; avoiding redundant activities; and leveraging existing resources, including funds, people and leadership attention, toward common objectives.

State Performance Measure 6: *The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System.*

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	7	7	5.2	6.4	6.2
Annual Indicator	5.2	6.7	7.0	6.0	6
Numerator	34	45	49	43	
Denominator	65484	67365	70382	71609	
Data Source					CBDMP, 2007
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6	5.8	5.6	5.6	5.4

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Source: State of California, Department of Public Health, California Birth Defects Monitoring Program (CBDMP) Registry, 2007.

Numerator: Confirmed cases of NTDs in 2007 among fetal deaths plus live births in monitored counties (provisional). The provisional data for 2007, as well as all data reported in prior years, include only anencephaly and spina bifida cases. Including encephaloceles that are not part of another syndrome for prior years data would increase the numerators and rates as follows: 2003 = 54 cases, 8.5 per 10,000; 2004 = 40 cases, 6.1 per 10,000; 2005 = 52 cases, 7.7 per 10,000; 2007 = 47 cases, 6.6 per 10,000. Encephalocele data for 2006 are not yet available from CBDMP, and 2006 indicator data reported in the table are still provisional.

Denominator: Fetal deaths plus live births in monitored counties. The number of counties included in the registry was reduced beginning in 1998. Data since 1998 are from eight counties in the Central Valley. Analysis carried out by CBDMP of the neural tube defect incidence data suggest the comparability of the 8-county sample with the larger sample used through 1997. The eight counties are deemed sufficient by CBDMP for surveillance purposes in this state.

Notes - 2006
State of California, Department of Public Health, 2006 California Birth Defects Monitoring Program (CBDMP) Registry.

Numerator: Confirmed cases of NTDs in 2006 among fetal deaths plus live births in monitored counties (provisional). The provisional data for 2006 as well as all data reported in prior years, include only anencephaly and spina bifida cases. Including encephaloceles not part of another syndrome for prior years data would increase the 2003 numerator to 54, and the rate to 8.5 per 10,000; the 2004 NTD numerator would increase to 40 and the rate to 6.1 per 10,000 ; the 2005 NTD numerator would increase to 52 and the rate to 7.7 per 10,000. NOTE: the manual matching process performed to determine NTD-related encephalocele cases that were not part of another syndrome detected two additional cases of spina bifida for 2003. Thus, without adding encephaloceles to the 2003 data reported previously, those numbers should be updated to a numerator of 51 and a rate of 8.1 per 10,000 live births and fetal deaths.

Denominator: Fetal deaths plus live births in monitored counties. The number of counties included in the registry was reduced beginning in 1998. Data since 1998 are from eight counties in the Central Valley. Analysis carried out by CBDMP of the neural tube defect incidence data suggest the comparability of the 8-county sample with the larger sample used through 1997. The eight counties are deemed sufficient by CBDMP for surveillance purposes in this state.

a. Last Year's Accomplishments
Between 2001 and 2007, the incidence of neural tube defects, calculated for spina bifida and anencephaly only, has fluctuated between 5.2 and 8.1 per 10,000 (using the corrected number for 2003, as reported in the 2007 Field Note to Form 11). The provisional incidence for 2007 is 6.0, again based on only those two NTDs. The HP 2010 target is to reduce the occurrence of spina bifida and other NTDs to 3 new cases per 10,000 live births.

In the footnotes to SPM 6 we expanded our reporting of NTDs to include neural-tube-related encephaloceles that are not part of another syndrome (i.e., not part of a syndrome that has a suite of symptoms, only one of which is an encephalocele). When we include encephaloceles, the incidence of NTDs has gone from 8.5 in 2003, down to 6.1 in 2004, back up to 7.7 in 2005, and back down to 6.6 as a preliminary rate for 2007. The incidence data, provided by the California Birth Defects Monitoring Program (CBDMP), are based on eight counties in the Central Valley.

The MCAH Division continues its long-standing efforts to improve folic acid intake before and during pregnancy, since folic acid intake around the time of conception is associated with lower rates of NTDs. MCAH continues to collaborate with and provide technical assistance to MCAH programs, other CDPH programs and outside groups such as the March of Dimes. A folic acid page was added to the MCAH website, providing information on folic acid needs, sources, recommendations, and resources: http://cdph.ca.gov/folicacid .

MCAH continued to encourage CDC, MOD, NCFA (National Council on Folic Acid) and others to work towards the fortification of corn tortillas with folic acid since Latinas--who have a higher risk for NTDs--tend not to consume the folic acid-fortified grain products currently on the market.

MCAH distributed information about ordering free folic acid, brochures, posters, bookmarks and other materials through its networks during the third National Folic Acid Week (in January 2008).

MCAH staff actively participated on the Preconception Health Council of California (PHCC), a partnership between the MCAH Division and the March of Dimes California Chapter (MOD). PHCC provides information, tools and resources to local communities about the importance of achieving optimal health for women before pregnancy, including adequate folic acid intake, as a means to improving poor birth outcomes like neural tube defects.

MCAH hosted the Second National Preconception Conference, held October 29-31, 2007 in Oakland, California. Folic Acid was highlighted in posters and presentations produced by MCAH. "Trends in Folic Acid Supplement Intake Among Women of Reproductive Age--California, 2002--2006 "--a report produced by MCAH in conjunction with CDC and released in the MMWR on October 26, 2008--was highlighted at the conference (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5642a3.htm?s_cid=mm5642a3_e).
The MMWR shared findings from the California Women's Health Survey, which indicate folic acid supplement use is decreasing among California Hispanic women and among women of lower educational attainment, women who are at increased risk for neural tube birth defects.

In response to the MMWR report MCAH convened a group of 30 stakeholders in February 2008 to strategize about targeted and evidence based interventions to increase folic acid intake among California Latinas and women with lower educational attainment. An additional meeting with MCAH staff was held in April 2008. MCAH compiled the recommendations from both groups and drafted an implementation plan with folic acid promotion activities targeted in areas with a high proportion of Latinas of childbearing age.

A question on folic acid use before pregnancy had been re-introduced into California's MIHA survey in both 2005 and 2006. These data were analyzed and 2006 data were published on our MIHA web site:
http://ww2.cdph.ca.gov/data/surveys/Pages/StatewideTablesfromthe2006MaternalandInfantHealthAssessment(MIHA)survey.aspx

MCAH continued to provide support to the LHJs for folic acid activities. Examples include:

- Plumas County MCAH clinics distributed folic acid supplement information to all women of childbearing age.
- Sonoma County featured Folic Acid Week on the news and alerts section of their web site.
- In Sutter County, several articles featuring information about folic acid were written for local publications, including the county Wellness Newsletter.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. The MCAH Division produces and distributes pamphlets, posters, and other educational materials, in Spanish and English, which promote folic acid use among women of reproductive age.			X	
2. The MCAH Division collaborates with and provides technical assistance regarding folic acid use to local programs, including AFLP, BIH, and CPSP; and other programs in CDHS, such as WIC, GDB, and the Nutrition Network.				X
3. Folic acid promotion is undertaken through distribution of the CPSP “Steps to Take” guidelines, CDAPP Guidelines for Care, and AFLP's Nutrition and Physical Activity Guidelines for Adolescents.			X	
4. Information about neural tube defects and folic acid is provided on the websites of MCAH, the California Birth Defects Monitoring Program, and the Genetic Disease Screening Branch.			X	
5. MCAH collaborates with national agencies to advocate for the continued fortification of the grain supply.				X
6. MCAH collaborates with organizations and committees to develop strategies for increasing awareness of the importance of folic acid consumption among providers and consumers.				X
7. MCAH publicizes National Folic Acid Week annually to all MCAH Programs, state nutritionists and CDPH nutrition networks.			X	
8.				
9.				
10.				

b. Current Activities

The PHCC launched a comprehensive preconception health website for the state, featuring low literacy handouts and other information for consumers, as well as provider resources such as toolkits, best practices, and links to other sites. Folic acid consumption is one of the key preconception health topics. This website takes the place of the provider packet Every Woman Every Time, that was produced by March of Dimes and Sutter Medical Center Sacramento and was in need of revision.

Two questions about folic acid are included in the 2009 versions of both the California Women's Health Survey (CWHS) and the Maternal Infant Health Assessment (MIHA) surveys that are currently in the field.

Following the implementation plan suggested by the Folic Acid stakeholder group last year, MCAH sponsored a multi-pronged folic acid awareness campaign targeting Latinas of reproductive age in the spring of 2009. This campaign included radio PSAs, mini-dramas and talk shows; revised folic acid brochures and posters; development of a training curriculum for health promoters; a small-scale vitamin distribution campaign at selected WIC centers and family planning clinics; and a provider education campaign about folic acid being a covered benefit under Medi-Cal.

MCAH sent out information through its networks about National Folic Acid Week (January 5th-12th) and the upcoming California folic acid awareness campaign.

c. Plan for the Coming Year

The MCAH Division will continue its efforts to promote folic acid use among women of reproductive age.

MCAH programs will continue to be represented at the National Council on Folic Acid (NCFA). NCFA is working to expand fortification efforts and develop additional training and educational materials.

Folic acid educational materials, including the newly revised pamphlet and poster, will continue to be distributed across the state via local MCAH, OFP, WIC and GDSP programs, as well as by the March of Dimes. These resources are also available on MCAH's folic acid website.

MCAH will conduct an evaluation of the Spring 2009 folic acid awareness campaign and produce a report for distribution to attendees of the 2008 Folic Acid stakeholder meeting.

The PHCC website will include an interactive quiz for consumers so they can gauge their preconception health. The quiz will have a section on folic acid use. The website will also include a section where providers can register as partners, upload materials, participate in discussion forums and share resources.

MCAH will publicize the preconception health website to healthcare and public health providers and other agencies and groups across the state who serve women of reproductive age.

MCAH will collaborate to ensure that folic acid education is included in the revised version of the "Sweet Success: Guidelines for Care" State Program Guide for the California Diabetes and Pregnancy Program.

MCAH plans to implement a preconception social marketing campaign with "First Time Motherhood" grant funds from HRSA/MCHB. One component of the campaign is dissemination of information about folic acid to Latina women of reproductive age in targeted geographic areas using new media such as text messaging and web-based strategies.

MCAH will continue to encourage the MCAH local health jurisdictions to work on folic acid. Examples of their planned activities include:

- San Francisco County received Vitamin Settlement monies and will be conducting a multimedia folic acid awareness campaign targeting women at highest risk.

- Lassen County will conduct educational presentations on preconception health and folic acid.

- San Benito County will post folic acid facts on a bulletin board in the Public Health Department lobby. Immunization clinic rooms and community outreach events will display perinatal/women's health educational information, including folic acid information.

- Ventura County will distribute Folic Acid Campaign materials to health care professionals and community agencies.

- Yolo County will distribute March of Dimes folic acid materials, WIC and Dairy Council Nutrition pamphlets to providers.

State Performance Measure 7: *The percent of newly referred clients to the CCS program whose cases are opened within 30 days of referral.*

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			76	72	77

Annual Indicator		75.7	70.4	76.2	81.1
Numerator		20638	34053	37977	43201
Denominator		27269	48387	49871	53263
Data Source					CMS Net and LA County
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	82	83	84	85	86

Notes - 2008
This measure is the percent of newly referred clients to the CCS program whose cases are opened within 30 days of referral.

The data are CMS Net data for 57 counties and data from LA County for FY 2007-08. The 57 counties opened 76 percent of their cases within 30 days of referral and LA County opened 97.3 percent of their cases within 30 days of referral.

Notes - 2007
This measure is the percent of newly referred clients to the CCS program whose cases are opened within 30 days of referral.

The data are CMS Net data for 56 counties and data from LA County for FY 2006-07. Sacramento is not collecting comparable data and so it is not included in this measure.

Notes - 2006
This measure is the percent of newly referred clients to the CCS program whose cases are opened within 30 days of referral.

The data are CMS Net data for 56 counties and data from LA County for FY 2005-06. Sacramento is not collecting comparable data and so it is not included in this measure.

a. Last Year's Accomplishments
SPM 07 was a new California State Performance Measure in 2006. SPM 07, the percent of newly referred clients to the CCS program whose cases are opened within 30 days of referral, is 81.1 percent for FY 07-08, compared to 76 percent in 06-07. Although the percentage is higher, possibly due to counties reviewing and evaluating their processes for opening cases, the delay in accessing needed services nevertheless continues to be an issue for families. There are several factors that contribute to delays in opening newly referred cases such as staffing shortages in the CCS offices and in the hospitals.

Decreasing the time interval between referral to the CCS program and receipt of CCS services was identified as one of the top ten state priorities during the five year needs assessment. Families and providers have repeatedly identified long intervals of time from referral to CCS to authorization of services as a barrier to accessing needed services and as a source of frustration. There is no single reason for delays in opening newly referred cases, but through this measure, the CCS program has been identifying areas in the process of determining program eligibility and implementing process improvements that are increasing the percentage of cases opened within 30 days of referral.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CCS will identify areas for improvement in the eligibility		X		

determination as staffing allows.				
2. CCS will identify factors influencing the length of time from CCS referral to authorization and to receipt of services as staffing allows.		X		
3. Strategies to reduce the referral process is to station CCS workers in hospitals as staffing allows.				X
4. Facilitating provision of medical and financial information from families and providers to expedite eligibility determinations and service authorizations as staffing allows.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CCS workers continue to be stationed in hospitals, when and where the budget allows, to streamline the referral process. Exemptions to fill vacant positions to process referral authorizations are requested. Referrals identified as "expedite" are prioritized. Plans to redesign the referral process are on hold due to the staffing shortage.

As part of the strategies and actions developed by CHLA workgroup, CCS workers have been stationed in selected hospitals to streamline the referral process for CCS services.

Available data from the 56 counties are being compared with LA County and the CMS Branch has begun to analyze the variation between LA County and the 56 counties on CMS Net. LA County practices are beginning to be evaluated for "best practices."

c. Plan for the Coming Year
CMS will continue to station CCS workers in hospitals when and where the budget allows to streamline the referral process. CMS will fill vacant positions to process referral authorizations, and will prioritize referrals identified as "expedite."

There will be further discussions with LA County and approximately six other counties that have the shortest interval between their new referrals and opening a case within 30 days, in order to determine their "best practices" that could be applied to the remaining counties.

The effectiveness of CCS workers stationed in hospitals to improve the referral process and decrease the time interval between CCS referral and receipt of CCS services will be evaluated.

Continuing analysis of cases that take longer than 30 days to open will identify reasons for delays and what actions, if any, could be taken to improve upon delays. A tool will be developed so that county and regional office programs can randomly audit cases opened after 30 days, categorize reasons for delays, and initiate possible interventions.

State Performance Measure 8: *The percent of births resulting from an unintended pregnancy.*

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

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Performance Objective			42.1	40.9	40.5
Annual Indicator	42.4	41.3	43.2	44.6	44.6
Numerator	228085	222148	239285	247549	
Denominator	538020	537394	554168	555219	
Data Source					MIHA, 2007
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	40.1	39.7	39.3	39.3	39.3

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Source: 2007 Maternal and Infant Health Assessment Survey, MCAH Program, California Department of Public Health. Numerator: Number of women who delivered a live birth who reported that they had wanted to get pregnant later, hadn't wanted to get pregnant then or in the future, or weren't sure what they wanted. Denominator: Number of women who delivered a live birth who reported when they had wanted to get pregnant. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year.

Notes - 2006
Source: 2006 Maternal and Infant Health Assessment Survey, MCAH Program, California Department of Public Health. Numerator: Number of women who delivered a live birth who reported that they had wanted to get pregnant later, hadn't wanted to get pregnant then or in the future, or weren't sure what they wanted. Denominator: Number of women who delivered a live birth who reported when they had wanted to get pregnant. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year.

a. Last Year's Accomplishments
The proportion of births resulting from an unintended pregnancy became a California state performance measure in 2006. Data on pregnancy intentions are collected via California's Maternal and Infant Health Assessment Survey, an annual, population-based survey modeled on PRAMS.

The percent of births resulting from unintended pregnancy in California women (age 15 and over) increased again in 2007, reaching an estimated 44.6% of all births. This is up from 43.2% in 2006, and 41.3% in 2005. Prior to that, the proportion of unintended pregnancies had been steadily declining from 1999 (estimated at 49%) through 2005. California's unintended pregnancy rate is high compared to the U.S. overall, and exceeds the HP 2010 target of 70% of all pregnancies being intended. In 2002 (the most recent year for which data are available), 35% of recent births in the United States were unintended. [68]

Unintended pregnancy among women giving birth in California in 2007 was highest for African American women (64%), compared to 49% for Hispanic women, 37% for White women, and 33% for Asians/Pacific Islanders. U.S. data suggest that the differences between African American and other women are somewhat larger in California than the nation as a whole. In 2002, 51% of recent births to African American women in the U.S. resulted from unintended pregnancy, compared to 44% of births to Hispanic women and 29% to White women. [69] Unintended pregnancy rates are highest for adolescents. Women with unintended pregnancies miss out on preconception health counseling; are less likely to receive early or adequate prenatal care; are more likely to smoke or drink during pregnancy; and are more likely to have low birth weight babies. [70] Risks for teens include lower educational prospects and a greater risk of living in poverty. Costs to society include increased health care and welfare expenditures and increased

risk of child abuse and neglect. [71]

MCAH and OFP supported several programs to help women avoid unintended pregnancy by decreasing risky behavior, increasing access to and use of effective contraceptive methods, and improving the effectiveness with which all methods are used. OFP programs included Family PACT; the Community Challenge Grant (CCG) Program; the TeenSMART Outreach (TSO) program; the Male Involvement Program (MIP) and the Information and Education (I&E) Program. MCAH Division programs include AFLP and BIH.

During 2007-08, 161 agencies provided over 211,018 teen and parent participants pregnancy prevention training through CCG, I&E, and MIP programs. Another 85,000 individuals received pregnancy prevention information via TSO programs that linked individuals of reproductive age to Family PACT clinical services.

OFP contracted with the UCSF Bixby Center for Reproductive Health Research & Policy for Family PACT program monitoring and evaluation. The Bixby Center estimated that in 2002 the Family PACT program averted 205,000 unintended pregnancies that would have led to 94,000 births. Each pregnancy averted saved Federal, State, and local governments an average of $5,431 in medical, welfare, and social service costs over the next two years and $10,508 over the next 5 years. [72]

MCAH Division staff participated on the Preconception Health Council of California (PHCC), a partnership between MCAH and the March of Dimes. The PHCC plays a pivotal role in relaying the importance of preconception care and reproductive life planning to local communities, helping women decrease unintended pregnancy and achieve optimal pregnancy spacing.

MCAH participated in the Adolescent Sexual Health Workgroup (ASHWG), a collaborative effort between CDPH, California Department of Education, and key non-governmental organizations. ASHWG works to create a coordinated, collaborative, and integrated system to promote and protect the sexual and reproductive health of California youth, ensuring access to family planning services in order to reduce the rate of unintended pregnancy.

The MCAH Division also supported local activities related to the prevention of unintended pregnancy. Examples include Alameda County's Healthy Passages program, which promotes comprehensive health and well-being for adolescents and young adults; the Contra Costa County Teen Age Program to promote adolescent health and reduce the incidence of teenage pregnancy; and Santa Cruz County's efforts to reduce births to teens age 17 and younger through outreach and collaboration.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The MCAH and OFP Divisions support several programs that help women avoid unintended pregnancy by decreasing risky behavior and increasing access to and promoting the use of effective contraceptive methods.				X
2. The Family PACT Program provides family planning services, testing and treatment of sexually transmitted diseases, and education and counseling to low-income Californians.	X			
3. The Information and Education Program (I&E) provides pregnancy prevention training and referrals to adolescents.		X		
4. The Community Challenge Grant (CCG) program promotes community-based partnerships to develop effective local teen pregnancy prevention programs and to promote responsible				X

parenting.				
5. The Adolescent Family Life Program (AFLP) utilizes case management and mentoring to assess and address the risks and resources of adolescent clients and their children, including prevention of subsequent pregnancies.		X		
6. The Black Infant Health Program (BIH) incorporates discussion of contraception and pregnancy spacing into its case management and health promotion activities.		X		
7.				
8.				
9.				
10.				

b. Current Activities
Family PACT serves approximately 1.7 million clients a year, including about 350,000 adolescents. Family PACT conducts ongoing client outreach, provider recruitment, training, and technical assistance. New FDA-approved contraceptive methods have been added to the benefits package. The CCG and I&E Programs continue to reach teens with pregnancy prevention information and referrals. California's 2008-09 Budget Act eliminated the MIP and TSO programs.

AFLP provides services to about 17,000 teens a year.

The PHCC launched a preconception health website with resources for consumers and providers. Reproductive life planning is one of the key components.

The MCAH Division is incorporating reproductive life planning into the revised BIH model, which will be piloted next year. BIH reaches approximately 6500 women a year.

ASHWG developed core competencies for providers of adolescent sexual and reproductive health services and completed the first stage of a Data Integration Project that presents data about STDs, HIV and Teen Birth Rates in a uniform format for better comparison across indicators and to facilitate the development of coordinated interventions.

The MCAH Division produced a Teen Birth Rate Resource, with maps and tables of teen birth rates by race/ethnicity and geographic area, for targeting of teen pregnancy prevention efforts. MCAH also presented on ASHWG's Data Integration Project at the annual AMCHP conference.

c. Plan for the Coming Year
Prevention of unintended pregnancy will continue to be a major issue for California, given the current high proportion and the demographics of California's population. It is projected that Hispanics will become the largest race/ethnic group in California by the year 2011. The high birth rates for Hispanic women and the high proportion of their births that are unintended at the time of conception suggest that this demographic trend will put upward pressure on the overall proportion of births that are unintended.

Family PACT, CCG, I&E, and AFLP will continue their teen pregnancy prevention efforts.

The Family PACT Medicaid Demonstration Project Section 1115 Waiver has been extended by the Centers for Medicare and Medicaid Services through September 30, 2009, to continue negotiations of the State's renewal application and the Special Terms and Conditions of the Waiver.

The MCAH Division will continue participation on ASHWG and will be expanding the Data Integration Project to include behavioral data from the Department of Education and other

sources.

The PHCC will continue to collaborate with the California Family Health Council (CFHC) to integrate preconception health promotion and reproductive life planning messages into Family PACT and Title X-funded clinics. It will also develop a patient-friendly reproductive life planning tool, which will be featured on the PHCC website and made available to Family PACT and Title X clinic patrons. The PHCC will market its website to family planning and women's health care providers, as well as other agencies and groups across the state that serve women of reproductive age.

State Performance Measure 9: *The percent of 9th grade students who are not within the Healthy Fitness Zone for Body Composition.*

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			32.8	32.9	32.7
Annual Indicator	32.9	33.1	32.0	31.3	30.3
Numerator	136011	147308	144156	140123	139081
Denominator	413409	445038	450488	447676	459013
Data Source					CA Dept of Education, 2008
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	32.5	32.3	32.1	31.9	31.7

Notes - 2008
Source: California Department of Education. 2008 California Physical Fitness Test Results, accessed on September 1, 2009 at http://data1.cde.ca.gov/dataquest/PhysFitness/PFTestSt2007.asp?cYear=2007-08&cChoice=PFTest1&RptNumber=0.

Numerator: The number of 9th grade students whose body composition is not within the Healthy Fitness Zone. Denominator: The number of 9th grade students tested for body composition. Note: The denominator and percent of 9th grade students not within the healthy fitness zone for body composition were available from the website. The numerator was calculated by multiplying the denominator by the percent not in the Healthy Fitness Zone.

Notes - 2007
Source: California Department of Education. 2007 California Physical Fitness Test Results, accessed on 1/14/09 at http://data1.cde.ca.gov/dataquest/PhysFitness/PFTestSt2007.asp?cYear=2006-07&cChoice=PFTest1&RptNumber=0.
A summary report, 2007 California Physical Fitness Testing: Report to the Governor and the Legislature, is available at http://www.cde.ca.gov/ta/tg/pf/documents/reporttogov.pdf. Accessed 1/14/2009.

Numerator: The number of 9th grade students whose body composition is not within the Healthy Fitness Zone. Denominator: The number of 9th grade students tested for body composition. Note: The denominator and percent of 9th grade students not within the healthy fitness zone for body composition were available from the report. The numerator was calculated by multiplying the denominator by the percent.

Notes - 2006
California Department of Education. 2006 California Physical Fitness Testing: Report to the Governor and the Legislature. Sacramento, CA, December 2006.

Numerator: The number of 9th grade students whose body composition is not within the Healthy Fitness Zone. Denominator: The number of 9th grade students tested for body composition. Note: The denominator and percent of 9th grade students not within the healthy fitness zone for body composition were available from the report. The numerator was calculated by multiplying the denominator by the percent.

a. Last Year's Accomplishments
SPM 9, added in FY 2006-07, addresses the prevalence of 9th graders who are outside the healthy fitness range for body composition per the California Department of Education's Annual Physical Fitness Test. Chronic health problems are associated with body composition scores below and above the HFZ. In 2007, the percent of 9th grade students not within the Healthy Fitness Zone (HFZ) for Body Composition further decreased to 31.3 percent, compared to 32.0 percent in 2006. From 2000 to 2005 this percentage was higher, fluctuating between 32.3 and 35.3 percent.

Forty-three percent of Pacific Islander 9th grade students were not within the HFZ for Body Composition, compared to 38 percent of Hispanics, 35 percent of African American, 34 percent of American Indian/Alaskan, 26 percent of Filipino, 24 percent of White and 19 percent of Asian students. A gender difference in rates has also been observed. A higher proportion of 9th grade male students (33%) are not within the HFZ compared to females (30%).

The MCAH Division and CMS Branch have been involved with program planning, implementation and evaluation in the CDC-funded California obesity prevention initiative entitled Nutrition, Physical Activity and Obesity Prevention Program. In addition, MCAH Division and the CMS Branch actively participated in the CDPH Obesity Prevention Group (OPG), the Inter-Agency Nutrition Coordinating Council (IANCC) and the CMS/MCAH/WIC/GDSP Nutrition Coordinating Committee.

The majority of the MCAH local health jurisdictions are also working to promote nutrition and physical activity to address the obesity epidemic. For example, Colusa County developed "The Mileage Club," a competition between K-6th graders to exercise regularly for 12 weeks. Del Norte County participates in the Del Norte Unified School District Nutrition Network meetings and meets with school nurses to address childhood obesity. Lassen County holds a 100% Me Day to educate middle school children ages 11-15 years old on the importance of good nutrition, exercise and a healthy diet. Marin County provided training, materials and technical support to the Bahia Vista Nutrition Education/Garden Coordinator in supporting 21 K-4th grade teachers to integrate gardens, health and fitness in the classroom, and participate in various workshops including healthy eating/body image. 348 youth attended a Peer Summit that included nutrition/body image. The Mono Nutrition Task Force was able to eliminate all non-nutritious food and drink from all schools in Mono County. Santa Cruz County gave awards to schools with outstanding school wellness plans that will result in well-nourished, active children who are better learners.

In addition to the school-based efforts above, LHJs have implemented other child-based efforts. Mendocino County held a Kids Fitness and Nutrition Fair. Modoc County was involved with a Summer Soccer Camp. Santa Barbara County held their first annual Childhood Obesity Summit. They removed snack and soda vending machines from the Boy's and Girl's Club and partnered with Fit Youth to promote a media campaign featuring nutrition education and healthy messages through the use of bus ads, television and workshops.

LHJs have also undertaken efforts directed to the broader community and healthcare providers. Humboldt County conducted a "Call to Action" of community representatives to prioritize

goals/strategies for Humboldt Communities for Activity and Nutrition, a plan to address activity, healthy eating and policy to improve the health of community members. Imperial County assisted in implementing farmers' markets and health fairs to promote healthy eating and physical activity. Monterey County conducts a "Just Run" program encouraging community physical activity for healthy families. Shasta County hosts Healthy Shasta's "Walk This Way" community event to educate families on healthy eating, exercise, and where to access health resources. Sutter County held a Hawk Flight Earth Day Festival and hosted a jump rope activity for children. Sonoma County trained 72 healthcare providers to screen and counsel families on obesity, sponsored a Wellness Festival for Santa Rosa School District, redesigned clinic screening tools for well child visits to specifically address nutrition and exercise issues, and conducted teen cooking classes in low-income housing. San Luis Obispo County developed physician toolkits for addressing childhood obesity.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The MCAH Division and CMS Branch participate in the CDPH Obesity Prevention Group, the Inter-Agency Nutrition Coordinating Council, and the Center for Family Health Nutrition Coordinating Committee.				X
2. The MCAH Division and CMS Branch have been involved with program planning, implementation and evaluation in the CDC-funded Nutrition, Physical Activity and Obesity Prevention Program.				X
3. The AFLP and BIH Programs continue to promote healthy food choices and physical activity by distributing nutrition and physical activity guidelines and holding discussions on how to cut fat and lower calories.		X		
4. The CMS Branch continues the collection of data from CHDP nutrition assessments by CHDP providers for infants, children, and adolescents and forwards the data to CDC for entry into PedNSS.				X
5. Local MCAH health programs have worked with school districts to introduce healthy food choices into school cafeterias and increase opportunities for physical activities in the school curricula.		X		
6. MCAH develops and/or provides nutrition education materials and initiatives, nutrition assessment materials, technical assistance and consultation, and funding opportunities to MCAH programs and colleagues.				X
7.				
8.				
9.				
10.				

b. Current Activities

MCAH Division and CMS Branch are actively planning the 2009 Childhood Obesity Conference to be held in Anaheim, California. The conference will build upon the past four conferences by promoting collaboration, showcasing evidence-based prevention interventions, accelerating the obesity prevention movement, and featuring community efforts.

MCAH is on the planning committee for the 2009 Weight of the Nation, a forum to highlight progress in the prevention and control of obesity through policy and environmental strategies. It is

framed around four intervention settings: community, medical care, school, and workplace. The CDC will use the lessons learned from the conference to produce a "National Road Map for Obesity Prevention and Control," guidelines for investing in integrated obesity prevention and control initiatives.

The MCAH Division and CMS Branch continue to be involved with strategic planning of the CDC-funded California obesity prevention initiative entitled Nutrition, Physical Activity and Obesity Prevention Program.

The local health jurisdictions continue to include outreach, education and guidance to families related to appropriate diet and exercise. Inter- and intra-county coalitions have been established to plan and implement programs designed to reduce obesity within the school age population, such as introducing healthy food choices into school cafeterias and increasing opportunities for physical activities in the school curricula.

c. Plan for the Coming Year

The MCAH Division and CMS Branch will continue to actively participate in coalitions and committees promoting nutrition and activity. MCAH provides nutrition and physical activity resources and intervention ideas to MCAH Action, which is the self-directed organization of the 61 California MCAH jurisdiction directors.

Existing MCAH and CMS programs will continue to promote healthy lifestyles that include increasing physical activity, reducing television viewing, and consuming five fruits and vegetable servings per day. AFLP will continue to promote healthy food choices and physical activity through distribution of nutrition and physical activity guidelines and a cookbook targeted to teens. MCAH will be updating and adding at a minimum one new chapter to the Adolescent Nutrition and Physical Activity Guidelines for AFLP. Updates will include new science-based guidelines and culturally competent recommendations.

The MCAH Division continues to provide nutrition and physical activity resources and intervention ideas to MCAH health jurisdiction directors and other MCAH colleagues. Local health jurisdictions will continue to support local obesity-related coalitions; participate in First 5 funded councils and activities; evaluate local childhood obesity data and share findings with health care and public health workers through mapping and reports; develop and implement county nutrition plans; support school health including walk to school efforts; provide community nutrition and physical activity classes, including those utilizing the National Office of Women's Health BodyWorks curriculum for parents of tweens; participate in Healthy Eating and Living Collaboratives; use media to promulgate messages; and collaborate with other programs serving families and children.

The Preconception Health Initiative will continue its collaborations with organizations and programs that reach adolescents with information about healthy eating and active living.

An ongoing activity for the CMS Branch is the collection of data from CHDP nutrition assessments by CHDP providers for infants, children, and adolescents. State and local CHDP nutritionists will also continue to develop and implement nutrition education, provide consultation and training to CHDP providers, and coordinate follow-up and referrals to related programs.

The CHDP program will continue to provide cholesterol and fasting blood glucose screening tests for adolescents at risk for obesity and/or cardiovascular disease. Appropriate care management and referrals to resources will be initiated for adolescents with abnormal laboratory values. The CHDP program will continue collaborating with Blue Cross of California on efforts to ensure BMI screening is being performed in provider offices.

State Performance Measure 10: *The percent of women, aged 18 years or older, reporting intimate partner physical, sexual or psychological abuse in the past 12 months.*

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

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			9.6	8.4	8.3
Annual Indicator	9.7	8.5	7.6	7.7	7.7
Numerator	1026644	896672	856984	861184	
Denominator	10546784	10549890	11298656	11199170	
Data Source					CWHS, 2007
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8.2	8.1	8	7.9	7.9

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Sources: California Department of Public Health, California Women's Health Survey (CWHS), 2007. Numerator: Number of women (18 years old or older) reporting any intimate partner physical, sexual, or psychological/emotional abuse in the past 12 months. Denominator: Number of women (18 years old or older) completing at least one of a series of nine questions in the CWHS on intimate partner abuse. Results are weighted using the California Department of Finance population data for 2000 (file name Race/Ethnic Population with Age and Sex Detail, 2000-2050), May 2004.

2006-07 data should not be compared to prior year data. Beginning in 2006, women without intimate partners are included in the denominator. Recalculated rates for prior year data using this method: 2005 = 8.1%; 2004 = 9.2%; 2003 = 8.3%.

Notes - 2006
Sources: California Department of Public Health, California Women's Health Survey (CWHS), 2006. Numerator: Number of women (18 years old or older) reporting any intimate partner physical, sexual, or psychological/emotional abuse in the past 12 months. Denominator: Number of women (18 years old or older) completing at least one of a series of nine questions in the CWHS on intimate partner abuse. Results are weighted using the California Department of Finance population data for 2000 (file name Race/Ethnic Population with Age and Sex Detail, 2000-2050).

2006 data should not be compared to prior year data. Beginning in 2006, women without intimate partners are included in the denominator. Recalculated rates for prior year data using this method: 2005 = 8.1%; 2004 = 9.2%; 2003 = 8.3%.

a. Last Year's Accomplishments
SPM 10 was new in 2006, but was similar to the former SPM 08. The measure was changed to be more inclusive of the spectrum of intimate partner violence (IPV), including sexual and psychological abuse. The term "intimate partner" refers to current and former spouses as well as dating partners. For this year and all previous years to 2003, the reporting of this measure is being expressed as the percent of intimate partner violence among all adult women, regardless of involvement in an intimate partnership.

Over the past four years, SPM 10 has fluctuated between 7.6% and 9.7%. In 2007 SPM 10 was 7.7 percent, similar to 2006. Overall rates were higher for Hispanic (12.2%) and African American (9.1%) women than for Asians (6.6%) and Whites (5.7%). These data are from the California Women's Health Survey (CWHS).

Of the IPV reported in 2007, about half (3.8% of all adult women) was physical or sexual in nature, and half (3.9% of all adult women) was psychological.

To combat the serious health threat of IPV, the Battered Women Shelter Program (BWSP) was established in 1994 to provide comprehensive shelter-based services for women experiencing intimate partner violence in all its forms, and their children. Also known as the Domestic Violence Program (DVP), the OFP-funded shelter agencies served approximately 105,500 women and their children in FY 2007-08.

MCAH and OFP continue to inform stakeholders by analyzing and presenting data on IPV from the CWHS and Maternal and Infant Health Assessment (MIHA) survey.

MCAH Division staff actively participated on the Preconception Health Council of California (PHCC), a partnership between the MCAH Division and the March of Dimes California Chapter (MOD). PHCC provides information, tools and resources to local communities focusing on the importance of achieving optimal health for women before pregnancy, including freedom from family violence, as a means to improving poor birth outcomes.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The OFP Program's Battered Women Shelter Program (BWSP) currently funds 94 shelter-based grantees to provide direct services to battered women and their children.		X		
2. All BWSP grantees are required to incorporate domestic violence prevention activities and outreach to unserved/underserved populations into their ongoing shelter-based services.		X		
3. Grantees are required to develop a policy statement and implementation plan to provide services to women from varying cultural and linguistic backgrounds.				X
4. Technical assistance and training is provided to all 94 BWSP domestic violence shelter agencies to help ensure competent services are provided to unserved/underserved populations.				X
5. MCAH contracts with the San Diego State Center for Injury Prevention, Policy and Practice (CIPPP) to develop SafetyLit, a web-based resource of violence related literature and resources.				X
6. CIPPP provides technical assistance to LHJs who are expanding resources or capacity to better address DV, and maintains the Injury Prevention Website at www.injuryprevention.org.				X
7. MCAH funds local Child Death Review Teams in many counties and some deaths are attributable to DV event.			X	
8. AFLP uses chart prompts to assess teens for behavioral risks assessments involving safety.	X			
9.				
10.				

b. Current Activities
MCAH promotes awareness of best practices in intimate partner violence through the San Diego State University Center for Injury Prevention, Policy and Practice (CIPPP). CIPPP prepares "SafetyLit," a web-based resource of violence literature, maintains the Injury Prevention website (www.injuryprevention.org) and provides technical assistance to LHJs.

MCAH collaborates with EPIC and FHOP to collect violent injury data. EPIC reviews OSHPD data for IPV related injuries and deaths. The Behavioral Risk Factor Surveillance System tracks adverse childhood events such as exposure to IPV and access to guns in the home. The CWHS and the MIHA survey include questions about the presence of children during an IPV event, as well as the prevalence of IPV. MCAH also supports the Child Death Review Teams, which include child deaths in IPV-affected homes.

The DVP is improving access to shelter services for target populations, and provided funding for an Unserved/Underserved Training and Technical Assistance Project. Needs assessments for each targeted population were done at 94 shelter programs, and training was provided to 5 regions to expand services to underserved populations. The contractors also developed a tool to track shelter agency clientele. The DVP is focusing on children exposed to IPV, and distributed the "First Impressions" DVD to all shelters. OFP also maintains www.safenetwork.net, which has a compendium of resources for IPV victims.

c. Plan for the Coming Year
In the coming year, OFP will continue to fund 94 DVP grantees to provide emergency and nonemergency direct services to victims of domestic violence; prevention activities; and outreach to underserved populations. These predominantly secondary and tertiary prevention activities will help to reduce the prevalence of intimate partner violence in California.

The DVP will seek resources to assist existing DVP grantees with language assistance needs for domestic violence victims and their children.

The DVP will redesign its www.SafeNetwork.net website to provide additional information for domestic violence victims and providers. The redesigned site will prominently display governmental and private foundation funding opportunities for providers.

The MCAH Division's Preconception Health and Healthcare Initiative's (PHHI) new website (www.everywomancalifornia.org) will connect people working in preconception health and feature links to information, tools and resources related to the prevention of intimate partner and family violence.

The Preconception Health Council of California (PHCC) will guide the planned revision and reprinting of the preconception provider/patient resource packet, including the section on IPV.

E. Health Status Indicators
Introduction
After years of increase, the low birth weight rate held steady for the past three years. However, it is still higher than the HP 2010 goal and remains a strong focus of CDPH and DHCS efforts. Targeted programs such as AFLP, BIH, CDAPP and CPSP work to improve outcomes in specific populations. Public health interventions such as tobacco cessation, perinatal substance abuse treatment and domestic violence prevention help minimize risk.

The 2007 death rate due to unintentional injuries in children 0-14 was the lowest in the past five years, and hospitalization rates for nonfatal injuries decreased as well. Recent years have also shown progress in reducing the impact of motor vehicle collisions on children and young adults, yet traffic-related deaths in ages 15-24 remain much higher than the HP 2010 target.

Chlamydia--the most common reportable communicable disease in California--is costly, with long term reproductive health consequences and poor perinatal/neonatal outcomes including prematurity, pneumonia and conjunctivitis. California STD surveillance systems operated by local and state STD control programs under Title 17 reporting regulations provide key strategies and data.

California's population is diverse, and neither race nor ethnicity alone provides a complete picture. Because the demographic categorization requested by HRSA in HSIs 6-12 differs from that commonly used in California, only minimal analysis has been provided in this section.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	6.7	6.9	6.9	6.9	6.8
Numerator	36481	37653	38517	38918	37663
Denominator	544666	548679	562135	566079	551550
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birthweight were excluded from the denominator.

Notes - 2007
Source: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birthweight were excluded from the denominator.

Notes - 2006
Source: State of California, Department of Public Health, Center for Health Statistics, 2006 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birthweight were excluded from the denominator.

Narrative:
In 2007, the percent of live births which were LBW was 6.9 percent. While the proportion of deliveries with LBW had been increasing since 2000, this figure has held steady for the past three years. The HP 2010 target is 5%.

Among racial and ethnic groups, African American infants were twice as likely as infants of most other groups to be LBW. In 2007, 12.1 percent of African American infants were LBW, compared

to 6.3 to 7.6 percent for other populations. However, the 2007 rate was the lowest it has been in five years. From 2003-2005, between 12.6 to 12.8 percent of African American infants were LBW. This figure dropped to 12.3 percent in 2006, then 12.1 for the most recent year for which data are available.

For Asians and Pacific Islanders in 2007, 7.6 and 6.9 percent of live births were LBW, respectively. This compares to 7.7 and 7.5 percent LBW in 2006. Whites and Hispanics have had the lowest rates over the past five years, with between 6.0 and 6.7 percent of live births LBW in 2003-2007. In 2007, 6.3 percent of Hispanic infants and 6.4 percent of White infants were LBW. Although the percent of American Indian live births that were LBW has fluctuated by year, this was highest in 2007 at 7.6 percent.

Moderately low birth weight (MLBW), between 1,500 to 2,499 grams, is most commonly associated with intrauterine growth restriction or delivery between 32 and 37 weeks gestation, called Late Preterm Infants/Near Term Infants (LPI/NTI). LPI/NTI is associated with factors such as: lower order multi-fetal pregnancies, maternal age less than 17 years, perinatal factors such as pre-eclampsia, over and under weight gain in pregnancy, induction and augmentation of labor, and cesarean delivery. Maternal pre-existing conditions such as over and under weight, diabetes, hypertension, and life style issues such as tobacco, alcohol and drugs also contribute to the risk of LPI/NTI.

MLBW infants experience a nearly three-fold increase in neonatal and postneonatal mortality, excess hospital costs up to six times that of infants born between 37-40 weeks gestation, increased risk of neonatal complications such as hypoglycemia, hyperbilirubinemia, Respiratory Distress Syndrome, suspected infection or sepsis and feeding difficulties.

Further efforts to understand the risks and optimize outcomes for MLBW infants are underway in collaboration with California Perinatal Quality Care Collaborative, as well as the California Maternal Quality Care Collaborative based at Stanford University. Primary data collection and evaluation, and hospital and provider based quality improvement efforts, focus on LPIs as well as causes of maternal complications such as hemorrhage and infection. Other MCAH Division partners in these efforts include the California Children's Services, California Association of Neonatologists, Regional Perinatal Programs of California, California Perinatal Transport Systems, CDAPP and the California Pregnancy Related and Pregnancy Associated Mortality Review.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	5.2	5.2	5.2	5.3	5.2
Numerator	27437	27796	28595	28975	27948
Denominator	528124	531377	544762	548564	534215
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

Source: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birth weight were excluded from the denominator.

Notes - 2007
Source: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birth weight were excluded from the denominator.

Notes - 2006
Source: State of California, Department of Public Health, Center for Health Statistics, 2006 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birth weight were excluded from the denominator.

Narrative:
In 2007, the percent of live singleton births which were LBW was 5.3. This is a slight increase over the prior years, from 5.1 percent of live singleton births LBW in 2003, and 5.2 percent in 2004-2006.

Racial and ethnic patterns for LBW singleton births are similar to those seen for all LBW births. Among African American live singleton births in 2007 9.9 percent were LBW. For Asians and Pacific Islanders in 2007, 6.1 percent of live singleton births were LBW. LBW was least common among Hispanic and White infants, at 5.1 percent and 4.2 percent of live singleton births, respectively.

The Black Infant Health program, among other MCAH Division efforts, continues to address disparities in birth outcomes between African Americans and Whites. The program provides women, their families and the community with services addressing factors that negatively impact birth outcomes. Strategies to prevent prematurity and reduce low birth weight include culturally competent approaches to increasing timely and adequate use of prenatal care, educating women to modify behaviors that may promote pre-term labor, and educating women on how to recognize the signs of pre-term labor.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.2	1.2	1.2	1.2	1.1
Numerator	6440	6790	6693	6805	6298
Denominator	544666	548679	562135	566079	551550
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birth weight were excluded from the denominator.

Notes - 2007
Source: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birth weight were excluded from the denominator.

Notes - 2006
Source: State of California, Department of Public Health, Center for Health Statistics, 2006 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birth weight were excluded from the denominator.

Narrative:
Births less than 1,500 grams are classified as very low birth weight (VLBW). The percent of live births which were VLBW in 2007 was 1.2 percent. This figure has remained constant over the past five years. This is slightly higher than the Healthy People 2010 goal of 0.9 percent.

Among racial and ethnic groups, African American infants were twice as likely as infants of most other groups to be VLBW. In 2007, 2.7 percent of African American live births were VLBW. After having risen to 3.0 percent in 2005, this proportion has decreased back to the same level it was five years ago (2.7 percent in 2003). Comparatively, all other racial and ethnic groups were generally between 1.0 and 1.5 percent VLBW births from 2003-2007.

Birth weights of less than 1,500 grams are almost exclusively related to prematurity with gestational ages of less than 32 weeks. While not all causes of severe prematurity are well understood, clearly women who have had previous preterm births, are carrying higher-order multi-fetal pregnancies, are African American, or are at the extremes of maternal age, have well documented risk of severe preterm delivery. Pre-existing medical conditions and life style issues as seen in the MLBW population also play a significant role in increasing risk.

VLBW infants are at significantly increased risk of infant mortality; nearly 105 times greater than infants born at normal birthweight. Morbidities associated with VLBW include Respiratory Distress Syndrome, intraventricular hemorrhage, patent ductus arteriosus, necrotizing enterocolitis and retinopathy of prematurity.

Efforts to prevent severe prematurity include those discussed above in 1a. Emphasis on improved prepregnancy health and wellness by providing access to preconception care are vital to these efforts.

Optimizing the outcome of VLBW infants requires improvement in risk appropriate maternal-fetal care. To evaluate variation, understand the issues and provide information on mortality rates within California, the MCAH Division funds several data projects. The Perinatal Profiles of California (PPOC), based at the School of Public Health, University of California, Berkeley, is a risk adjusted mortality database that also reports on sentinel events such as the proportion of VLBW infants born outside of tertiary care facilities. Improved Perinatal Outcomes Data Reports (IPODR) is a web based data report allowing evaluation of perinatal outcomes at the county and zipcode levels.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.9	0.9	0.9	0.9	0.9

Numerator	4813	4920	4900	4983	4695
Denominator	528124	531377	544762	548564	534215
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birth weight were excluded from the denominator.

Notes - 2007
Source: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birth weight were excluded from the denominator.

Notes - 2006
Source: State of California, Department of Public Health, Center for Health Statistics, 2006 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birth weight were excluded from the denominator.

Narrative:
In 2007, the percent of live singleton births which were VLBW was 0.9 percent. Over the past five years this figure has remained constant.

Among racial and ethnic groups, African American singleton infants are the most likely to be VLBW. In 2007, 2.1 percent of African American live singleton births were VLBW. Comparatively, 1.3 percent of Pacific Islander singleton births were VLBW in 2007, while rates of VLBW Asian, Hispanic, White and American Indian singleton infants were between 0.7 and 0.9 percent. Although the percent of African American singleton infants born at VLBW remains substantially higher than for other groups, it should be noted that the 2007 figure (2.1 percent) is the lowest observed for this group over the past five years, as from 2.2 to 2.4 percent of live singleton African American births were VLBW in 2003 through 2006.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	5.8	6.4	5.5	5.3	5.3
Numerator	463	511	453	436	
Denominator	7951488	7930829	8228513	8200066	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over					

the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2007 Death Statistical Master File (ICD-10 Group Cause of Death Codes 295-330). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006-2007 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 6.9; 2001 = 6.2; 2002 = 5.8; 2003 = 6.0; 2004 = 5.6; 2005 = 6.2.

Notes - 2006
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2006 Death Statistical Master File (ICD-10 Group Cause of Death Codes 295-330). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 6.9; 2001 = 6.2; 2002 = 5.8; 2003 = 6.0; 2004 = 5.6; 2005 = 6.2.

Narrative:
Unintentional injury is the leading cause of death in children under aged 1 through 14. In 2007, the death rate due to unintentional injuries among children aged 0-14 years was 5.3 per 100,000. Although death rates from fatal accidental/unintentional injuries to children aged 0-14 have fluctuated over the past five years, the 2007 rate is the lowest observed over that period and represents the first time the rate was below 5.5 per 100,000 from 2000 through 2007.

Under a contract with the MCAH Division, the Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University serves as a resource center on child and adolescent injury prevention. CIPP provides technical assistance and training to local MCAH programs to integrate injury prevention interventions into their programs, policy development and outreach activities. CIPP also participates in the development of public education strategies and policy to change behaviors and the environment (e.g., pool barriers, helmet use, automobile safety, and home safety). .

Although reductions in MCAH's contract with CIPPP due to Title V budget cuts in FFY 2005-06 resulted in elimination of the annual statewide conference and bimonthly injury prevention teleconferences and a decreased level of technical assistance availability, CIPPP continues to provide support to local health jurisdictions to identify and prioritize injury problems, select appropriate interventions, and conduct program evaluation.

The MCAH Division also collaborates with the CDPH EPIC Branch on child injury prevention activities, including local training programs, SIDS and the Child Death Review Team, SAFE-KIDS California Advisory Committee, the Strategic Coalition on Traffic Safety, and the Battered Women

Shelter Program. MCAH and EPIC are meeting on an ongoing to basis to address issues related to shaken baby syndrome, the Electronic Death Recording System (EDRS) and SIDS. MCAH and EPIC also collaborated on participation in the National Center for Child Death Review's "Keeping Kids Alive" symposium, held in May 2009.

Additionally, MCAH provides funding to local health jurisdictions to support local efforts to promote maternal and child health, including child injury prevention. Grants from the California Office of Traffic Safety (OTS) have allowed counties to expand their child injury prevention programs. Many local health jurisdictions also participate in Safe Kids Coalitions, and MCAH continues to work with the Safe Kids California Advisory Committee.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	3.1	3.2	2.6	2.3	2.3
Numerator	250	257	218	191	
Denominator	7951488	7930829	8228513	8200066	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
A manual indicator is reported for 2007 based on 2008.

Notes - 2007
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2007 Death Statistical Master File (The ICD-10 codes for fatal MV traffic injuries are: V29-V79(.4-.9), V81-V82(.1), V83-V86(.0-.3), V12-V14,V20-V28(.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V892). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2007 should be not compared to data reported in previous years due to changes in methodology used for calculating this indicator. The methodology was updated for consistency between fatal and nonfatal injury reporting. The rate now includes only motor vehicle traffic incidents. Rates for prior years using these updated inclusion criteria: 2000 = 2.6; 2001 = 2.7; 2002 = 2.6; 2003 = 3.2; 2004 = 2.7; 2005 = 2.8; 2006 =2.4.

Notes - 2006
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2006 Death Statistical Master File (ICD-10 Group Cause of Death Codes 296-306). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 2.9; 2001 = 3.1; 2002 = 2.8; 2003 = 3.5; 2004 = 3.0; 2005 = 3.1.

Narrative:
Among fatal injuries, those due to motor vehicle collisions are most frequent. In 2007, the date rate from unintentional injuries due to motor vehicle accidents was 2.3 per 100,000 children aged 0-14 years. Motor vehicle traffic accidents accounted for 44% of all fatal unintentional injuries to children aged 0-14 years. As the 2007 rate reflects a change in methodology used to calculate this indicator, data in the table cannot be directly compared to rates reported in prior years.

Death rates from unintentional injuries due to motor vehicle collisions in children under age 15 fell significantly from 5.4 deaths per 100,000 in 1990 to 2.9 deaths per 100,000 in 2000. Accounting for methodological changes in the calculation of this indicator, the revised rate then oscillated between 2.6 and 3.2 per 100,000 during 2000-2005, but further decreased to 2.4 per 100,000 in 2006 and 2.3 per 100,000 in 2007. Rates for Hispanic (2.9 per 100,000) and African American (2.8 per 100,000) children were twice as high as those for Whites (1.5 per 100,000) and Asians (1.4 per 100,000)

The Statewide Coalition on Traffic Safety (SCOTS) task force was established to unite traffic safety stakeholders and promote interagency public/private partnerships using diverse evidence based interventions to reduce motor vehicle fatalities in California. The MCAH Division is an active participant in the task force, which includes representatives from over 20 state and national agencies including the EPIC Branch, the California OTS, the California Alcohol and Beverage Control, the California Department of Education, the California Department of Transportation, law enforcement agencies, the California Emergency Medical Services Authority, the California Department of Alcohol and Drug Programs, the California Department of Motor Vehicles, Mothers Against Drunk Driving, the American Automobile Association, SafeKids West Coast, the UC Berkeley Traffic Safety Center, the Federal Motor Carrier Safety Administration, the Federal Highway Administration, and the National Highway Traffic Safety Administration.

In 2007 the overall number of motor vehicle fatalities in California decreased by 6.2% to the lowest rate since California began calculating more than 60 years ago. Efforts to reduce drunk driving, increased seat belt usage, high gas prices, and growth in the popularity of safety classes for teen drivers may be factors.

The California Office of Traffic Safety reported that the state's child safety seat usage rate reached a record high of 94.4% in 2008, up from 87.7% in 2007. In 2002, California law was changed requiring children to be properly secured in a child seat or booster seat until they are at least 6 years old or weigh 60 pounds, an increase from the prior requirement of 4 years or 40 pounds. A new provision effective in January 2005 requires that children be secured in an appropriate child passenger restraint in the back seat of a vehicle until at least 6 years old or 60 pounds.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	19.9	19.8	20.3	18.2	18.2
Numerator	1051	1077	1118	1024	

Denominator	5294261	5434214	5505180	5641589	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2007 Death Statistical Master File (The ICD-10 codes for fatal MV traffic injuries are: V29-V79(.4-.9), V81-V82(.1), V83-V86(.0-.3), V12-V14,V20-V28(.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V892). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2007 should be not compared to data reported in previous years due to changes in methodology used for calculating this indicator. The methodology was updated for consistency between fatal and nonfatal injury reporting. The rate now includes only motor vehicle traffic incidents. Rates for prior years using these updated inclusion criteria: 2000 = 14.2; 2001 = 18.7; 2002 = 21.0; 2003 = 20.8; 2004 = 19.7; 2005 = 19.7; 2006 =19.8.

Notes - 2006
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2006 Death Statistical Master File (ICD-10 Group Cause of Death Codes 296-306). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 14.4; 2001 = 19.2; 2002 = 21.3; 2003 = 21.3; 2004 = 20.2; 2005 = 20.2.

Narrative:
In 2007, the date rate from unintentional injuries due to motor vehicle traffic collisions was 18.2 per 100,000 children aged 15 through 24 years.

After increasing significantly from 14.2 deaths per 100,000 in 2000 to 20.8 deaths per 100,000 in 2003, fatal motor vehicle traffic collision injury rates in this age group have trended downward over the past five years.

Although the recent decreases are a positive sign overall, deaths due to motor vehicle traffic injuries in this age group continue to be elevated and remain much higher than the HP 2010 objective of 9.2 deaths per 100,000 for the general population. Injury is the leading cause of death among adolescents and young adults aged 15-24 years, and among fatal injuries those due to motor vehicle collisions are most frequent. (Denominators are based on the number of children aged 0-14 and the number of adolescents/young adults aged 15-24 rather than the number of miles driven. Projections are based on the 2000 Census.)

The SCOTS task force, as mentioned in 3b, was established to engage traffic safety stakeholders throughout the state in public and private partnerships to employ diverse evidence based interventions to reduce motor vehicle fatalities in California. The MCAH Division's participation in SCOTS led to an increased awareness among California's motor vehicle injury stakeholders regarding the rise of fatal MVT injuries in California's adolescent and young adult populations several years ago, resulting in adoption of this particular indicator as a priority area for the task force.

Other measures of teen driver and passenger safety also improved in 2007. According to Fatality Analysis Reporting System data reported by the California Office of Traffic Safety, the number drivers age 20 or younger involved in fatal crashes dropped 16.4% from 727 in 2006 to 608 in 2007. Additionally, the percent of unrestrained passenger vehicle occupant "teenaged" fatalities was 46%, leading the nation. Alcohol impaired (BAC of .08 or greater) driver fatalities in those aged 16-19 also dropped, down 22% from 209 in 2006 to 163 in 2007.

Over the past decade California has enacted strong legislation related to teen drivers. California was the first state to pass a Graduated Driver's License law that included a passenger limit for teen drivers, which took effect in July 1998. More recently, new restrictions effective in January 2006 require drivers under age 18 to have had their license for at least one year before being allowed to drive between 11 p.m. and 5 a.m. or transport young passengers under age 20 without a parent or guardian in the car.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	260.8	239.0	210.9	198.0	198
Numerator	20735	18954	17350	16233	
Denominator	7951488	7930829	8228513	8200066	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2007. Principal external cause of injury codes were used (E800-E999). Data exclude cases with iatrogenic codes (adverse effects of medical care and drugs), unknown age, newborns, persons who died in the hospital, and records erroneously listing a "place of injury" code (E849.0-E849.9) as the principal code. Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006-2007 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 284.9; 2001 = 273.4; 2002 = 266.2; 2003 = 257.3; 2004 = 250.7; 2005 = 229.2.

Notes - 2006
Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2006. Principal external cause of injury codes were used (E800-E999). Data exclude cases with iatrogenic codes (adverse effects of medical care and drugs), unknown age, newborns, persons who died in the hospital, and records erroneously listing a "place of injury" code (E849.0-E849.9) as the principal code. Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 284.9; 2001 = 273.4; 2002 = 266.2; 2003 = 257.3; 2004 = 250.7; 2005 = 229.2.

Narrative:
In 2007, there were 198.0 nonfatal injuries per 100,000 children aged 14 years and younger.

Hospitalization rates for all nonfatal injuries among children aged 0-14 years has decreased since 2000, when it was 284.9 per 100,000. By 2003 it had dropped to 257.3 per 100,000, and the downward trend has continued over the past five years, falling below 200 per 10,000 in 2007.

The nonfatal injury rate is highest for African American children aged 0-14, at 265.4 per 100,000 in 2007, followed by White children at 214.8 per 100,000. Rates are lower among Hispanic (184.2 per 100,000), Asian/Pacific Islander (110.3 per 100,000) and American Indian (93.1 per 100,000) children aged 0-14 years.

Nonfatal injuries include unintentional, self-inflicted, and assault injuries. Unintentional injuries include injuries due to falls, motor vehicle accidents, poisoning, natural/environmental causes and other causes. As child injury data only include cases ending in death or hospitalization, the true magnitude of these injuries is underestimated.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	36.8	30.9	26.5	23.0	23
Numerator	2929	2449	2182	1887	
Denominator	7951488	7930829	8228513	8200066	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2007. Principal external cause of injury codes were used (ICD9-CM codes E810-E819). Data exclude cases of unknown age, newborns, and persons who died in the hospital.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.
Tabulations (by place of residence) were done by the MCAH Branch.

Data for 2006-2007 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 39.6; 2001 = 35.9; 2002 = 36.4; 2003 = 35.9; 2004 = 35.4; 2005 = 29.6.

Notes - 2006
Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2006. Principal external cause of injury codes were used (ICD9-CM codes E810-E819). Data exclude cases of unknown age, newborns, and persons who died in the hospital.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.
Tabulations (by place of residence) were done by the MCAH Branch.

Data for 2006 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 39.6; 2001 = 35.9; 2002 = 36.4; 2003 = 35.9; 2004 = 35.4; 2005 = 29.6.

Narrative:
Motor vehicle traffic crashes are the second leading cause of hospitalized nonfatal injuries among children aged 0-14 in California. Nonfatal injuries due to falls are the leading cause of hospitalizations in this population. Like hospitalization rates for all nonfatal injuries among children under 15 years of age, those due to motor vehicle traffic crashes among children aged 0-14 have also decreased over the past five years.

In 2007, the rate of nonfatal hospitalizations due to motor vehicle crashes was 23.0 per 100,000. This was down from 26.5 per 100,000 in 2006 and 29.6 per 100,000 in 2005. Since 2003 (35.9 per 100,000), the rate has declined by more than 35%.

The MCAH Division participated in the development of California's Statewide Strategic Highway Safety Plan (SHSP) spearheaded by the California Department of Transportation as a result of the August 2005 federal legislation entitled the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (SAFETEA-LU). In addition to identifying key safety needs and providing a comprehensive structure for data-driven decision-making, the SHSP provides a framework for California safety agencies to collaborate in aligning and leveraging collective resources to achieve significant reductions in fatalities and injuries on all public roads in the State. The MCAH Division participated in the California Strategic Highway Safety Summit, and has continued work with the statewide group addressing public awareness and education.

MCAH Division programs such as AFLP, CPSP, and BIH provide educational materials on appropriate use of car seats.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	161.9	153.5	146.7	135.4	135.4
Numerator	8569	8341	8074	7638	
Denominator	5294261	5434214	5505180	5641589	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
A manual indicator is reported for 2008 based on 2007.

Notes - 2007
Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2007. Principal external cause of injury codes were used (ICD9-CM codes E810-E819). Data exclude cases unknown age, newborns and persons who died in the hospital.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.
Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006-2007 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 147.7; 2001 = 152.0; 2002 = 162.4; 2003 = 164.2; 2004 = 164.5; 2005 = 156.0.

Notes - 2006
Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2006. Principal external cause of injury codes were used (ICD9-CM codes E810-E819). Data exclude cases unknown age, newborns and persons who died in the hospital.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.
Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 147.7; 2001 = 152.0; 2002 = 162.4; 2003 = 164.2; 2004 = 164.5; 2005 = 156.0.

Narrative:
Motor vehicle traffic crashes are the leading cause of hospitalized nonfatal injuries among youth aged 15-24 in California. While hospitalization rates in this population increased during the first part of the decade--rising from 147.7 per 100,000 in 2000 to 164.5 per 100,000 in 2004--this rate has decreased markedly over the past three years. In 2007, there were 135.4 per 100,000 nonfatal injuries due to motor vehicle traffic crashes in youth aged 15 through 24 years. (Numerators are based on principal diagnoses codes in hospital discharge data.)

As active partners in both the Statewide Coalition on Traffic Safety (SCOTS) task force and the Statewide Strategic Highway Safety Plan (SHSP) coalition, the MCAH Division has assisted in motor vehicle related injury control efforts for children, adolescents and young adults by establishing common statewide goals and priorities; strengthening injury prevention and control partnerships; sharing data, knowledge and resources; avoiding redundant activities; and leveraging existing resources, including funds, people and leadership attention, toward common objectives.

The MCAH Division also participates on the UC Berkeley Center for Traffic Safety's Teen Traffic Safety Task Force, which is developing a document summarizing proven and promising practices in reducing tee traffic injuries. This document will be disseminated to MCAH stakeholders statewide.

In addition, local health jurisdictions implement a variety of injury prevention efforts targeted to adolescents. Examples include teen drinking and driving prevention, seat belt campaigns, and safe driving classes.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	22.3	22.8	22.8	23.1	23.5
Numerator	29083	30766	31783	33303	34616
Denominator	1305573	1348905	1395105	1438740	1470271
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Numerator: California Department of Public Health, STD Branch, Chlamydia , Cases and Rates by Race/Ethnicity, Gender and Age Group, California, 2008 Provisional Data. Available at: http://www.cdph.ca.gov/data/statistics/Documents/STD-Data-Chlamydia-Provisional-Tables.pdf. Accessed September 1, 2009.

Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007. Accessed October 2, 2008.

Notes - 2007

Numerator: California Department of Public Health, STD Branch, Chlamydia , Cases and Rates by Race/Ethnicity, Gender and Age Group, California, 2007. Available at: http://ww2.cdph.ca.gov/data/statistics/Documents/STD-Data-LHJ-StateSummary.pdf. Accessed October 2, 2008. The full report, Sexually Transmitted Disease in California, 2007, is available at http://www.cdph.ca.gov/data/statistics/Documents/STD-Data-2007-Report.pdf. Accessed 4/6/2009.
Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007. Accessed October 2, 2008.

Notes - 2006
Numerator: California Department of Public Health, STD Branch, Chlamydia , Cases and Rates by Race/Ethnicity, Gender and Age Group, California, 2006. Available at: http://www.dhs.ca.gov/ps/dcdc/STD/docs/Chlamydia%202002-2006%20Provisional%20Tables.pdf. Accessed January 8, 2008.
Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007. Accessed January 8, 2008.

Narrative:
Chlamydia trachomatis (CT) infection is the most common reportable communicable disease in California. There were over 142,000 cases of CT infection in 2007, accounting for nearly 79% of reported STD cases statewide. The majority of cases were in women, primarily young women. In 2007, over 70,000 cases were reported among females aged 15-24 years, accounting for 69% of female CT cases.

The rate per 1,000 women aged 15 through 19 years with a reported case of CT was 23.1 in 2007. The rate has increased over the past five years, up from 22.2 cases per 1,000 women aged 15-19 in 2003.

Female African Americans aged 15-19 continue to have the highest CT rate at 63.7 per 1000 in 2007, up from 62.8 per 1000 in 2006. The 2007 rates for Whites (8.5 per 1000) and Asian/Pacific Islanders (6.2 per 1000) also increased slightly in 2007, while the rate for Latinas (17.0 per 1000) declined slightly.

It should be noted, however, that while case-based CT rates show consistent increases over time, this may be due to increased screening and use of more sensitive screening tests. Most CT infections are asymptomatic and case detection is dependent upon screening levels. As California has high screening levels for young women compared to national estimates, data from sentinel prevalence monitoring in specific health care settings are important for comparison with case-based rates.

For 15-24 year old females seen across health care settings, CT prevalence has been fairly stable since 2000. In 2007, overall female positivity in STD clinics decreased from 11.4 percent in 2006 to 10.8 percent. CT positivity in females aged 15 to 24 years in family planning sites decreased from 6.4 percent in 2006 to 6.2 percent in 2007, while this was 18.8 percent in STD clinics. Both figures exceed the HP 2010 objective of 3 percent for females age 15-24 in STD and family planning clinics. CT positivity levels in managed care settings rose slightly from previous years, which may reflect an actual increase in prevalence or changes in screening practices.

Many CT control strategies focus on young women. With effective public and private partnerships and involvement of key community stakeholders, STD Control Branch efforts, coordinated with resources from CDPH partners, include:

1) Community and individual behavior change interventions to increase awareness and screening, particularly awareness of CT screening for adolescent girls.

2) Clinical and laboratory services to increase CT screening among sexually active women age 25 and younger in managed care, family planning, and juvenile detention settings.

3) Public/private collaboration to develop innovative strategies to reduce disparities in CT infection rates among populations of special emphasis, specifically adolescents and African Americans.

4) Quality improvement efforts including analysis of individual provider screening data, provider feedback, and chart audits of low performers to enhance CT screening among women age 25 and under.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	8.6	9.1	9.7	10.1	10.2
Numerator	56488	59668	62758	65472	66734
Denominator	6550538	6579780	6486794	6501606	6524678
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Numerator: California Department of Public Health, STD Branch, Chlamydia , Cases and Rates by Race/Ethnicity, Gender and Age Group, California, 2008. Available at: http://www.cdph.ca.gov/data/statistics/Documents/STD-Data-Chlamydia-Provisional-Tables.pdf. Accessed September 1, 2009.

Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007. Accessed October 2, 2008.

Notes - 2007
Numerator: California Department of Public Health, STD Branch, Chlamydia , Cases and Rates by Race/Ethnicity, Gender and Age Group, California, 2007. Available at: http://ww2.cdph.ca.gov/data/statistics/Documents/STD-Data-LHJ-StateSummary.pdf. Accessed October 2, 2008. The full report, Sexually Transmitted Disease in California, 2007, is available at http://www.cdph.ca.gov/data/statistics/Documents/STD-Data-2007-Report.pdf. Accessed 4/6/2009.
Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007. Accessed October 2, 2008.

Notes - 2006
Numerator: California Department of Public Health, STD Branch, Chlamydia , Cases and Rates by Race/Ethnicity, Gender and Age Group, California, 2006. Available at: http://www.dhs.ca.gov/ps/dcdc/STD/docs/Chlamydia%202002-2006%20Provisional%20Tables.pdf. Accessed January 8, 2008.

Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007.

Narrative:
In 2007, 10.1 per 1,000 women aged 20 through 44 years had a reported case of chlamydia. More than 65,000 cases were reported among females aged 20-44 years, representing 64% of the reported female CT cases overall.

While the chlamydia rate among women aged 20-44 is considerably lower that for women aged 15-19, this figure has similarly been rising over the past five years. Rates for women aged 20 through 44 increased from 8.4 per 1,000 in 2003, to 9.1 per 1,000 in 2005, up to 10.1 per 1,000 in 2007.

However, as discussed in HSCI 5a above, the increases seen in case-based CT rates may be due to screening practices, including targeted screening of older women and the use of more sensitive screening tests. Use of case rates alone may not be adequate for evaluating impact of CT control interventions in statewide or local settings/populations. Other health status measures to consider include: CT positivity rates, the percent having been tested for CT in the past year, repeat testing rates (to reduce repeat infections), and population-based or clinic-based behavioral surveillance to assess awareness and access to CT testing.

Additionally, the combined 20-44 years age group is not particularly useful for monitoring populations at risk for CT, as case rates in women 20-24 and 25-29 are significantly higher than rates among women age 30 and older. In 2007, CT rates among women were highest for the 20-24 group at 28.6 per 100,000 women.

The STD Control Branch attempts to reduce CT prevalence by working in the domains of behavior change, clinical and laboratory services, surveillance, quality improvement, and leadership. In addition to efforts outlined in HSCI 5a above, the Branch has released guidelines for expedited partner therapy and field therapy for CT to address infections among partners. Surveillance efforts aim to enhance timeliness and completeness of CT case data and prevalence monitoring test result data through electronic transmission. Leadership and partner development efforts include initiatives such as 1) working with outside partners to address inequities in CT rates associated with race/ethnicity, and 2) partnering with medical groups to provide CT screening rates to individual providers.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	543287	436385	31180	2247	60159	2479	10837	0
Children 1 through 4	2167138	1720449	108005	5032	210899	6962	115791	0
Children 5 through 9	2640636	2107925	148405	10783	242647	8531	122345	0
Children 10 through 14	2849005	2289688	182184	17385	267207	10446	82095	0
Children 15	2955147	2343406	210627	19450	293494	11454	76716	0

through 19								
Children 20 through 24	2686442	2100464	185071	18150	309047	11220	62490	0
Children 0 through 24	13841655	10998317	865472	73047	1383453	51092	470274	0

Notes - 2010

Narrative:
The population of California infants and children aged 0-24 years has continued to increase, reaching 13,841,655 in 2007.

By race, 10,998,317 (79%) were White; 1,383,453 10%) were Asian; 865,472 (6%) were African American; 470,274 (3%) had More Than One Race Reported; 73,047 (0.5%) were American Indian or Alaska Native (AIAN), and 51,092 (0.4%) were Native Hawaiian or Other Pacific Islander (NHPI). The population was fairly evenly distributed among five-year-interval age categories.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	270105	273182	0
Children 1 through 4	1073667	1093471	0
Children 5 through 9	1336609	1304027	0
Children 10 through 14	1481648	1367357	0
Children 15 through 19	1672339	1282808	0
Children 20 through 24	1616714	1069728	0
Children 0 through 24	7451082	6390573	0

Notes - 2010

Narrative:
Of the 2007 population aged 0-24 years, a total of 6,390,573 (46%) were of Hispanic ethnicity.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	663	530	65	6	13	3	32	14
Women 15 through 17	17582	14724	1284	150	447	53	623	301
Women 18	35810	29243	3030	300	1013	180	1334	710

through 19								
Women 20 through 34	413842	320571	21887	2069	47554	2086	10229	9446
Women 35 or older	98168	70982	3932	288	17696	382	2005	2883
Women of all ages	566065	436050	30198	2813	66723	2704	14223	13354

Notes - 2010

Narrative:
The total number of live births to California women in 2007 was 566,089.

The mother's race for 436,058 (77%) births was White; for 66,724 (12%) it was Asian; for 30,199 (5%) it was African American; for 14,223 (2.5%) More Than One Race was Reported; for 2,813 (0.5%) mother's race was AIAN; and for 2,705 (0.5%) it was NHPI. For 13,367 (2.4%) births, the mother's race was Other or Unknown.

By age, 17,582 of these births were to women age 15-17, 35,810 to women age 18-19, 413,842 to women age 20-34, and 98,168 to women age 35 or older. The number of live births to women under age 15 years decreased from 681 in 2006 to 663 in 2007, while all other age groups exhibited slight increases.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	133	521	9
Women 15 through 17	3738	13660	184
Women 18 through 19	10339	25078	393
Women 20 through 34	187295	221102	5445
Women 35 or older	59571	36541	2056
Women of all ages	261076	296902	8087

Notes - 2010

Narrative:
The total number of live births to California women in 2007 was 566,089. The mother's ethnicity for 296,908 (52%) of these births was Hispanic. Younger mothers were more likely to be of Hispanic ethnicity; 79% of live births to women under age 15 and 78% of births to women aged 15-17 years were to Hispanic mothers, while 37% of live births to women aged 35 and older were to Hispanic mothers.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	2941	2100	361	11	228	17	208	16
Children 1 through 4	495	366	45	6	49	3	23	3
Children 5 through 9	294	224	27	1	26	4	10	2
Children 10 through 14	365	284	39	2	22	4	12	2
Children 15 through 19	1435	1050	199	11	96	9	61	9
Children 20 through 24	2250	1696	293	17	159	23	36	26
Children 0 through 24	7780	5720	964	48	580	60	350	58

Notes - 2010

Narrative:
The number of deaths of children age 0-24 in California in 2007was 7,780.

By race, 5,720 (74%) of the deaths were White; 964 (12%) were African American; 580 (7.5%) were Asian; 350 (4.5%) were More Than One Race Reported; 48 (0.6%) were AIAN; and 60 (0.8%) were NHPI. For 58 (0.7%) child deaths, race was Other or Unknown.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	1414	1526	1
Children 1 through 4	243	251	1
Children 5 through 9	125	168	1
Children 10 through 14	190	175	0
Children 15 through 19	771	661	3
Children 20 through 24	1245	1003	2
Children 0 through 24	3988	3784	8

Notes - 2010

Narrative:

Of the 7,780 deaths of children age 1-24 years in California in 2007, 3,784 (49%) were of Hispanic ethnicity.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	11155213	8897853	680401	54897	1074406	39872	407784	0	2007
Percent in household headed by single parent	26.3	24.9	51.7	31.7	19.4	45.0	18.6	0.0	2008
Percent in TANF (Grant) families	9.0	8.0	31.8	14.6	5.0	25.1	1.7	0.0	2007
Number enrolled in Medicaid	3391309	2627229	350916	15750	224219	0	688	172507	2007
Number enrolled in SCHIP	895440	577893	18363	2567	92341	0	0	204276	2008
Number living in foster home care	71268	49353	19034	1037	1796	0	0	48	2008
Number enrolled in food stamp program	1380189	708773	202788	2716	105842	0	327841	32229	2007
Number enrolled in WIC	1985918	1718307	120687	9569	84868	7974	33773	10740	2008
Rate (per 100,000) of juvenile crime arrests	3229.0	3102.0	9046.0	2208.0	1000.0	4364.0	0.0	0.0	2007
Percentage of high school drop-outs (grade 9 through 12)	4.2	2.8	7.3	6.0	2.0	5.7	0.0	5.4	2006

Notes - 2010

State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. http://www.dof.ca.gov/html/Demograp/Data/RaceEthnic/Population-00-50/RaceData_2000-2050.php.

Hispanic ethnicity is reported for Hispanic group in this file. Non Hispanic ethnicity is summed across non Hispanic race groups: White, Asian, Pacific Islander, Black, American Indian, and multirace.

Source: Current Population Survey, Annual Social and Economic Supplement, March 2008. CPS Table Creator for 2008. URL: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Numerator: Universe, California, Ages 0-19, Persons in Male-Headed Primary Familes, No Spouse Present + Universe, California, Ages 0-19, Persons in Female-Headed Primary Familes, No Spouse Present

Denominator: Universe, California, Ages 0-19, Persons -- All

Numerator: Number of children ages 0 to 18 in CalWORKs assistance units during FFY 2007. California Department of Social Services, Federal Data Reporting and Analysis Bureau. Ad hoc SAS analysis completed 1/28/2009, not yet published by CDSS.

Denominator: Number of children ages 0 to 18 in CY 2007. State of California, Department of Finance. Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007.

Source: California Department of Health Care Services, Medical Care Statistics Section

Notes:
1. Beneficiaries include all persons 0-19 years of age enrolled in Medi-Cal in October 2007.
2. Medi-Cal code for Asians includes other Pacific Islanders.
3. More Than One Race Reported category included only Amerasian ethnicity code (A). There were no other codes to identify persons of more than one race.
4. White category includes persons identified as White or Hispanic.
5. Medical Care Statistics Section used their MCSS Pivot tables (which come directly from the MEDS system and the 35-File claims records) for this current year. Two years ago Medical Care Statistics Section used the MIS-DSS database to arrive at the data for this indicator.

Source: Managed Risk Medical Insurance Board, HFP Monthly Enrollment Reports, Current Enrolled for December 2008. Accessed January 12, 2009, at http://www.mrmib.ca.gov/MRMIB/HFP/Dec_07/HFPRpt5A.pdf.

Notes:
1. The count for Asian includes Native Hawaiian and Other Pacific Islander.
2. The HFP Monthly Enrollment Report does not include a More Than One Race Reported category.

Source: California Department of Social Services, Federal Data Reporting and Analysis Bureau. Ad hoc request, completed 12/12/2008. Data represent number of children in food stamp households during FFY 2007, in both public assistance and non-assistance households.

Notes:
1. The count of total Asian includes Native Hawaiian and Other Pacific Islander.
2. Race data are not comparable to prior years due to the addition of a mixed race category for FFY 2007.

Source: California Department of Public Health; Women, Infants and Children Program; Research and Evaluation Section. Unpublished data, October 2008. Data is for the period from October 2007 to September 2008.

Source: State of California, Department of Justice, Bureau of Criminal Information and Analysis, Criminal Justice Statistics Center. These data include felony and misdemeanor offenses age 19 and younger. Numerator: Adult and Juvenile Arrests Reported, 2007, Level of Offense by Race/Ethnic Group and Age. Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail 2000-2050. Sacramento, California, July 2007.

Notes:
1. Data not available for More Than One Race Reported category.

Data Source: California Department of Education, Educational Demographics Unit. Number of Dropouts in California Public Schools, Grades 9-12 by Grade Level and Ethnicity Group, 2006-2007. Accessed 10/2/2008 at http://dq.cde.ca.gov/dataquest/DropoutReporting/GradeEth.aspx?cDistrictName=State&cCountyCode=00&cDistrictCode=0000000&cSchoolCode=0000000&Level=State&TheReport=GradeEth&ProgramName=All&cYear=2006-07&cAggSum=StTotGrade&cGender=B.

Rates are 1-year rates based on (the number of grade 9-12 dropouts / the number of grades 9-12 enrollments) * 100.

Notes:
1. Total count of Asians includes Asians and Filipinos.
2. Other and Unknown includes those identified as multiple race or no response.

Source: University of California, Center for Social Services Research. http://cssr.berkeley.edu/ucb%5Fchildwelfare/PIT.aspx. Accessed 1/16/2009. Data represent point-in-time caseload on 1/1/2008.

Notes:
1. Total count for Asian include Pacific Islander.
2. Total count for Other and Unknown is based on Missing category in source document.
3. The source document does not include a More Than One Race category.

Narrative:
The 2007 population of California age 0-19 was 11,155,213. By race, 80% were White; 10% Asian; 6.1% African American; 3.7% More Than One Race; 0.5% AIAN; and 0.4% NHPI.

Of those ages 0-19, 26.3 percent lived in a household headed by a single parent in 2008. This is similar to 2007, and down from prior years (27.3 to 28.8 in 2004-2006). The proportion living in households headed by a single parent has been consistently highest for African American children (51.7% in 2007); figures are also high for NHPI (45%) and AIAN (31.7%) children.

9.0 percent of those 0-19 years received Temporary Assistance for Needy Families (TANF) in 2007. By race, 31.6% of African American, and 23.2% of NHPI children got TANF, compared to 8.2% of White, 5.9% of AIAN; 4.9% of Asian, and 1.4% of mixed race children.

The number of children enrolled in Medi-Cal (Medicaid) in 2007 was 3,391,309. This was up 50,000 from the previous year, but both years were lower than the earlier years of this period.

In 2007, 895,440 children were enrolled in Healthy Families (SCHIP), up from 866,031 in 2007. Over the past five years, Healthy Families enrollment has increased by 28 percent. 2007 enrollment includes 577,893 White children (including Hispanic), 92,341 Asian; 18,363 African American; and 2,567 AIAN. Race was Other/Unknown for 204,276 (23%) children enrolled in Healthy Families in 2007. Enrollment increases over the past five years have occurred among most race groups, although the number of African American enrollees has remained flat.

The foster care caseload was 71,268 at the end of 2007. This figure has been steadily decreasing since 2003, when it was 89,913.

In 2007, 1,380,189 children were enrolled in the Food Stamp Program, indcluding: 708,773 White (499,901 Hispanic, 208,872 non-Hispanic); 327,841 More Than One Race Reported; 202,788

African American; 105,842 Asian/Pacific Islander; 2,716 AIAN; and 32,229 Other/Unknown children.

Of those aged 0-19 years, 1,985,918 were enrolled in WIC in 2008. This includes 1,718,307 White (including Hispanic); 120,687 African American; 84,868 Asian; 33,773 More Than One Race; 9,569 AIAN; 7,974 NHPI; and 10,740 Other/Unknown.

There were 3,229 arrests per 100,000 for juvenile felony and misdemeanor offenses among those under 19 years in 2007. This was an increase over 2006, and although the rate has fluctuated this is the highest observed over the past five years. Arrest rates continue to be highest for African American (9,046 per 100,000 children) and NHPI (4,364 per 100,000) juveniles.

In the 2006-07 school year, high school dropouts (grades 9-12) increased to 4.2 percent. This was an increase over the 3.5 percent seen the previous year, which had also been an increase over the 3.1 to 3.3 percent rates seen in the three prior years. By race, 7.3 percent of African American, 6.0 percent of AIAN, 5.7 percent of NHPI, 2.8 percent of White, and 2.0 percent of Asian students dropped out. All rates increased for the second straight year.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	5834368	5320845	0	2007
Percent in household headed by single parent	24.6	28.1	0.0	2008
Percent in TANF (Grant) families	8.2	9.9	0.0	2007
Number enrolled in Medicaid	1151426	2123219	116664	2007
Number enrolled in SCHIP	384166	487551	23723	2008
Number living in foster home care	39500	31720	48	2008
Number enrolled in food stamp program	880288	499901	0	2007
Number enrolled in WIC	434021	1551897	0	2008
Rate (per 100,000) of juvenile crime arrests	3344.0	2970.0	0.0	2007
Percentage of high school drop-outs (grade 9 through 12)	3.4	5.2	5.4	2006

Notes - 2010

State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. http://www.dof.ca.gov/html/Demograp/Data/RaceEthnic/Population-00-50/RaceData_2000-2050.php.

Hispanic ethnicity is reported for Hispanic group in this file. Not Hispanic or Latino includes White, Black/African American, American Indian/Native Alaskan, Asian, Native Hawaiian/Other Pacific Islander, and More Than One Race.

Source: Current Population Survey, Annual Social and Economic Supplement, March 2008. CPS Table Creator for 2008. URL: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Numerator: Universe, California, Ages 0-19, Persons in Male-Headed Primary Familes, No Spouse Present + Universe, California, Ages 0-19, Persons in Female-Headed Primary Familes, No Spouse Present

Denominator: Universe, California, Ages 0-19, Persons -- All

Numerator: Number of children ages 0 to 18 in CalWORKs assistance units during FFY 2007. California Department of Social Services, Federal Data Reporting and Analysis Bureau. Ad hoc SAS analysis completed 1/28/2009, not yet published by CDSS.

Denominator: Number of children ages 0 to 18 in CY 2007. State of California, Department of Finance. Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007.

Source: California Department of Health Care Services, Medical Care Statistics Section

Notes:
1. Beneficiaries include all persons 0-19 years of age enrolled in Medi-Cal in October 2007.
2. Total Non Hispanic category includes persons grouped in the White, African American, American Indian, Asian, and More Than One Race, categories, and those categorized as Other within the Other and Unknown category.
3. Ethnicity Not Reported category includes persons grouped in the Unknown category, with no response or no valid data.
4. Medical Care Statistics Section used their MCSS Pivot tables (which come directly from the MEDS system and the 35-File claims records) for this current year. Two years ago Medical Care Statistics Section used the MIS-DSS database to arrive at the data for this indicator.

Source: Managed Risk Medical Insurance Board, HFP Monthly Enrollment Reports, Current Enrolled for December 2008. Accessed January 12, 2009, at http://www.mrmib.ca.gov/MRMIB/HFP/Dec_07/HFPRpt5A.pdf.

Notes:
1. Total Non Hispanic includes persons grouped in the White, African American, American Indian or Native Alaskan, Asian race categories, as well as those grouped as Other under the Other and Unknown category.
2. The HFP Monthly Enrollment Report does not include a More Than One Race Reported category.

Source: California Department of Social Services, Federal Data Reporting and Analysis Bureau. Ad hoc request, completed 12/12/2008. Data represent number of children in food stamp households during FFY 2007, in both public assistance and non-assistance households.

Note: The count of Total Not Hispanic or Latino includes White Not of Hispanic Origin, Black Not of Hispanic Origin, American Indian/Alaska Native, Asian/Pacific Islander, More Than One Race Reported, and Unknown.

Source: California Department of Public Health; Women, Infants and Children Program; Research and Evaluation Section. Unpublished data, October 2008. Data is for the period from October 2007 to September 2008.

Note: Total Not Hispanic or Latino includes White, Black/African American, American Indian/Native Alaskan, Asian, Native Hawaiian/Other Pacific Islander, More Than One Race Reported, and Other and Unknown.

Source: State of California, Department of Justice, Bureau of Criminal Information and Analysis, Criminal Justice Statistics Center. These data include felony and misdemeanor offenses age 19 and younger. Numerator: Adult and Juvenile Arrests Reported, 2007, Level of Offense by Race/Ethnic Group and Age. Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail 2000-2050. Sacramento, California, July 2007.

Note: Total Not Hispanic or Latino includes White, Black/African American, Asian, Native Hawaiian/Other Pacific Islander, and Other.

Data Source: California Department of Education, Educational Demographics Unit. Number of Dropouts in California Public Schools, Grades 9-12 by Grade Level and Ethnicity Group, 2006-2007. Accessed 10/2/2008 at
http://dq.cde.ca.gov/dataquest/DropoutReporting/GradeEth.aspx?cDistrictName=State&cCountyCode=00&cDistrictCode=0000000&cSchoolCode=0000000&Level=State&TheReport=GradeEth&ProgramName=All&cYear=2006-07&cAggSum=StTotGrade&cGender=B.
Rates are 1-year rates based on (the number of grade 9-12 dropouts / the number of grades 9-12 enrollments) * 100.

Notes:
1. Total count of Not Hispanic or Latino includes White, Black/African American, American Indian/Native American, Asian, and Native Hawaiian/Other Pacific Islander. 2. Total count of Ethnicity Not Reported includes those identified as multiple race or no response.

Source: University of California, Center for Social Services Research. http://cssr.berkeley.edu/ucb%5Fchildwelfare/PIT.aspx. Accessed 1/16/2009. Data represent point-in-time caseload on 1/1/2008.

Note: Total count for Ethnicity Not Reported is based on Missing race category in source document.

Narrative:
The 2007 population of California age 0-19 was 11,155,213. Of these, 5,320,845 (48%) were of Hispanic ethnicity.

Hispanic children age 0-19 years were more likely to live in a household headed by a single parent. This was true for 28.1 percent of Hispanic children in 2008, compared to 24.6 percent of those who are not Hispanic.

The Hispanic population age 0-19 was also more likely to receive Temporary Assistance for Needy Families (TANF) By ethnicity, 9.9 percent of Hispanic children received TANF benefits in 2007, while 8.2 percent of children who were not Hispanic received TANF.

The number of children (0-19 years) enrolled in Medi-Cal (Medicaid) in 2007 was 3,391,309. Of those enrolled, 2,123,219 were of Hispanic ethnicity.

In 2007, 895,440 children were enrolled in Healthy Families (SCHIP), up from 866,031 in 2007. Of these, 487,551 (54%) were of Hispanic ethnicity.

The caseload for children living in foster home care was 71,268 at the end of 2007. Of these, 31,720 (45%) were of Hispanic ethnicity. The proportion of children living in foster home care who are Hispanic has increased steadily over the past five years, from 37% in 2003.

In 2007, 1,380,189 children ages 0-19 were enrolled in the Food Stamp Program. Of these children, 499,901 (36%) were identified to be of Hispanic ethnicity, although this appears to be an undercount due to the addition of a Mixed Race category (24%) for 2007. In the prior year, 60%

of children enrolled in the Food Stamp Program were Hispanic.

A majority of those aged 0-19 enrolled in WIC in 2008 were Hispanic. The proportion of WIC-enrolled children who are Hispanic has increased steadily over the past five years, from 72% in 2004 to 78% in 2008. A total of 1,551,897 Hispanic children were enrolled in 2008.

In 2007, there were 3,229 arrests per 100,000 population for juvenile felony and misdemeanor offenses among those 19 years old and younger. The arrest rate for Non-Hispanic juveniles was slightly higher than for Hispanic juveniles (3,344 vs. 2,970 per 100,000), the reverse of the prior year. Arrest rates by ethnicity have tended to fluctuate over the past five years.

For the 2006-2007 school year, the overall percentage of high school dropouts (grades 9-12) increased to 4.2 percent. Hispanic students continued to have higher dropout rates than non-Hispanic students, although increases were observed for both groups in 2007. During the 2006-2007 school year, 5.2 percent of Hispanic students and 3.4 percent of non-Hispanic students dropped out of high school.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	10898643
Living in urban areas	10898643
Living in rural areas	256570
Living in frontier areas	0
Total - all children 0 through 19	11155213

Notes - 2010
Source: Percent of the State population living in urban and rural areas from the United States Department of Agriculture, Economic Research Service, Population, Income, Education, and Employment State Fact Sheets: California.
http://www.ers.usda.gov/statefacts/ca.htm. Accessed October 3, 2008. Urban and rural (metro and nonmetro) definitions are based on the Office of Management and Budget June 2003 classification. Estimated number of children living in urban (metropolitan) areas was calculated as total population 0-19 minus the estimated number of children living in rural (non-metropolitian) counties. Estimated number of children living in rural counties was calculated by multiplying the estimated number of children in the state by the percent of overall state population living in rural counties.

Denominator Source: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.

Source: Percent of the State population living in urban and rural areas from the United States Department of Agriculture, Economic Research Service, Population, Income, Education, and Employment State Fact Sheets: California.
http://www.ers.usda.gov/statefacts/ca.htm. Accessed October 3, 2008. Urban and rural (metro and nonmetro) definitions are based on the Office of Management and Budget June 2003 classification. Estimated number of children living in urban (metropolitan) areas was calculated as total population 0-19 minus the estimated number of children living in rural (non-metropolitan) counties. Estimated number of children living in rural counties was calculated by multiplying the estimated number of children in the state by the percent of overall state population living in rural counties.

Denominator Source: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.

Source: Percent of the State population living in urban and rural areas from the United States Department of Agriculture, Economic Research Service, Population, Income, Education, and Employment State Fact Sheets: California.
http://www.ers.usda.gov/statefacts/ca.htm. Accessed October 3, 2008. Urban and rural (metro and nonmetro) definitions are based on the Office of Management and Budget June 2003 classification. Estimated number of children living in rural (non-metropolitan) areas was calculated by multiplying the estimated number of children in the state by the percent of overall state population living in rural counties. Source document did not include a Frontier category.

Denominator Source: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.

Source: Percent of the State population living in urban and rural areas from the United States Department of Agriculture, Economic Research Service, Population, Income, Education, and Employment State Fact Sheets: California.
http://www.ers.usda.gov/statefacts/ca.htm. Accessed October 3, 2008. Urban and rural (metro and nonmetro) definitions are based on the Office of Management and Budget June 2003 classification. Estimated number of children living in rural (non-metropolitian) areas was calculated by multiplying the estimated number of children in the state by the percent of overall state population living in rural counties. Source: Percent of the State population living in urban and rural areas from the United States Department of Agriculture, Economic Research Service, Population, Income, Education, and Employment State Fact Sheets: California.
http://www.ers.usda.gov/statefacts/ca.htm. Accessed October 3, 2008. Urban and rural (metro and nonmetro) definitions are based on the Office of Management and Budget June 2003 classification. Estimated number of children living in rural (non-metropolitan) areas was calculated by multiplying the estimated number of children in the state by the percent of overall state population living in rural counties. Source document did not include a Frontier category.

Denominator Source: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.

Narrative:
Of the 11,155,213 children less than 20 years old in 2007, only 256,570 lived in rural areas. The majority of children lived in metropolitan or urban areas. Overall, 2.3 percent of the state's population lives in non-metropolitan counties.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	36246576.0
Percent Below: 50% of poverty	5.0
100% of poverty	12.7
200% of poverty	32.7

Notes - 2010

Source: Current Population Survey, Annual Social and Economic Supplement, March 2008, U.S. Census Bureau. Data extracted with online data tool, CPS Table Creator: www.census.gov/hhes/www/cpstc/cps_table_creator.html.

Numerator and Denominator: Persons in Poverty Universe. Poverty status is reported for the survey year, but is based upon family income in the calendar year prior to the survey.

Source: Current Population Survey, Annual Social and Economic Supplement, March 2008, U.S. Census Bureau. Data extracted with online data tool, CPS Table Creator: www.census.gov/hhes/www/cpstc/cps_table_creator.html.

Numerator and Denominator: Persons in Poverty Universe. Poverty status is reported for the survey year, but is based upon family income in the calendar year prior to the survey.

Source: Current Population Survey, Annual Social and Economic Supplement, March 2008, U.S. Census Bureau. Data extracted with online data tool, CPS Table Creator: www.census.gov/hhes/www/cpstc/cps_table_creator.html.

Numerator and Denominator: Persons in Poverty Universe. Poverty status is reported for the survey year, but is based upon family income in the calendar year prior to the survey.

Source: Current Population Survey, Annual Social and Economic Supplement, March 2008, U.S. Census Bureau. Data extracted with online data tool, CPS Table Creator: www.census.gov/hhes/www/cpstc/cps_table_creator.html.

Numerator and Denominator: Persons in Poverty Universe. Poverty status is reported for the survey year, but is based upon family income in the calendar year prior to the survey.

Narrative:
In 2007, 5.0 percent of the total California population of 36,246,577 was living below 50 percent of the federal poverty level (FPL). A total of 12.7percent were living below 100 percent FPL, and 32.7 percent were living below 200 percent FPL. This was a slight increase over 2006, when 32.2 percent of the population was below 200 percent of the FPL.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	10352918.0
Percent Below: 50% of poverty	6.7
100% of poverty	17.7
200% of poverty	41.7

Notes - 2010
Source: Current Population Survey, Annual Social and Economic Supplement, March 2008, U.S. Census Bureau. Data extracted with online data tool, CPS Table Creator: www.census.gov/hhes/www/cpstc/cps_table_creator.html.

Numerator and Denominator: Persons in Poverty Universe. Poverty status is reported for the survey year, but is based upon family income in the calendar year prior to the survey.

Source: Current Population Survey, Annual Social and Economic Supplement, March 2008, U.S. Census Bureau. Data extracted with online data tool, CPS Table Creator: www.census.gov/hhes/www/cpstc/cps_table_creator.html.

Numerator and Denominator: Persons in Poverty Universe. Poverty status is reported for the survey year, but is based upon family income in the calendar year prior to the survey.

Source: Current Population Survey, Annual Social and Economic Supplement, March 2008, U.S. Census Bureau. Data extracted with online data tool, CPS Table Creator: www.census.gov/hhes/www/cpstc/cps_table_creator.html.

Numerator and Denominator: Persons in Poverty Universe. Poverty status is reported for the survey year, but is based upon family income in the calendar year prior to the survey.

Source: Current Population Survey, Annual Social and Economic Supplement, March 2008, U.S. Census Bureau. Data extracted with online data tool, CPS Table Creator: www.census.gov/hhes/www/cpstc/cps_table_creator.html.

Numerator and Denominator: Persons in Poverty Universe. Poverty status is reported for the survey year, but is based upon family income in the calendar year prior to the survey.

Narrative:
The percent of children under twenty years old living below 50 percent of the FPL dropped slightly in 2007 to 6.7 percent, down from 7.1 percent in 2006. A total of 17.7 percent of children were living below 100 percent FPL, and 41.7 percent were living below 200 percent FPL.

F. Other Program Activities

Telephone Hotlines

Both the State and local MCAH jurisdictions have phone hotlines that provide information regarding maternal and child health services and programs. There are several statewide toll free telephone hotlines run by the State, including ones for MCAH and BabyCal.

BabyCal (800-BABY-999) provides information about the importance of prenatal care, practicing healthy behaviors during pregnancy, and the availability of state programs that can help pay for prenatal care services.

In January 2004 the MCAH Branch added a hotline (866-241-0395) specific to MCAH services. It is staffed during office hours and, outside of office hours, is answered with a recorded message.

The number of calls to the BabyCal and MCAH numbers combined was nearly 20,000 in FY 2003-2004, down from 38,000 in FY 2002-03. The decline is attributed to the discontinuation in June 2003, of the media and outreach campaigns for BabyCal.

/2008/ The combined number of calls to the BabyCal and MCAH numbers was 11,580 in FY 2005-06, down from 13,780 in FY 2004-05. //2008//

/2009/ In February 2007 the name of the state toll free hotline changed to ‘MCAH Toll Free Information Line'. The combined number of calls to the MCAH and BabyCal lines was 8,565 in FY 2006-07, down from 11,580 in FY 2005-06. Although the number of calls to the MCAH Line has been decreasing, the number of individuals accessing information through the MCAH web pages has increased. MCAH web pages received over 196,000 hits from December 2007 through July

2008 (the most recent months for which data is available). //2009//

/2010/Calls to the state MCAH hotline rose 65% to 14,146 in FY 2007-08, and LHJs reported 42,239 calls to local hotlines as well. MCAH web pages are an increasingly important source of information, with nearly 14,000 views per month since December 2007.//2010//

Emergency Preparedness

/2008/
CDPH public health emergency preparedness efforts are consolidated in the Emergency Preparedness Office (EPO) to coordinate activities related to implementation of the CDC Public Health Emergency Preparedness (PHEP) grant, the federal Hospital Preparedness Program (HPP) grant and the state general funds for pandemic influenza preparedness and responses to natural disasters such as earthquakes, fires, and floods. EPO works with programs throughout CDPH to prepare for and respond as needed to emergencies.

Under the CDC PHEP Cooperative Agreement, CDPH allocates approximately 70 percent of funds to local health departments to implement local response capacity, including pandemic influenza preparedness. CDPH and local health departments share responsibility to assure that all requirements under this grant are met, including meeting the needs of special populations. This responsibility is carried out in all grant activities, including development of state and local emergency response plans, risk communication messages, and training programs for local health department staff and the medical community.

Under the HPP Grant, 80 percent of direct service funds support preparedness and response activities conducted by hospitals, poison control centers, emergency medical service agencies, and clinics. To date, HPP expenditures have covered procurement of personal protective equipment, increasing isolation capacity, and establishment of hospital pharmaceutical caches to assure that medical personnel are protected during a bioterrorism incident. CDPH has undertaken two projects to develop advisory materials and train medical providers in addressing the mental health issues Californians may experience during a bioterrorist event.

The CMS Branch has undertaken one of the mental health projects to assure that pediatric primary care providers have the necessary skills to care for the mental health needs of children. CMS is receiving $300,000/year for this four-year project which began in October 2003. CMS is collaborating with EPO and the Department of Mental Health to develop a training curriculum and training sessions that will link pediatric primary care providers, local bioterrorism networks, experts on childhood trauma, public and mental health agencies, and medical societies. An on-line course is available to provide pediatric primary care providers with tools to address the mental health needs of children in the event of a large scale disaster or bioterrorism event.

The MCAH/OFP Branch has begun work on the California Perinatal Transport Systems Northern and Southern programs for the integration of perinatal populations into existing disaster preparedness plans at the hospital, local, county, and statewide emergency response system levels.//2008//

/2009/Although funding for CPeTS Emergency Preparedness Activities was cut in September 2007, collaborative agreements among hospitals for transport in case of an emergency situation continues. RPPC Region 4 has selected emergency preparedness as its quality improvement topic this year. The topic has been a focus in regional presentations and has also been included in the recently updated websites for RPPC, CDAPP and Breastfeeding.//2009//

/2008/The MCAH/OFP Branch promotes optimal infant feeding for mother-infant dyads in emergency situations via participation on the US Breastfeeding, the Office of Women's Health Breastfeeding Group, and the Breastfeeding Promotion Advisory Group. The Branch has also

provided optimal infant feeding and care resources/guidelines on their web site; see http://www.mch.dhs.ca.gov/programs/bfp/emergency-prep.htm.
//2008//

/2010/MCAH staff are active in developing CDPH's Public Health Emergency Response Plan and Procedures, and are participating in a pandemic influenza outbreak exercise.//2010//

March of Dimes

The MCAH/OFP Branch collaborates with the California March of Dimes (MOD) on perinatal health issues. The MOD invests in community services and education, with a specific focus on decreasing the disparities in infant mortality among ethnic groups.

The MOD is currently in its third year of an eight year Prematurity Campaign. The revised goals of the campaign are to 1) raise awareness of the problems of prematurity to 60 percent for women of childbearing age and 50 percent for the general public by 2010 and 2) Reduce the rate of premature birth from 12.1 percent in 2002 to 7.6 percent in 2010, in accordance with the Healthy People 2010 objective.

To meet these goals, MOD is collaborating with the MCAH/OFP Branch at the state and county levels to 1) increase awareness of the signs and symptoms of preterm labor through CPSP and BIH-based educational classes, clinic displays, and community events; 2) educate healthcare providers about prematurity risk detection and reduction through annual Prematurity Summits and the development and dissemination of tools to identify women at increased risk for preterm delivery; and 3) provide funding to agencies that are reaching high-risk communities with education and support services.

Additionally, Comenzando bien™, a culturally and linguistically appropriate prenatal education curriculum for Latina women, has been implemented and evaluated in a number of sites across the state. In the Central Valley, Comenzando bien™ boasts an 81 percent graduation rate and significant reported changes in behavior related to prenatal care, nutrition, and exclusive breast feeding.

/2007/ Currently a Preterm Labor Assessment protocol is being promoted and implemented; an African American faith-based prematurity prevention program has been initiated; and a strategic plan for preconception care is being developed. //2007//

/2008/ A statewide council is developing an action plan for preconception health and health care; MOD is funding three multi-year preconception/Interconception demonstration projects; and a national preconception summit in collaboration with CDC is planned. //2008//

/2009/ The Preconception Council is implementing its strategic plan; the preterm labor protocol is being implemented and evaluated in 30 hospitals; and the Preconception Summit with CDC was attended by 600 people. //2009//

/2010/ The Preconception Health Council launched its website and held 2 conferences (525 attendees).//2010//

Nurse Family Partnerships

Eight counties in California utilize Nurse Family Partnerships (the David Olds home visiting model) to follow high-risk, first-time pregnant women, mothers and families. The Olds model is a home visitation model that utilizes public health nurses; other counties utilize a home visitation

format with staff ranging from Promotoras to registered nurses.

/2010/A few local Public Health Departments are developing their own home visiting programs to provide assessment, health education, and referral services to mothers and infants.//2010//

G. Technical Assistance

/2008/
Capacity Assessment

The MCAH/OFP Branch requests training and resource materials in the area of capacity assessment, including:

1) Clinical capacity assessment (availability of and access to clinics, maternity beds, neonatal intensive care units, etc);

2) Clinical workforce assessment at state and county levels (physicians, obstetrician/gynecologists, pediatricians, dentists, nurses, etc);

3) Public health capacity assessment (epidemiologists, program evaluators, etc); and

4) Integration of needs assessment, capacity assessment, and implementation planning.
//2008//

/2009/ The MCAH Program requests training and resource materials in the area of capacity assessment, specifically on:
1) developing process indicators related to direct healthcare services
2) community-level capacity assessment
3) linking needs analysis with capacity assessment to identify priorities and resource allocation
4) "train the trainer" on conducting state and community-level capacity assessment
5) internal organizational capacity assessment
6) scope and breadth in assessing systems capacity beyond MCAH services
//2009//

/2010/ The MCAH Program continues to request the technical assistance items listed in prior years //2010//

/2007/

Annual MCAH California Conference

The MCAH/OFP Branch requests assistance in reviving an annual (or bi-annual) MCAH California Conference. The conferences would be a collaborative effort undertaken by the MCAH/OFP Branch, MCAH Action (the statewide organization of local MCAH Directors), and the University of California Berkeley School of Public Health.

Such conferences were held annually in California prior to discontinuation in 2002 due to budget constraints. The conferences were well attended, with approximately 700 participants each.

Conference locations alternated between northern and southern California.
The conference provided opportunities for participants -- from the state, local jurisdictions, academia, and other interested groups -- to network and strategize on issues affecting the health

of women, children and families in California. Each year the conference had a theme. The Branch encouraged interested parties to submit general or scientific abstracts on current and emerging MCAH issues pertinent to the theme. Programs that addressed the conference theme were recognized.
//2007//

Methodological training in epidemiology and program evaluation

The MCAH/OFP Branch Epidemiology and Evaluation Section (MCAH-EES) has an excellent staff of researchers and analysts for epidemiological analyses and evaluation of Title V programs. However, MCAH-EES requests training for recent hires and junior research staff on several aspects of the methodology of epidemiological analyses of maternal, child, and adolescent health and program evaluation. The CMS Branch would also benefit from receiving training on these issues, including epidemiological methods, analyses of the cost-effectiveness or budget neutrality of programs, and the analysis of trend data. While it would be desirable to obtain this training directly through seminars and workshops offered at CDC, HRSA, and other Federal agencies, policies designed to address budget constraints in California prohibit out-of-state travel.

A workshop on epidemiology (e.g., risk ratios, sensitivity, specificity, validation, and bias) and appropriate statistical analyses commonly used in maternal, child, and adolescent health would be valuable to both the MCAH/OFP and CMS Branches. Applied examples, including examples of analyses commonly used by comparable state and federal entities, would demonstrate concepts and inform possible areas for enhanced analysis and program development. Many MCAH/OFP Branch programs are local; data collected at the state level may be useful for smaller areas, so an overview of small-area and geographic analysis would also enhance current and suggest future analyses.

Technical assistance on how to conduct cost-effectiveness, cost-benefit, and cost avoidance analyses for Title V programs would also be very beneficial for staff. During the current era of budget shortfalls in California, there has been greater scrutiny by decision-makers as to the cost-effectiveness and fiscal neutrality of programs run by the MCAH/OFP and CMS Branches. Technical assistance on the steps involved in analyses, parameters to consider, accepted methodologies, and effective presentation of results would supplement staff's ability to provide this critical information to program managers and administration officials.

/2009/Hands-on training on smoothing techniques to deal with geographic areas (e.g., census tracts) for which there are too few observations to generate statistically stable counts or rates; recommended statistical tests for use with geospatial data, including for smoothed data.//2009//

Maternal Morbidity and Mortality

The CDC reports that more than 40 percent of women experience some type of complication during childbirth; many of these complications are preventable. Maternal morbidity is a serious public health problem that can impact maternal, fetal, and infant health and can lead to maternal death.

The MCAH/OFP Branch is working to monitor maternal morbidity. The MCAH/OFP Branch is developing a Maternal Quality Improvement (MQI) project and has contracted with an academic research group to assess variation in maternal outcomes and an evidence-based quality improvement collaborative to analyze the data. The MCAH/OFP Branch requests assistance in the development of systems for identifying, reviewing, and analyzing maternal morbidity that will serve as a framework for improved maternal standards of care.

The maternal mortality ratio for California in 2003 was 15.2 maternal deaths per 100,000 live births. Mortality among African American women was about three times higher than among non-

Hispanic White women. The MCAH/OFP Branch will be conducting a Pregnancy-Related and Pregnancy-Associated Mortality Review Project under an agreement with the University of California, San Francisco. The goal of the study is to analyze causes of and risk factors contributing to pregnancy-related and pregnancy-associated deaths so that the MCAH/OFP Branch and its stakeholders can develop a public health component to reduce such deaths.

The MCAH/OFP Branch requests technical assistance from the CDC on how to conduct such reviews, including study design, data for linkages and case selection, medical record review protocols, guidance on determination of whether cases are pregnancy-related or pregnancy-associated, development of recommendations to reduce mortality based on findings, and implementation of recommendations.

Consumer Involvement - Youth

The MCAH/OFP Branch requests assistance in how to obtain youth input into decision-making for the Branch and its adolescent-related programs. Currently, the Branch does not have sufficient manpower to carry out this activity, but would like to include more youth input into our decision-making process.

Consumer Involvement - Families

Based on feedback given in a previous federal block grant review, the Branch requests training on consumer/family involvement in the needs assessment and other Title V activities at both the state and local level. This is a Title V requirement and the Branch has been asked to be more proactive in including families.

Evaluation of Clinical Outcomes

The CCS program has embarked on a quality initiative to assure that children receive appropriate services in an environment of dwindling financial and professional resources. The CMS Branch is requesting assistance in acquiring skills to develop and evaluate appropriate outcome and performance measures for clinical practice.

Strategic Planning and Facilitation

The CMS Branch has developed a collaborative relationship with the stakeholder community through the Title V Needs Assessment process, which is expected to continue with the development of strategies and activities as the next steps in the process. Additionally, there are issue-specific collaborations with families and agency partners to address and improve family-centeredness and client outcomes in the coming years. As the Branch moves into more infrastructure-building activities, it will be very helpful to have a core group of staff who are trained in strategic planning and facilitation techniques.

V. Budget Narrative

A. Expenditures

/2008/ The budget and expenditures for FFY 2008 are presented in Forms 2, 3, 4, and 5. //2008//

/2009/ The budget and expenditures for FFY 2009 are presented in Forms 2, 3, 4, and 5. //2009//

/2010/ The budget and expenditures for FFY 2010 are presented in Forms 2, 3, 4, and 5. //2010//

B. Budget

Since the enactment of the Omnibus Budget Reconciliation Act (OBRA) 89, California has maintained the availability of Title V funds under both the maintenance of effort and the match requirements. The California Title V agency will continue to do so in the coming year.

The proposed allocation of Title V funds for California for FFY 2007 is $44,430,440. Preventive and primary services for pregnant women, mothers, and infants are designated to receive $12,230,634 (27.53 percent of the total), preventive and primary services for children to receive $14,394,384 (32.40 percent), and CSHCN to receive $15,374,114 (34.60 percent).

/2008/ The proposed allocation of Title V funds for California for FFY 2008 is $44,452,058. Preventive and primary services for pregnant women, mothers, and infants are designated to receive $12,562,689 (28.26) percent of the total), preventive and primary services for children to receive $14,523,469 (32.67 percent), and CSHCN to receive $14,523,500 (32.67 percent). //2008//

/2009/ The proposed allocation of Title V funds for California for FFY 2009 is $42,942,093. Preventive and primary services for pregnant women, mothers, and infants are designated to receive $13,324,644 (31.03 percent of the total), preventive and primary services for children to receive $13,546,232 (31.55 percent) and CSHCN to receive $13,253,235 (30.86 percent). //2009//

/2010/ The proposed allocation of Title V funds for California for FFY 2010 is $43,328,678. Preventive and primary services for pregnant women, mothers, and infants are designated to receive $13,206,536 (30.49 percent of the total), preventive and primary services for children to receive $13,463,557 (31.07 percent) and CSHCN to receive $13,840,603 (31.94 percent). //2010//

State Match/Overmatch

At the time the Title V Annual Report and Grant Application for FFY 2007 was written, California was to receive $44,430,440 in Federal Title V Block Grant funds for FFY 2007. The required match was $33,322,830. California's FFY 2007 expenditure plan for MCAH programs included $964,859,736 in State funds. Consequently, the state-funded expenditures for preventive and primary health care services for the Title V populations exceeded the required 4:3 matching ratio.

/2008/ California expects to receive $44,452,058 in Federal Title V Block Grant funds for FFY 2008. The required match is $33,339,044. California's FFY 2008 expenditure plan for MCAH programs includes $753,798,124 in State funds. Consequently, the state-funded expenditures for preventive and primary health care services for the Title V populations exceed the required 4:3 matching ratio. //2008//

/2009/ California expects to receive $42,942,093 in Federal Title V Block Grant funds for FFY

2009. The required match is $32,206,569. California's FFY 2009 expenditure plan for MCAH programs includes $707,354,582 in State funds. Consequently, the state-funded expenditures for preventive and primary health care services for the Title V populations exceed the required 4:3 matching ratio. //2009//

/2010/ California expects to receive $43,328,678 in Federal Title V Block Grant funds for FFY 2010. The required match is $32,496,509. California's FFY 2010 expenditure plan for MCAH programs includes $1,245,840,182 in state funds. The dramatic increase in California's expenditure plan for FFY 2010 for the provision and coordination of services to the Title V MCAH population is due to the reporting of CSHCN data on actual expenditures. Previously the Electronic Data Systems (EDS) MR 922 report was used to provide the data for these numbers. However, a change to the EDS system for this report changed something in the data compilation and the numbers are not correct as they are grossly understating the expenditure data. Therefore, numbers from last year's data submission to this year's data submission show a marked increase for the expenditures as the number is projected upon the actual expenditure data from FY 08/09 instead of the MR922 report. Reporting of expenditure data has been updated and is no longer using one of the reports it has used in prior years. The report did not capture all the expenditure data. //2010//

Administrative Costs Limits

In FFY 2007 no more than 10 percent of the Federal Title V MCH Block Grant funds will be used for administrative costs related to each program component. During FFY 2006, California expended only 5.47 percent of Title V funds on administrative costs.

/2008/ In FFY 2008 no more than 10 percent of the Federal Title V MCH Block Grant funds will be used for administrative costs related to each program component. During FFY 2008, California will expend only 6.39 percent of Title V funds on administrative costs. //2008//

/2009/ In FFY 2009 no more than 10 percent of the Federal Title V MCH Block Grant funds will be used for administrative costs related to each program component. During FFY 2009, California will expend only 6.56 percent of Title V funds on administrative costs. //2009//

/2010/ In FFY 2010 no more than 10 percent of the Federal Title V MCH Block Grant funds will be used for administrative costs related to each program component. During FFY 2010, California will expend only 6.50 percent of Title V funds on administrative costs. //2010//

Definition of Administrative Costs

In this Application, administrative costs are defined as the portion of the Title V dollars used to support staff in the MCAH and CMS Branch Operations Sections. Funds supporting State program and data staff (but not administrative staff) in the MCAH/OFP and CMS Branches are considered to be program rather than administrative costs.

Administrative costs include staff and operating costs associated with the administrative support of specific MCAH/OFP Branch and CMS Branch programs. These support functions include, but are not limited to, contract management, accounting, budgeting, personnel, audits and appeals, maintenance of central contract files, and clerical support for these functions.

/2010/ Title V dollars have not been used in the CMS Branch for Administrative Costs. //2010//

"30-30" Minimum Funding Requirement

At least 30 percent of the MCH Title V Block Grant funds will be used for children's preventive and primary care services delivered within a system which promotes family-centered, community-based, coordinated care. At least 30 percent of the Title V Block Grant funds will be used to provide services to CSHCN delivered in a manner which promotes family-centered, community-based, coordinated care.

In some cases, the CDPH uses estimates to assess expenditures for both individuals served and the types of services provided. These estimates are based on the target population and program activities authorized in statute, excluding the State budget, and specified in the scope of work for each contractor. Requiring contractors to bill according to actual amounts spent on each type of individual served and by service provided is not possible within current administrative and fiscal policies. Changing State contractual policies would result in undue financial and administrative hardship to local governments and non-profit community-based organizations. This added burden without increased funding would result in many of them not being able to continue to provide needed services to women and children in the state.

Maintenance of State Effort

CDPH has an ongoing commitment to provide maternal and child health services to women and children within the State of California. This commitment includes continued support to local health jurisdictions, local programs, clinics and Medi-Cal providers for maternal and child health services.

It is the State's intent to ensure that State General Fund contributions to these local programs, which are also funded in part by the Federal Title V Block Grant, be administered by the MCAH/OFP and CMS Branches. The State's General Fund contribution for FFY 2007 was $964,859,736 which was $877,700,986 greater than the State's General Fund contribution of $87,158,750 in base year FFY 1989.

/2008/ The State's General Fund contribution for FFY 2008 is $753,798,124 which is $666,639,374 greater than the State's General Fund contribution of $87,158,750 in base year FFY 1989.//2008//

/2009/ The State's General Fund contribution for FFY 2009 is $707,354,582 which is $620,195,832 greater than the State's General Fund contribution of $87,158,750 in base year FFY 1989. //2009//

/2010/ The State's General Fund contribution for FFY 2010 is $1,245,840,182 which is $1,158,681,432 greater than the State's General Fund contribution of $87,158,750 in base year FFY 1989. //2010//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.