Maternal and Child Health Services Title V Block Grant

State Narrative for California

Application for 2009 Annual Report for 2007

Document Generation Date: Sunday, September 21, 2008

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 8
A. Overview 8
B. Agency Capacity 25
C. Organizational Structure 37
D. Other MCH Capacity 42
E. State Agency Coordination 46
F. Health Systems Capacity Indicators 55
Health Systems Capacity Indicator 01: 55
Health Systems Capacity Indicator 02: 57
Health Systems Capacity Indicator 03: 59
Health Systems Capacity Indicator 04: 59
Health Systems Capacity Indicator 07A: 61
Health Systems Capacity Indicator 07B: 63
Health Systems Capacity Indicator 08: 65
Health Systems Capacity Indicator 05A: 67
Health Systems Capacity Indicator 05B: 69
Health Systems Capacity Indicator 05C: 70
Health Systems Capacity Indicator 05D: 71
Health Systems Capacity Indicator 06A: 72
Health Systems Capacity Indicator 06B: 73
Health Systems Capacity Indicator 06C: 74
Health Systems Capacity Indicator 09A: 75
Health Systems Capacity Indicator 09B: 77
IV. Priorities, Performance and Program Activities 79
A. Background and Overview 79
B. State Priorities 80
C. National Performance Measures 85
Performance Measure 01: 85
Performance Measure 02: 88
Performance Measure 03: 92
Performance Measure 04: 95
Performance Measure 05: 98
Performance Measure 06: 101
Performance Measure 07: 103
Performance Measure 08: 106
Performance Measure 09: 110
Performance Measure 10: 114
Performance Measure 11: 117
Performance Measure 12: 121
Performance Measure 13: 124
Performance Measure 14: 127
Performance Measure 15: 131
Performance Measure 16: 134
Performance Measure 17: 137
Performance Measure 18: 141

D. State Performance Measures 144
State Performance Measure 1: 144
State Performance Measure 2: 147
State Performance Measure 3: 150
State Performance Measure 4: 153
State Performance Measure 5: 156
State Performance Measure 6: 160
State Performance Measure 7: 164
State Performance Measure 8: 166
State Performance Measure 9: 169
State Performance Measure 10: 172
E. Health Status Indicators 175
F. Other Program Activities 185
G. Technical Assistance 187
V. Budget Narrative 191
A. Expenditures 191
B. Budget 191
VI. Reporting Forms-General Information 194
VII. Performance and Outcome Measure Detail Sheets 194
VIII. Glossary 194
IX. Technical Note 194
X. Appendices and State Supporting documents 194
A. Needs Assessment 194
B. All Reporting Forms 194
C. Organizational Charts and All Other State Supporting Documents 194
D. Annual Report Data 194

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

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

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

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; expires May 31, 2009.

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//

An attachment is included in this section.

II. Needs Assessment

In application year 2009, 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 in July 2005, was the culmination of more than three years of planning, analysis and evaluation among local health jurisdictions 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 the local and statewide needs of MCAH and CSHCN populations.

Each Branch undertook inclusive efforts to produce a comprehensive needs assessment. From 2003 to 2004, the MCAH/OFP Branch took a multi-level approach that involved collaborations with the University of California San Francisco (UCSF) and the state's 61 local health jurisdictions. Fifty-five of the 61 jurisdictions (90 percent) 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 stakeholder meeting. The participants discussed the data and issues and, based on agreed criteria for ranking, provided recommendations for setting state priorities.

The CMS Branch's assessment for CSHCN included an evaluation of internal capacity, with assistance from the Family Health Outcomes Project (FHOP) at UCSF in the collection and analysis of data as well as the facilitation of the stakeholder process for the identification of issues and the prioritization of needs. The CMS Branch invited 37 stakeholders to participate in the identification and prioritization components of the needs assessment process. All-day meetings were held in January and April 2005, in which criteria for ranking were selected and weighted, issues were identified, data were reviewed, and priorities were agreed upon for the three priority objectives for CSHCN. The priorities for CSHCN were taken directly from the output of the stakeholder process, using the top three prioritized needs.

/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. Selected examples include: (1) comprehensive assessment of the Black Infant Health (BIH) Program based upon 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 an 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 implemented by LHJs; (8) analysis of prenatal alcohol consumption data using multiple data sources; (9) preconception health status report; (10) analysis and dissemination of gestational diabetes trends. In addition, the MCAH Program is collaborating with the UCSF and LHJs to develop a capacity assessment tool for Title V 2010-2014 Local Needs Assessment. //2009//

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 that address the priorities was the next step in the process. A multi-level approach was followed to provide various avenues for input from partners. The MCAH/OFP Branch oversaw the following activities to ensure a comprehensive process:

• Input from MCAH/OFP Branch Section Chiefs and Program Managers;
• On-site meetings with local MCAH representatives from nine counties throughout the state;
• Input 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 based 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 the CSHCN priority areas identified in the needs assessment. The CMS Branch is one of the principals in the California Champions for Progress project, an initiative funded by the Health Resources and Services Administration (HRSA). The other partners in this project are Family Voices of California, Children's Regional Integrated Service Systems (CRISS), and the Los Angeles Partnership for Special Needs Children located at the University of Southern California, University Center of Excellence in Developmental Disabilities at Children's Hospital Los Angeles. This group expanded the stakeholder group that had developed the list of prioritized needs to include representatives from local education, mental health, regional center, county welfare, managed health care and foundations.

The Champions stakeholder group met seven times over nine months in professionally facilitated work group meetings to consider strategies that would assist the state to achieve the six MCHB core performance measures and to meet the priorities identified by the state in its needs assessment process. Each stakeholder was charged with assisting in developing strategies for action, circulating draft documents within member organizations for feedback and support, and reaching consensus within the group on the final plan. The CMS Branch extracted the objectives and strategies that related to the three CMS priority goals. The CCS Family Advisory Committee then reviewed the document and provided comments and suggestions.

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.

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//

III. State Overview

A. Overview

Demographics

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

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

The population increase is the result of the natural increase (the difference between the number of births and deaths), which accounts for a little over half of the total population increase, plus net migration to the state. Foreign immigration to the state far exceeded domestic migration for the period 2000-2005, with net foreign immigration totaling 1,165,624 and net domestic migration totaling 220,165. [9]

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

In 2003, there were almost 7.6 million women of childbearing age (15-44) in California. Women of childbearing age represent 22 percent of the state's total population. The 10.2 million children under age 19 account for 29 percent of the population, including 2.5 million under the age of 5 (7 percent), and over 500,000 under one year (1.5 percent). [11] Nationally, children ages 19 and under make up 28 percent of the population, and those under 5 make up 7 percent. [12] Between 2003 and 2009, the female teen population (ages 15-19) in California is projected to increase by 14 percent, and the Hispanic teen female population is projected to increase by 28 percent. [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 the number of California's teen births. [14] Hispanics accounted for 71 percent of teen births in 2004 [15], while only accounting for 42 percent of the total teen population (age 15-19). [16]

The aging of the state's population is having an impact on the health and well-being of mothers and children. In California, 16 percent of all households contain at least one caregiver for someone aged 50 or older. Three quarters of those caregivers are women, and 31 percent have their own children living at home. This can pose a financial and emotional burden on families, particularly those who are low-income and/or have working mothers. [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 and increase in size.

Diversity

In addition to its overall population expansion, California continued to experience growth in its ethnic diversity. The fastest growing group is Hispanics. Hispanics, as a proportion of the state population, increased from 26 percent in 1990 to 32 percent in 2000. [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 and 2004, although the rate of growth appears to be slowing. Riverside and Placer Counties grew at the highest rate, increasing in population by approximately 4 percent each year. [28] Other counties projected to experience large increases in population include San Joaquin, Merced, and Madera. [29]

Economy

In 2004, the 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 has experienced recovering from the recent economic recession. California's unemployment rate in 2005 was 5.4 percent, compared to the national rate of 5.1 percent. The drop in the unemployment rate in

Fiscal Year (FY) 2003-04 was the first drop in unemployment since FY 1999-00. [31] The forecast through 2008 projects that California's unemployment rate will not fall or change significantly, suggesting that the slow pace of economic growth in the state will continue. [32]

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

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

The federal definition for low-income is household income of less than 200 percent of the poverty level; 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] The population growth occurring in California only compounds this problem, as the construction of new housing units cannot keep pace with increasing demand.

While the actual cost of housing varies between different regions in California, the problem exists throughout the state. Even in lower-cost areas, affordable housing is becoming increasingly scarce. In California's rural counties, a family would need to earn at least $10.33/hour (153 percent of minimum wage) working full-time in order to afford a Fair Market Rent apartment ($537/month for a two bedroom apartment). [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 participated in the labor force. [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. Continuing to raise the rates of enrollment in public insurance programs, especially among immigrants and non-English speaking populations, remains a challenge for the state.

Another challenge for the state is meeting the health care needs of the large number of undocumented immigrants, many of whom are migrant workers. While the number of undocumented immigrants in California is difficult to measure, a recent study suggested that 2.4 million undocumented immigrants were in the State of California in 2002, over a quarter of the nation's estimated 9.3 million. Forty percent of these undocumented immigrants are women. [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. Ultimately senators said the $14.9 billion plan was too risky a financial commitment when California faces a $14.5 billion budget gap. //2009//

Major State Initiatives

/2009/

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

>Safe motherhood

The MCAH Program works 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 has 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 topics of maternal care and morbidity are being established, including 3rd & 4th degree lacerations, labor induction, and post-partum depression.

In July 2007 the MCAH Program began working with CMQCC 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. After reviewing proposals from the LHJs, two to four LHJs will be selected for a two year project beginning in July 2008.

The MCAH Program also developed the first statewide Pregnancy-Associated Mortality Review (PAMR) Project in partnership with UCSF and the Public Health Institute (PHI). The goal of PAMR is to examine the medical and psychosocial morbidities and events leading up to death for women who died from pregnancy-related causes or within one year of pregnancy (pregnancy-associated deaths) so that MCAH and its stakeholders can develop a public health component to reduce such morbidities and deaths. The PAMR Advisory Committee, administered by CMQCC, reviewed the 60 cases selected for the first year's (2002) cohort. African American women are over-sampled to address the disparity in maternal mortality and morbidity. A report of the findings and recommendations is being prepared by MCAH, CMQCC and PHI and is expected to be released in the summer of 2008.

MCAH identified 50 pregnancy-related cases for the 2003 cohort; a sampling of the 144 pregnancy-associated cases will also be reviewed. Data abstracting for these cases began in January 2008 using forms that were revised to reflect efficiencies identified in the first year's review. The Advisory Committee's review of the cases from the 2003 cohort began in March 2008.

> Preconception health

The MCAH Program is collaborating with various stakeholders to improve preconception health in California. A key strategy is promoting preconception health and healthcare initiatives by integrating messages and activities into patient education programs 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. These plans have been combined into a set of comprehensive recommendations that inform the preconception activities outlined in the State MCAH Program's Title V Implementation Plan.

PCCC partnered with the Centers for Disease Prevention and Control (CDC) to host the Second National Summit on Preconception Health and Health Care in October 2007, where numerous public and private partners were represented. This event presented best practices to implement the CDC's recommendations on preconception care. The MCAH Program prepared and distributed a publication detailing the state of preconception health in California.

To quantify the impact of preconception health on perinatal outcomes, a study was conducted examining the impact of preconception hospitalizations on subsequent pregnancy and birth outcomes among women aged 15-44 in California. Preliminary findings were presented at the 2nd National Summit.

> Reorganization of CDHS

CDHS was reorganized into two departments effective July 2007. The new California Department of Public Health (CDPH) will protect and promote health through a focus on population-wide interventions, while the new Department of Health Care Services (DHCS) will focus on the financing and delivery of individual healthcare services.

Since the reorganization, the MCAH Program (formerly MCAH Branch) is in CDPH, and the CMS Branch is in DHCS. MCAH and CMS will continue to work collaboratively as California's Title V partners and to ensure the many programs and organizations under MCAH continue to provide for the health and well being of mothers, infants, children, families, and children with special health care needs.

The CDPH has developed a strategic plan with a vision that focuses on healthy individuals and families in healthful communities. One of the major goals in the strategic plan is to: Increase the quality of life, reduce disparities and promote health equity. MCAH is the lead agency for the objective: Reduce deaths of infants under one year of age.

> Prenatal screening services, umbilical cord blood banking, and pregnancy blood banking

Legislation passed in September 2006 will expand CDPH's capacity to discover causes, develop prevention strategies, and increase surveillance of birth defects and genetic diseases throughout the state. CDPH contracts with the California Birth Defects Monitoring Program (CBDMP) to conduct research and surveillance of birth defects and maintain a birth defect registry. This new legislation will reorganize CBDMP to become part of the MCAH Program. CBDMP will continue to collaborate with the Genetic Disease Screening Program (GDSP) to maintain the Pregnancy Blood Bank, which stores prenatal screening blood samples from GDSP's Prenatal Screening Program.

A prenatal screening fee increase implemented in 2007 will enable GDSP to collect, process, and store more blood samples than prior capacity as well as enable CBDMP to 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 will also modernize and expand GDSP's Prenatal Screening Program to include the quadruple maternal serum marker test. This will improve the early diagnosis and management of genetic and congenital disorders. First trimester testing is expected to

begin January 2009.

CBDMP links birth defects registry data with the pregnancy blood sample inventory as well as with other databases of vital statistics. A link to GDSP's Test Request Form (TRF) database of prenatal genetic screening results has also been validated. 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 areas, and is changing the areas 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.

> Teen Birth Rate Resource Project (TBRR)

MCAH is collaborating 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. The TBRR will identify geographic locations in California with higher or lower teen birth rates so organizations can apply for resources and to target interventions to locations with greater need. The TBRR will also show whether teen birth rates have changed over time, and if this change varies by race/ethnicity and location.

> Perinatal Care Quality Improvement

California Children's Services (CCS), in collaboration with the Regional Perinatal Programs of California (RPPC), is working with CCS-approved Neonatal Intensive Care Units (NICUs) to develop their Regional Cooperation Agreements (RCAs).

The RCA is a requirement for all hospitals participating in the CCS Program. The RCA requires written agreements between Regional, Community and/or Intermediate NICUs, specifying mutual responsibilities. CCS and RPPC developed a toolkit and conducted a series of workshops across the state in 2007 to assist hospitals in the development and implementation of the RCA. The new CMS website location for the toolkit is www.dhcs.ca.gov/formsandpubs/publications/Pages/CCSPubs.aspx.

> Neonatal Quality Improvement Initiative

The CMS Branch and California Children's Hospital Association (CCHA) are jointly sponsoring a statewide Quality Improvement Collaborative (CCHA-CCS QI), and collaborating with the California Perinatal Quality Care Collaborative (CPQCC) to improve neonatal care by working toward eliminating catheter related blood stream infections (CABSIs) in NICUs. The CCHA-CCS QI Collaborative hospitals and participants are neonatologists, nurses, and administrators from the eight CCS-approved California children's hospitals and the six CCHA associate members which are the CCS-approved University of California (UC) medical centers and Sutter Memorial Medical Center (Sacramento).

Outcomes and observational process data were tracked from baseline through the course of the 9-month Initiative, ending in July 2007. A major focus of the evaluation was a detailed analysis of the processes each site uses to implement and maintain evidence-based best practices. The most efficient and effective practices will be shared with all sites.

The Collaborative delineated evidence-based processes of care to reduce neonatal nosocomial infections with the goal of eliminating CABSIs. In the first year of the collaborative, the 13 Regional NICUs collectively reduced their CABSIs by 29 percent for all weight groups. This initiative has begun a second year with all 22 CCS-approved Regional NICUs participating, and aided by a grant from the Blue Shield Foundation. The participating NICUs held meetings in January and June 2008 and the consensus was to continue to work on reducing CABSIs and to form special interest groups (SIGs) focused on vascular access devices, antibiotic use, checklists and root cause analysis, surgical infections, and ventilator associated pneumonia. Each NICU has selected one or more of these SIGs for participation.

> Pediatric Critical Care

The CCS Program has structured a system of 19 CCS-approved pediatric intensive care units (PICUs) to assure that infants, children, and adolescents have access to appropriate quality specialty consultation and intensive care services throughout the state. CCS sets standards for all CCS-approved PICUs and periodically conducts site visits to help ensure standards are followed; standards include requirements for submitting annual morbidity/mortality data to CCS.

The CMS Branch, in collaboration with the UC Davis School of Medicine, is developing an infrastructure for Pediatric Critical Care quality care improvement. This project will assess the need for statewide benchmarking standards to direct quality improvement efforts; conduct key informant interviews with recognized leaders in pediatric critical care; analyze existing quality improvement efforts related to pediatric critical care; and develop a methodology and reporting tool to analyze pediatric intensive care quality improvement activities. This planning effort will identify optimal approaches to the design of a future database and methods for data collection from California PICUs to meet the needs of quality improvement efforts.

A survey of PICU medical directors identified varied opinions about the importance of benchmarking and quality improvement efforts, as well as changes in the available PICU reporting systems. CMS in collaboration with the CCS PICU Technical Advisory Committee is reviewing the reporting systems currently available, both nationally and in California, to evaluate, assess and develop a single reporting system to meet the quality improvement needs of CCS-approved PICU medical directors and the needs for the CMS to assess the care and outcomes.

> Pediatric Palliative Care

The CMS Branch submitted a palliative care waiver to the Federal Centers for Medicare and Medicaid Services in May 2008 with a planned starting date of January 10, 2009. The Waiver will promote the development of a comprehensive Pediatric Palliative Care demonstration program for selected children with life limiting or life threatening conditions who are enrolled in the CCS program. This program should improve the quality of life for these children and their family members. In addition, by providing well-coordinated, comprehensive, continuous care, cost neutrality will be achieved by reducing hospital stays and other avoidable services.

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

> Mental health

The MCAH Program is working to address the mental health needs of infants, children, adolescents, and mothers. California Proposition 63 Mental Health Services Act (MHSA) provides funding for the expansion of mental health services for adults and children. MCAH Program 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, 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. Currently underway are the California Early Childhood Comprehensive Systems (CA ECCS) project and School Readiness Initiative (SRI). CA ECCS project provides state-level leadership for programs that help prepare children for kindergarten. In 2007, CA ECCS staff visited LHJs to identify recommended screening tools and models of service integration and will report these findings to various stakeholders. It is anticipated that the CA ECCS initiative will strengthen the health component of the SRI.

In June 2007, the Maternal and Child Health (MCH) Program of the UC Berkeley School of Public Health, in collaboration with the MCAH Program, the California March of Dimes and the 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 workgroup plans to hold the northern California continuing education conference in 2008 and a subsequent conference in southern California the following year.

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 are focused on recommending use of standardized screening tools within the revised Child Health Disability Program (CHDP) Health Assessment Guidelines.

> Human stem cell research and women's reproductive health

California is leading the nation in its support of the advancement of human stem cell research (HSCR) that seeks to develop treatments and cures of childhood and adult diseases.

The MCAH Program 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.

In 2006, the MCAH Program convened the HSCR Advisory Committee. The HSCR Program facilitated several Committee meetings, which resulted in the development of the HSCR guidelines. The HSCR Program and Committee also consulted with the California Institute for Regenerative Medicine (CIRM) to promote consistency between its stem cell regulations and those of CDPH.

In June 2007 CDPH approved the statewide guidelines for human stem cell research submitted by the Advisory Committee. These are available on the HSCR Program website. In an effort to remain current with recent advancements in stem cell research methods, the

HSCR Program expects to update the guidelines later this year.

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

> 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. The Alliance seeks to prevent childhood obesity by working with schools, food industry, and healthcare professionals, such as CDPH and DHCS staff.

Childhood obesity in low-income children is assessed through the Pediatric Nutrition Surveillance System (PedNSS) data. PedNSS reports from 2006 indicate statewide childhood overweight prevalence rates for children 2-5 years of age (16.2% overweight and 17.0% obese) and children/adolescents 5-20 years of age (18.4% overweight and 23.1% obese) are essentially unchanged from recent years. California ranks as the third highest prevalence rate among states participating in PedNSS for ages 2-5 years of age. The new website address for CHDP data is www.dhcs.ca.gov/services/chdp/Pages/PedNSS.aspx. The CHDP obtains nutrition status and prevalence data on more than 1.5 million youths from CHDP providers' Confidential Screening/Billing Report. Local CHDP programs have program performance measures related to monitoring and sharing county PedNSS data. More programs are using PedNSS data to determine prevalence rates of overweight in target populations and for promoting action to enhance nutrition and physical activity behaviors and environments.

MCAH is co-chairing two Women's Healthy Weight Collaboratives in Los Angeles (LA) and Sonoma County. The collaboratives receive technical support from the Association of Maternal and Child Health Programs (AMCHP), CityMatCH, and CDC.

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.

MCAH has been working with the MCAH jurisdictions to identify liaisons for the "walk to school" initiative and work with their school districts to have more participation in the Governor's and President's Physical Activity Challenges. Also, MCAH has been actively promoting healthy worksite practices within state and local MCAH programs.

MCAH has been working with the California Health Interview Survey (CHIS) to expand the physical activity questions for all age groups. MCAH continues to analyze nutrition, physical activity and body mass index (BMI) questions in CHIS and the Maternal and Infant Health Assessment (MIHA) Survey.

> Breastfeeding

The MCAH Program participated in the Breastfeeding Promotion Advisory Committee (BPAC) to develop strategies and implementation guidelines to promote breastfeeding in California by providing content and breastfeeding surveillance data. A collaborative with the Women, Infants and Children (WIC) Program exists to address recommendations from the report.

Members of a UC Davis Breastfeeding Data Committee worked with MCAH staff and private and public stakeholders to revise the instructions on the Newborn Screening Test form, revise the methodology for computing in-hospital breastfeeding rates, and revise breastfeeding surveillance data tables using the new methodology. The MCAH Program will continue to publish annual breastfeeding surveillance by race/ethnicity.

MCAH has initiated Birth and Beyond California, a quality improvement project, to provide training, technical assistance and resources to hospitals with low in-hospital exclusive breastfeeding rates. MCAH is partnering with WIC on developing a hospital administrator training to promote the use of the model hospital policies.

MCAH has continued participating in the US Breastfeeding Committee and its national promotion of workplace lactation support. Along with California's Office of Women's Health and WIC, MCAH has met with the California Labor Commissioner to develop a plan to increase awareness and enforce the California Workplace Accommodation Law.

> 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. MCAH developed a workgroup of key stakeholders including local BIH and MCAH staff, state MCAH staff, and UCSF CSDH staff to develop the new model and a comprehensive evaluation plan. Once developed, the model will be presented at regional meetings to solicit feedback.

> Black Infant Health / Fetal Infant Mortality Review (BIH/FIMR)

The BIH/FIMR Program was undertaken by the MCAH Program in response to the persistent disparity between African American and White infant mortality rates. The goal of BIH/FIMR is to reduce African American fetal and infant deaths through review of these deaths at the community level. BIH/FIMR uses the national FIMR model to collect detailed information about African American fetal and infant deaths beyond vital statistics. Eight BIH jurisdictions currently participate in the Program; all have an African American combined fetal and infant death rate above the average for the 17 BIH jurisdictions statewide and all have a FIMR program. The past three years of available data for fetal/infant mortality rates at the 17 BIH jurisdictions are being reviewed as part of the evaluation process to determine continued funding for the BIH/FIMR jurisdictions.

Using data obtained from BIH/FIMR, the LA MCAH Program implemented the LA Mommy and Baby Survey (LAMBS). While the African American infant mortality rate decreased from 2002 to 2003, it still remains high when contrasted with the rates for other ethnicities. The survey also revealed increased infant mortality among Hispanics. LA MCAH has undertaken efforts to reduce infant mortality in both African American and Hispanic communities.

The LA MCAH Program piloted LA HOPE (Los Angeles Health Overview of a Pregnant Event), a population-based survey that serves as a data collection tool for maternal interviews for the LA County FIMR program. The MCAH Program is assessing the Baby Abstracting System and Information NETwork (BASINET) system and comparing it with LA HOPE in an effort to determine an effective, streamlined process for centralized data collection.

> Implementation of BASINET for BIH/FIMR

The MCAH Program contracted with GO Beyond LLC to use BASINET for the BIH/FIMR Program. BASINET is a web-based project management system for fetal and infant mortality review that combines data abstraction, deliberations, and detailed on-demand reporting. Depending on the effectiveness of BASINET, it may be used in other counties with MCAH-supported FIMR projects to provide more centralized and comprehensive fetal and infant mortality data at the state and local level.

The eight jurisdictions using BASINET provided feedback on improving the system in an MCAH survey conducted in September 2007. MCAH is working with Go Beyond LLC to implement the suggested improvements.

> High-risk infants

The CCS Program requires regional affiliation among the 118 CCS-approved NICUs to assure access to appropriate intensive care services. These NICUs are designated as Intermediate, Community, and Regional and required to comply with CCS standards, including the submission of annual morbidity/mortality data. All CCS-approved NICUs submit annual data through the CPQCC and review their reports on-line.

Each CCS-approved NICU facility is required to have an organized High-Risk Infant Follow-Up (HRIF) program or a provision for these services by another NICU facility. The HRIF programs began collecting and submitting data to CMS as of July 2006. The CMS database contains 15,000 HRIF reports to date. HRIF is working with CPQCC to build upon the data that CCS-approved NICUs currently submit and to evaluate outcomes. This new data program will provide analysis of outcome data that can be linked to NICU hospital data. These data will enable the providers to assess care and target quality improvement activities.

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

> Improving quality of vital statistics data

The MCAH Program promoted changes to birth, death, and fetal death certificates to increase the data collection quality of vital statistics 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, there are 8 birth clerk workshops scheduled in 2008 throughout the state. The focus is to reduce the number of unknown or missing data items and to share best practices.

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

> Early childhood development

Proposition 10, the Children and Families First Act of 1998, imposes a surtax on cigarette sales, which generates about $600 million a year. The state-level First 5 California Commission receives 20% of the funds and local First 5 Commissions in each county receive 80 percent. First 5 recently authorized $400 million to its signature School Readiness Initiative (SRI) for 2006-2010.

First 5 has several other efforts addressing early childhood health and development including a gap insurance product, an oral health initiative, and an obesity media campaign. The MCAH Program follows the activities of First 5 and helps local staff prepare SRI proposals and identify the connections between their programs and First 5 activities.

MCAH received a multi-year grant from HRSA for the California Early Childhood Comprehensive Systems (CA ECCS) project. The project provides state-level leadership for early childhood health programs that help children be emotionally, socially, and physically prepared for kindergarten. CA ECCS supports the LA County Early Identification and Intervention Collaborative (EIIC) to improve and expand timely identification of, and intervention for, children with or at risk of delays, disabilities and other barriers to development.

MCAH received a technical assistance grant to lead a 15-month national consortium to develop policies to improve early identification of children with developmental problems. The ABCD Screening Academy Initiative's goal is to integrate standardized tools of children's development into preventive healthcare practices.

> Newborn Hearing Screening Program (NHSP) expansion

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

The NHSP has numerous infrastructure building blocks in place, which will support a seamless expansion of the program. These include standards for inpatient and outpatient screening providers, certification criteria for participation in the program, guidelines for infant audiological diagnostic evaluations, and Hearing Coordination Centers (HCCs). Each 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.

Through a competitive procurement process, 3 HCCs were selected to perform the Program's expansion. Each HCC has begun the work of certifying the new hospitals. As of March 2008, there were 187 hospitals certified, 12 of which were new expansion hospitals. It is estimated that all new hospitals will be certified by the end of 2008.

The program is expecting to release a Request for Proposals (RFP) to procure a data

management service to support the work of the hospitals, HCCs, and state staff in April 2008.

> Child health insurance coverage

DHCS has been improving Californians' health through expanded health insurance coverage. Efforts to increase enrollment in 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 2007, over 3.5 million children receiving CHDP assessments have been pre-enrolled for up to two months of no cost full-scope Medi-Cal benefits. Of these children, 69% requested joint applications from Medi-Cal/HF and 8% had their eligibility extended.

Effective June 2004, the CHDP Gateway was enhanced to allow deeming of Medi-Cal eligibility for infants if their mother's eligibility for Medi-Cal at the time of birth was confirmed. Eligibility is extended until the first birthday without requiring their parent(s) to complete a joint Medi-Cal/HF application. From June 2004 through December 2006, 157,378 infants were automatically enrolled in Medi-Cal and in FY 2006-07, 57,118 infants were automatically enrolled in Medi-Cal as the result of a Gateway transaction.

> Oral health promotion

CDPH is responding to the high prevalence of dental disease among California's children with a variety of strategies to increase awareness of oral health. In FY 2006-2007, 1,760,500 children received dental screenings through the CHDP program, a decrease of 2 percent from the previous year.

To assess the oral health status of elementary school children, the Office of Oral Health (OOH), the MCAH Program, and numerous other partners conducted dental screenings in 186 elementary schools and summarized the results in a report.

CDPH contracts with UCSF to oversee the OOH's California Children's Dental Disease Prevention Program (CDDPP). The CDDPP operates 33 school-based programs in 32 counties, providing fluoride rinses, oral home care instruction, and dental sealants. OOH has renewed all 33 contracts for the 2007-10 funding cycle in CDDPP. However, the number of children being served was reduced by 9000 from the previous 3-year cycle.

MCAH local programs continue to address oral health needs in 21 jurisdictions. Information has been collected regarding the extent of selected oral health programs within MCAH jurisdictions in California.

Under the guidance of the Community Water Fluoridation Program of the OOH, the Metropolitan Water District of southern California began fluoridating its water supply in the fall of 2007. OOH and CDPH developed a position statement to address safety concerns about using fluoridated tap water with infant formula.

State legislation enacted in 2007 requires that children have a dental check-up by May 31 of their first year in public school in an effort to establish a regular source of dental care. Data collected from these check-ups and forms by the California Department of Education (CDE) will indicate children who need follow-up care and will identify barriers to receiving care.

MCAH is collaborating with other state and advocacy groups to educate medical/dental providers about the importance of proper oral health care before and during pregnancy. Children Now along with Dental Health Foundation (DHF) presented a policy brief to the state Legislature recommending prenatal and early childhood best practices and guidelines. Plans are now going forward to obtain funding for a statewide conference of oral health experts and other health providers to develop guidelines about appropriate oral health care practices for women to reduce pregnancy complications caused by poor maternal oral health.

> Eliminating racial and ethnic disparities in health

Racial and ethnic disparities continue to exist in the areas of infant mortality, neonatal mortality, preterm delivery, low birthweight and maternal mortality in California. The MCAH Program makes cultural sensitivity a cornerstone of every program activity.

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

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

CDAPP incorporates cultural competence awareness in all CDAPP trainings and materials. To raise awareness of the disparities in diabetes among women of color, MCAH prepared a fact sheet titled "The Percentage of Resident California Women by Race/Ethnicity Hospitalized for Labor and Delivery in California with a Diagnosis of Gestational Diabetes in 2005."

The BIH programs have served as a national model by successfully identifying and enrolling the highest risk population, pregnant and parenting African American women, for focused interventions.

Newborn screening data indicates a great disparity in exclusive breastfeeding rates between White (64%) and Hispanic (32.1%) and African American (34.2%) mothers. MCAH and RPPC collaboratively offer training to staff in hospitals with the lowest exclusive breastfeeding rates.

More children and families of minority populations suffer from untreated tooth decay. Increasing awareness of Denti-Cal benefits among Medi-Cal recipients continues to be a challenge and priority of MCAH and our oral health partners.

> Adolescent health promotion

The state formed the California Initiative to Improve Adolescent Health, based on the National Initiative to Improve Adolescent Health by the Year 2010. In response to the interest among county MCAH directors and local agencies, the MCAH Program contracted with the National Adolescent Health Information Center (NAHIC) at UCSF. The NAHIC produced 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 with the California Adolescent Health Collaborative (AHC) to: 1) provide information, resources and expertise to support the provision of quality health care services to adolescents; 2) increase the capacity of local MCAH jurisdictions and their adolescent health practitioners to promote the health of adolescents and 3) influence policy with the intent of improving the health and well being of California's adolescents.

The California Adolescent Sexual Health Workgroup (ASHWG) is a standing workgroup committed to effectively address the sexual and reproductive health of adolescents. MCAH continues to have an active role on the ASHWG Steering Committee and the workgroup's two major activities: 1) the Data Integration Subcommittee is in the process of creating standardized statewide data sets for HIV, STD, and teen births that will be updated annually and made available online. In addition, similar data sets will be created for high-priority LHJs in California; 2) the Core Competencies Subcommittee has finalized the 2008 edition of the Core Competencies through a process that has involved California experts from various disciplines; a Web-based survey of teachers and practitioners; and a panel of national experts in adolescent sexual and reproductive health.

> Foster care

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

California has 86,000 foster children. HCPCFC has 271 PHNs in administrative care coordination and supervisory positions. Though the number of children in foster care is decreasing primarily due to DSS efforts to keep families together and work with the whole family, the children's medical complexity is increasing. Recognizing the need for specialty training, the DSS and DHCS collaborated this fiscal year to offer a training conference for HCPCFC PHNs and their respective CHDP Deputy Directors. The emphasis was on the practice of universal HCPCFC policies in a statewide uniform manner. This year's symposium will provide training in obesity and nutritional issues as it pertains to foster care children.

A Statewide Foster Care Executive Subcommittee has developed four best practice guidelines for PHNs statewide: 1) assurance of coordinated and continuous care; 2) universal review and updates of the content for the Health and Education Passport (HEP); 3) consultation and care coordination for out-of-county placement; and 4) guidelines for working in the juvenile probation departments (available at: www.dhcs.ca.gov/services/hcpcfc).

> Fetal Alcohol Spectrum Disorder (FASD) and the Substance Abuse Task Force

State and local health jurisdictions are active in FASD prevention and intervention, in addition to the MCAH Program being part of the statewide FASD Task Force. Several counties use the "4 P'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 to assess 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 the analytic capacity to use these data for prevention planning, design, and evaluation.

MCAH representatives participate in the Alcohol and Other Drug (AOD) Workgroup of the State Interagency Team. The goal is to identify interagency and systems issues that, if addressed, could improve identification and treatment of families and children impacted by alcohol and other drugs. The task of the workgroup is to assess and prioritize ways to strengthen services to children and families where there is a nexus between AOD and child safety, education, and workforce readiness/success, maternal and child health, and mental health.

Using data from the California Women's Health Survey (CWHS) and the MIHA Survey, MCAH 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.

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

> Impact of federal Title V reductions on California programs

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

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

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

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

Several of the DRA of 2005 provisions are expected to have a negative impact on MCAH programs. The provision regarding verification of citizenship is likely to be particularly

burdensome. In addition to affecting Medi-Cal, increased documentation requirements may impact other Medi-Cal-related programs including Family PACT and CPSP.

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

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

//2009//

An attachment is included in this section.

B. Agency Capacity

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

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

Youth Pilot Program (YPP) and Integrated Health and Human Services Pilot

/2008/
In the last two years, the above list of programs changed as follows:

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

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

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

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

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

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

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

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

> Support to local infrastructure

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

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

> 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//

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

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

/2009/The CPQCC/PQIP updated the "Early Onset Sepsis Toolkit" in March 2007 (originally developed in 2002).

CPQCC/PQIP has formed a quality improvement collaborative (CPQCC/CCS Hospital Associated Infection (HAI) Collaborative) in partnership with the CMS Branch addressing catheter associated blood stream infections in 19 Community NICUs. //2009//

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

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

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

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

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

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

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

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

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

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

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

> Infant Health Promotion

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

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

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

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

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//

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

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

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

to 4 percent.//2008//

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

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

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

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

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

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

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

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

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

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

Preventive and Primary Care for Children

> Access to care

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

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

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

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

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

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

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

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//

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

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

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

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

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

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

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

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

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

> Services for Children with Special Health Care Needs (CSHCN)

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

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

/2009/ The CCS MTP conducts multidisciplinary team conferences to support case

management and care coordination. The number of clients enrolled in the MTP has remained fairly stable for the past 5 years and is currently 26,119. //2009//

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

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

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//

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//

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//

> 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//

> 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.

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//

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//

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//

/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//

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.

/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//

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//

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//

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//

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//

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//

> 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 Epidemiology and Evaluation Section, 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 Epidemiology and Evaluation Section 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//

> 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//

> 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//

> 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//

/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//

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//

> 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//

/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.

>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, resolution of financial appeals, determination of eligibility for Medical Therapy Unit services, and program consultation/technical assistance. The ROS consultant staff are responsible for review and approval of Early and Periodic Screening, Diagnosis, and Treatment Supplemental Services requests statewide.

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//

/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//

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//

/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//

/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//

> 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//

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, both within and outside of CDHS, and with university and professional organizations on programs and projects related to Title V.

Inter- and intra-agency collaboration are vital for meeting the needs of children and CSHCN. Numerous collaborations exist with state and local public health agencies and relationships 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 beginning in 2003 from HRSA 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 coordinates a myriad of health-related programs at the state and local levels. The project is now in the implementation phase. //2007//

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 on the SIT. 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/The MCAH Program participates in the Alcohol and Other Drug (AOD) Workgroup of the SIT, working to assess ways of strengthening services to children and families in the areas of child safety, education, and workforce readiness/success, maternal/child health, and mental health. The workgroup completed a survey of substance use screening to

assess the effectiveness of various screening processes.

In September 2007 MCAH convened the State Screening Collaborative. CDPH and 9 other state agencies participate in this collaborative, focusing on coordination and identification of best approaches to program improvements.//2009//

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, and with the MCH Bureau grant work to improve 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//

Department of Developmental Services (DDS)

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

/2009/The CMS Branch continues participation on the statewide Interagency Coordinating Council (ICC) for the Early Start program and on the Integrated Services and Health Committee of the ICC. The CMS Branch executed a Data Use Agreement with DDS to obtain outcome data on Early Start program enrollments of infants identified with hearing loss through the Newborn Hearing Screening Program.//2009//

The MCAH/OFP Branch collaborates with the Early Start program at DDS on planning and implementation activities 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 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. The CMS Branch 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 document utilized for foster children within this system. The intent is 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 Health Education Passport (HEP).

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

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 on training providers and resolving program issues.

Childhood Lead Poisoning Prevention Branch (CLPP)

The CMS Branch, through CHDP, provides lead screenings for children. The CCS program covers the cost of the 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 requires 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/ The CMS Branch and the CLPP Program 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 who are utilizing the Lead Care II Analyzer to perform lead testing in provider offices, with electronic reporting of results to the CLPP Branch. To date, 27 providers have completed the process.

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

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 where possible. //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//

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 the 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)

The MCAH/OFP Branch collaborates with the EPIC Branch 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.

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 for the quality of its research to identify causes of birth defects. Title V funds are used to partially fund birth defects surveillance in five California counties, and to support and maintain the CBDMP website.

/2008/By act of the California State Legislature, the 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//

Office of Audits and Investigations

The MCAH/OFP Branch works 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 offices.

/2008/CDHS was reorganized into two departments effective July 2007, the CMS Branch will be in the Department of Health Care Services, and the other three Branches (MCAH/OFP, GDB, and WIC) will be in the California Department of Public Health (CDPH). In the organizational structure of 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 (GDB)
/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. The MCAH/OFP Branch 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, and to analyze and report the infant feeding data. MCAH uses infant feeding data from GDSP as a key indicator for hospital quality assessments.//2009//

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

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

/2009/The CMS Branch continues its participation in the NBS Program's Endocrine and Genetic Specialty statewide meetings. Both 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//

Women, Infants & Children (WIC) Supplemental Nutrition Branch

The MCAH/OFP and CMS Branches collaborate with WIC in a variety of areas, including the 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 when they are 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 the MCAH/OFP, CMS, and WIC Branches meet quarterly for nutrition coordination meetings. The CMS Branch ensures that the PedNSS data are available to WIC local agencies and assists WIC agencies with data interpretation.

/2008/WIC now has the PedNSS link on their home webpage for local programs to access when developing their annual nutrition education plans.//2008//

/2009/The CMS Branch continues to provide local WIC agencies with current data from the PedNSS as well as technical assistance with data interpretation.//2009//

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

/2008/
Universities

The MCAH/OFP and CMS Branches work closely with public health and other departments of the University of California and other state universities. These 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. The UCSF Family Health Outcomes Project (FHOP) provides consultation and training to local MCAH jurisdictions in monitoring and updating their local five year plan, data collection, identification of data sources, data analysis and survey development. The UCSF FHOP also provides consultation, data analysis, and stakeholder meetings and interviews for the Title V Needs Assessment. The UCSF also conducts, analyzes, and reports on the Maternal and Infant Health Assessment Survey.

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

/2008/There are now eight 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. The UCSF 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//

The CMS Branch has two contracts with San Diego State University (SDSU) Institute for Public Health (IPH) which began 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 has now completed the data analysis, and 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. For example, in FY 2002-03, more than 60 percent of expenditures were for services provided in previous years (compared to a 15-38 percent lag in claims payment in the previous 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//

California District of the American Academy of Pediatrics (AAP)

/2007/The CMS Branch 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. One of the Chapter Champions 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//

California Association of Neonatologists (CAN) and Stanford University

/2007/ The CMS and MCAH/OFP Branches 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 percent of CCS-approved NICUs are submitting their CCS data through CPQCC, with the anticipation that all 114 CCS-approved NICUs will submit data to CPQCC for CY 2006. CCS continues to work on issues of concern with CAN through representation by CAN members on the CMS NICU Technical Advisory Committee and representation of CMS on the CAN Executive Board.//2007//

/2008/ The CMS and MCAH/OFP Branches relationships with CAN and Stanford continue to strengthen. The CMS Branch participates in CAN/District IX Meetings. Both Branches are expanding their 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/The CMS Branch continues to participate in the 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//

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/The CMS Branch 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 Children's Specialty Care 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 Children's Specialty Care Coalition continues to be a stakeholder at meetings for the Title V strategic planning and implementation process. The Coalition provided input into a CCS Outpatient SCC Policy Letter introduced in January 2008 to clarify SCC's 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 Branch 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. The CMS Branch works closely with the hospitals as part of 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//

The CMS Branch has 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 the CCHA, the CMS Branch 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 nine-month effort to reduce CABSIs. //2008//

Other Professional Organizations

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

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

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

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

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.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	32.6	30.6	24.6	24.3	24.3
Numerator	8286	7905	6458	6559	
Denominator	2539962	2582390	2630401	2698813	
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 - 2007
A manual indicator is reported for 2007 based on 2006.

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

Notes - 2005
Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2005. 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, May 2004. Tabulations (by place of residence) were done by the MCAH/OFP Branch.

Narrative:
Health System Capacity Indicator 01 (HSCI-1) is the rate per 10,000 for asthma hospitalizations among children less than five years old. The child asthma hospitalization rate increased slightly to 24.3 in 2006. In prior years, the rate had steadily decreased from 33.6 in 2002 to 23.9 in 2005. This contrasted with national increases in asthma prevalence between 1980 and 2002 for children and adults [48, 49]. Based on primary diagnoses codes in 2006 hospital discharge data, California has achieved the Healthy People 2010 objective of reducing the rate to 25 per 10,000.

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 Public Health Initiative sponsored by the CDPH Chronic Disease Control Branch. As stated on its internet home page, "The mission of the California Asthma Public Health Initiative (CAPHI) 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 web site 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. Goals of the program are to improve the quality of clinical care, reduce asthma morbidity, and reduce/eliminate 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 will continue through June 30, 2008. [53]

Recent accomplishments of CAPHI include convening the Asthma Disparities Summit held February 6, 2007, in Berkeley, California and the development of an updated Strategic Plan for Asthma in California for 2008-2012, released in February, 2008. This new plan was built with input from several stakeholders. Many state agencies are involved in the new plan including CDPH, CDHCS, Emergency Medical Services Authority, Department of Education, Department of Social Services, Environmental Protection Agency, Air Resource Board, and the Occupational Safety and Health Administration. The goals for the plan are centered around the following areas: 1) implementation, monitoring, and evaluation; 2) surveillance and research; 3) health care; 4) indoor environments; and 5) outdoor environments. [54]

In addition, 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", in June of 2007, the first comprehensive source of California asthma data. [55]

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	67.3	66.3	73.7	71.3	71.5
Numerator	339207	418190	455151	460738	
Denominator	504371	630754	617571	646633	
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 - 2007
Manual indicator for 2007 is based on 2006.

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.

Notes - 2005
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 2004 -2005
Denominator is the unduplicated number of children under one year of age enrolled in Medi-Cal in FY 2004-2005.

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 2005-06, HSCI 02 was 71.3 percent, a decrease of 3.3% from FY 2004-05 (73.7 percent). The denominator, unduplicated Medi-Cal enrolled children less the one year of age (646,633 for FY 2005-06) has increased by 1 percent since FY 2004-05. The increase in this indicator is most likely due to Gateway and infant deeming.

The Memoranda of Understanding between MCMC plans and local CHDP programs continues. Each local CHDP program coordinates with MCMC plans to develop a procedure for working together. DHCS provides technical assistance to local CHDP programs and MCMC plans to resolve problem areas. The CHDP program provides outreach to providers and children and their families (such as health fairs). 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 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.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator		0.0	0.0	0.0	0.0
Numerator		0	0	0	0
Denominator		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 - 2007
Data is not availble for analysis.

Notes - 2006
Data is not available for analysis.

Notes - 2005
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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	78.7	78.5	78.4	78.7	78.7
Numerator	409931	413004	422294	434411	
Denominator	521117	526090	538752	552317	
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 - 2007
A manual indicator is reported for 2007 based on 2006.

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.

Notes - 2005
Source: State of California, Department of Health Services, Center for Health Statistics, 2005 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH/OFP Branch. 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 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index. The Kotelchuck Index is a measure of prenatal care utilization that includes both the mother's timing of initiation of prenatal care and the number of prenatal care visits compared to those recommended by the American College of Obstetricians and Gynecologists.

The Kotelchuck Index showed steady improvement in prenatal care utilization in California from 1989 through 2003, but leveled off between 2004 and 2006. Nearly seventy-nine percent (78.7 percent) of California women received adequate prenatal care in 2006, essentially unchanged from the 78.5 percent in the previous two years. For purposes of comparison, the rate was 58.7 percent in 1989. [56] While much progress has been made, the 2006 rate is still considerably lower than the national Healthy People 2010 goal of 90 percent.

A review of the distribution of this indicator by race/ethnicity (2006) shows moderate disparities. It ranges from a low of 64.3 percent for American Indians to a high of 81.6 percent for Whites. Hispanics and African Americans are closer to the upper end of the range, at 77.0 and 77.1 percent, respectively.

Several strategies have been used in California to improve prenatal care utilization, including expansion of Medi-Cal eligibility criteria, improved access to Medi-Cal through presumptive and continuous eligibility, a waived assets test, and reduced application paperwork. These were accomplished in California in the late 1980s, and the improvements in the rates in the 1990s are probably at least partly attributable to these changes. Also, several state programs support improvements in adequate prenatal care through direct and indirect delivery of services and support; these include the American Indian Infant Health Initiative (AIIHI), AFLP, BIH, CPSP, and WIC.

Statewide meetings of regional representatives in AFLP provide a forum for discussion of strategies for improving prenatal care utilization. Local programs have utilized various strategies and resources to educate community residents regarding the importance of prenatal care. Public Service Announcements and participation in radio talk shows have shown early evidence of success in Pasadena and parts of the Los Angeles Basin. Home visitation and individual follow-up of women requiring prenatal care have proven very successful in Sonoma County. Contra Costa and Los Angeles County MCAH agencies are working collaboratively with public and private agencies to identify and address health issues related to reproductive health, including prenatal care utilization.

One of the primary goals of BIH is to increase the number of African American women receiving prenatal care in the first trimester. This is accomplished by increasing community awareness of black infant morbidity and mortality through health fairs, provider coordination, media-radio, TV, billboards, and churches. Community health workers make home visits to clients to provide health education materials about black infant mortality and prematurity.

Future BIH activities in this area include working on the following:

1) How to identify pregnant women who are in their first trimester when this is not apparent during street outreach.

2) How to maintain the capacity of local sites to do community awareness activities, despite budget deficits. (Partnering with other agencies, such as the March of Dimes, is a possible short-term alternative.)

3) Increasing the numbers of African American clients that receive BIH services in each jurisdiction.

4) BIH is in the process of developing a single core model for all BIH sites. The new model will ensue that effective services are being provided to clients. In addition, the new model will have an evaluation to assess its effectiveness on meeting the program goals.

CPSP provides statewide guidance to obstetrical service providers regarding the importance of ensuring continuity of prenatal care for individual women while stressing the need for comprehensive education and referral to appropriate support services. Prenatal care providers are given a financial incentive when women are first evaluated in the first trimester of pregnancy.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	70.9	90.0	87.9	92.4	92.4
Numerator	3137700	3276077	3236633	3644145	
Denominator	4425540	3641413	3680740	3945697	
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 - 2007
A manual indicator is reported for 2007 based on 2006.

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.

Notes - 2005
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 2004-September 2005 (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 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 2005 counts. Source: Medical Care Statistics Section, California Department of Health 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 87.9 percent in 2005. (The methodology for calculating this indicator has changed, and the data reported for years prior to 2004 are not comparable.)

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. A Provider Manual and Local Program Guidance Manual are online and available to assist providers and local programs.

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. The Local Program Guidance Manual helps to ensure that there is uniformity among all local programs in daily functions and the Provider Manual is an up-to-date resource for enrollment, billing, the Gateway, and all program responsibilities. 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 will continue to recruit and enroll new providers and will utilize the Local Program Guidance Manual as a resource. Providers and their sites will be assessed 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.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	35.5	37.8	44.2	41.1	42
Numerator	342288	352522	353166	344152	
Denominator	964016	933287	798779	838216	
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 - 2007
Manual indicator for 2007 is based on 2006.

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.

Notes - 2005
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 2005-06.
Denominator is the revised HCFA-416 Form element number 1 for FY 2005-06.

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 2006-07, HSCI-7B was 41.1%, down from 44.2% in 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.

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 off the CHDP website.

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 also be available for downloading off the CHDP 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 Dental Subcommittee of the CHDP Executive Committee continues to work on dental updates and revisions to the CHDP Health Assessment Guidelines and other CMS publications to broaden the knowledge-base of providers, local program staff, families, and communities. 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. 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 will be available on CD, hardcopy, and includes two power point presentations for the counties to use to train CHDP providers. The CHDP website will also be a source for the manual.

In conjunction with the "Handbook" the CHDP Health Education Subcommittee is preparing a document entitled, "Patient Oral Health Education: Resources for CHDP Providers." This resource will enable providers to obtain information and brochures on 23 different oral health topics.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	22.6	10.9	8.7	32.5	31.1
Numerator	20940	8944	7318	27623	27058
Denominator	92790	82343	84235	85106	86914
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 - 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 for December, the midpoint of the current fiscal year, for children under 16 years of age. 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.

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 for December, the midpoint of the current fiscal year, for children under 16 years of age. 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.

Notes - 2005
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 2004-05. Since active cases on CMS Net represent an estimated 56.9 percent of all active CCS cases for CA for FY2004, the number with aid codes 20 and 60 from CMS Net is extrapolated for CA. Note that the CMS Net system now has the capability of identifying children through 15 years. There was a decrease in the identified number of children with aid code 60 possibly due to the fact that in September 2005, there was a change to the CMS Net system that has resulted in cleaner data regarding Medi-Cal eligibility. If this reasoning is correct, then the numerator for this measure should not decline any further in FY 2006-07.
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. 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 31.1 percent for FY 2007-08, compared to 32.5 percent in the previous year. The numerator, 27,058 (27,623 FY 2006-07), is the number of children under 16 years of age estimated to have SSI and receiving rehabilitative services. The denominator, 86,914 (85,106 for FY 2006-07), is the number of SSI beneficiaries under age 16.

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.

Eighteen counties are actively using MTU Online as of January 2008. Another two to four counties are in the process of becoming equipped for MTU Online use. The software is version 5 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 2006-07 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)	2006	payment source from birth certificate	6.8	6.9	6.9

Notes - 2009
Source: State of California, Department of Public Health, Center for Health Statistics, 2006 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 source includes private insurance, self-pay, no charge, other government programs, and medically indigent.

The percent low birth weight babies was quite similar for Medi-Cal and non-Medi-Cal in 2006: 6.8 percent and 6.9 percent, respectively. Neither population reached the Healthy People 2010 target of 5.0 percent.

There were no striking differences between Medi-Cal and non-Medi-Cal for any race/ethnic group.

MCAH 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. There are currently more than 1,500 Medi-Cal obstetrical providers approved to provide CPSP services and approximately 165,000 women served 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 an early-entry-into-care bonus and a case coordination bonus for each of their CPSP patients for whom three assessments and the initial pregnancy office visit are provided 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 the 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 could contribute to poor birth outcomes.

African American infants are twice as likely as infants of most other racial/ethnic groups to be born at low birth weight in California. BIH identifies pregnant and parenting African American women at risk for poor birth outcomes and provides them assistance in accessing and maintaining appropriate health care and other supportive services. BIH provided services to more than 14,270 pregnant and parenting African American women, infants, and children in 2006. Many BIH clients also receive Medi-Cal services. BIH is active in 17 local health jurisdictions which account for over 90 percent of the State's African American births. [57] The new single core model that is being developed, discussed above in Health Systems Capacity Indicator 04, will incorporate the latest evidence on how to decrease low birth weight of African American infants in California.

The MCAH Program and CMS Branch collaborate with the California Perinatal Quality Care Collaborative (CPQCC), which advocates for performance improvements in perinatal and neonatal outcomes. CPQCC has more than 120 member hospitals, which account for over 90 percent of the newborns requiring critical care in California. The Perinatal Quality Improvement Panel (PQIP), a workgroup of the CPQCC, is completing a Late Pre-term Infant Toolkit to assist hospitals in the care of infants 34 to 36 6/7 weeks gestation. The toolkit is designed to enhance awareness and sensitivity to issues of transition, infection, nutrition, discharge readiness and parenting.

The fourteen Regional Perinatal Programs of California (RPPC) provide consultation to all delivery hospitals in California, using current statewide and hospital specific outcomes data to address strategies to improve risk appropriate care. The RPPCs support the implementation of clinical quality improvement strategies by collaborating with maternal and neonatal providers to address evidence-based quality improvement projects. They also disseminate current perinatal

literature and provide hospitals with clinical competency standards as well as published hospital standards of care.

MCAH Program staff actively participate on the PCCC. The Council 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.

In 2007 two of the RPPC Regions, Community Perinatal Network in Los Angeles and Orange County, worked together to develop a Quality Improvement Toolkit, The Late Preterm Infant: Assessment, Management & Prevention of Morbidity & Mortality.

The MCAH Program and CMS are collaborating with the March of Dimes on its multi-year Prematurity Campaign (2003-2010). The goal of this multi-million dollar campaign is to invest in research, education and community programs in order to identify the causes of prematurity and develop strategies to improve birth outcomes.

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	2005	matching data files	6	4.6	5.5

Notes - 2009
Source: State of California, Department of Public Health, Center for Health Statistics, 2005 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 (6.0 per 1,000) than among non-Medi-Cal births (4.6 per 1,000) for 2005. Both rates are similar to rates for the previous two years. The rate for the Medi-Cal population increased slightly while the rate for the non-Medi-Cal population remained stable when compared to 2004. Neither the Medi-Cal population nor the non-Medi-Cal population has achieved the Healthy People 2010 goal of 4.5, but the rate in the non-Medi-Cal population is close.

The infant death rate was greater among Medi-Cal births than among non-Medi-Cal births for all race/ethnic groups except Hispanics. One notable difference between Medi-Cal and non-Medi-Cal by race/ethnic group was for Whites: 7.9 per 1,000 and 4.0 per 1,000, respectively. Also notable is that the rate increased in the Medi-Cal population from 2004 to 2005 for Whites (6.5 to 7.9), African Americans (12.8 to 13.3) and Asians (4.0 to 5.3).

Child Death Review Teams (CDRT) are expanding their capacity to make recommendations to

agencies and communities about how to prevent infant deaths and to take findings to action. The Epidemiology and Prevention for Injury Control (EPIC) Branch of CDHS has done a series of trainings for CDRTs to promote the recruitment of injury prevention specialists on teams to improve their prevention recommendations.

The State Child Death Review Council created a prevention committee that has generated interest in prevention within CRDTs. The Surrendered 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 Program is taking the lead on the goal's proposed objective for reducing infant mortality. An action plan is being developed by MCAH 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 will be centrally collected and reportable at the state and county level. The program will train local FIMR coordinators and increase collaborative community involvement through BIH. A state-level BIH/FIMR team will be created to address state-level systemic issues.

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.

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 assistance in enrolling women in a private or public health insurance program, assisting them to find a medical provider for care throughout their pregnancy, and providing follow-up to ensure continued access to care and assisting with issues or problems that arise during the perinatal period.

Several MCAH programs focus attention 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 05a.

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 on addressing 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 is working with Go Beyond LLC to implement the suggested improvements to the system.

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	2006	payment source from birth certificate	80.6	90.5	85.9

Notes - 2009
Source: State of California, Department of Public Health, Center for Health Statistics, 2006 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 (80.6 percent) than for non-Medi-Cal births (90.5 percent) in 2006. This difference was noted for all race/ethnic groups, with the greatest differences for Whites (17.3 percentage points), Asians/Pacific Islanders (16.4) and American Indians (11.5). The percent of Medi-Cal births and the percent of non-Medi-Cal births that received first trimester care were down slightly from the previous year (81.6 percent and 90.8, respectively). The non-Medi-Cal population achieved the Healthy People 2010 goal of 90 percent.

One of the reasons that 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] Representatives from the MCAH and OFP Programs actively participate on the Preconception Care Council of California. The Council plays a pivotal role in relaying the message of the importance of reproductive life planning and preconception care to local communities.

MCAH programs are important in identifying women in need of prenatal care at early stages in the pregnancy through community connections, community outreach, hotlines, and similar interventions. The programs are also critical in providing social support services, case management and client follow-up.

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 greater than or equal to 80% [Kotelchuck Index])	2006	payment source from birth certificate	75.4	81.5	78.7

Notes - 2009
Source: State of California, Department of Public Health, Center for Health Statistics, 2006 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, selfpay, 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 through 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. By this measure, 75.4 percent of Medi-Cal women and 81.5 percent of non-Medi-Cal women had adequate prenatal care in 2006. The percent of Medi-Cal women with adequate prenatal care remained the same as the previous year (75.4 percent), while the non-Medi-Cal percent was up slightly from the previous year (80.9 percent). Both groups are lower than the national Healthy People 2010 goal of 90 percent.

One of the reasons that 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] Representatives from the MCAH Program actively participate on the Preconception Care Council of California. The Council plays a pivotal role in relaying the message of the importance of reproductive life planning and preconception care to local communities.

MCAH programs are important in identifying women in need of prenatal care at early stages in the pregnancy through community connections, community outreach, hotlines, and similar interventions. The programs are also critical in providing social support services, case management and client follow-up.

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	YEAR	PERCENT OF

The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		**POVERTY LEVEL Medicaid**
Infants (0 to 1)	2006	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)	2006	250

Notes - 2009
Source: 2006 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 (05-13) specifying the 2006 Federal Poverty Levels (FPLs) for various programs.
http://www.dhs.ca.gov/mcs/mcpd/MEB/ACLs/PDFs/ACWDLs/2006ACLs/01thru09/c06-07.pdf

Notes - 2009
Source: 2006 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. http://www.mrmib.ca.gov/MRMIB/SchipBackground.html. Access Date: 04-16-08 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 are eligible for Medi-Cal if the family income is at or below 200 percent of the FPL. Eligibility criteria for HF changed in 2006. Infants are eligible for HF if the family income is between 200 and 250 percent of FPL.

In 2006, infants 0-1 year old born to women with family incomes between 200 and 300 percent of FPL and enrolled in the Access to Infants and Mothers Program (AIM), are eligible for 2 years in the AIM Program.

There are no anticipated changes to the eligibility criteria in the foreseeable 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 19) (Age range to)	2006	 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)	2006	 250 250

Notes - 2009
Source: 2006 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 (05-13) specifying the 2006 Federal Poverty Levels (FPLs) for various programs.
http://www.dhs.ca.gov/mcs/mcpd/MEB/ACLs/PDFs/ACWDLs/2006ACLs/01thru09/c06-07.pdf

Notes - 2009
Source: 2006 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.
http://www.mrmib.ca.gov/MRMIB/SchipBackground.html. Access Date: 04-16-08. The 250% of poverty levels reported by MRMIB represent the upper range levels for each population group. 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 and SCHIP/HF for children ages 1 to 19.

Children age 1-5 are eligible for Medi-Cal if the family income is at or below 133 percent of FPL; for children age 6-19, the eligibility level is 100 percent of FPL. Children age 1 -- 5 are eligible for HF if the family income is between 133 and 250 percent of FPL, and children age 6-18 are eligible for HF if the family income is between 100 and 250 percent of FPL.

There are no anticipated changes to the eligibility criteria in the foreseeable 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	2006	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	2006	300

Notes - 2009
Source: 2006 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 (05-13) specifying the 2006 Federal Poverty Levels (FPLs) for various programs.
http://www.dhs.ca.gov/mcs/mcpd/MEB/ACLs/PDFs/ACWDLs/2006ACLs/01thru09/c06-07.pdf

Notes - 2009
Source: 2006 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.

http://www.mrmib.ca.gov/MRMIB/SchipBackground.html. Access Date: 04-16-08. 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 are eligible for Medi-Cal if the family income is at or below 200 percent of the FPL. Pregnant women with family income levels between 200 and 300 percent of the FPL are eligible for the AIM Program.

There are no anticipated changes to the eligibility criteria in the foreseeable 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 - 2009

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 Program 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 Program 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 Program 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 Program 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 Program'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 Program 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 Program 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. The 2001 and 2003 surveys 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 Program staff sit on several CHIS Technical Advisory Groups, helping to develop topic areas and survey questions, and analyzing the data.

The MCAH Program 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. There are eight trainings scheduled from March through October 2008.

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)	1	No
California Student Survey	3	No
California Health Interview Survey	3	Yes

Notes - 2009

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

According to the 2005 CHIS survey, 6.5 percent of California youth age 12-17 years old smoked in the past 30 days. 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 will begin to 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 new anti-smoking ads Hollywood studios have agreed to place 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. Since smoking is correlated with adverse birth outcomes and it may be difficult for women to quit tobacco use during pregnancy, 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 MCAH programs, such as AFLP, and other local programs reaching teens to discuss tobacco use, especially in the context of culturally and age-appropriate reproductive life planning.

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

State Priorities and Relationship of Priorities, Performance Measures, and Capacity

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. All ten of California's priorities have one or more related national or state performance measures.
The ten priorities for Title V activities in California and the associated performance measures are:

Priority 1 - Enhance preconception care and work toward eliminating disparities in infant and maternal morbidity and mortality. There are five related performance measures:
> NPM 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);
> NPM 15 (Percentage of women who smoke in the last three months of pregnancy);
> NPM 17 (Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates);
> NPM 18 (Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester); and
> 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).

Priority 2 - Promote healthy lifestyle practices among MCAH populations and reduce the rate of overweight children and adolescents. There are two related performance measures:
> NPM 14 (Percentage of children, ages 2 to 5 years, receiving WIC services that have a Body Mass Index [BMI] at or above the 85th percentile); and
> SPM 09 (The percent of 9th grade students who are 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. There are two related performance measures:
> NPM 08 (The rate of birth [per 1,000] for teenagers aged 15 through 17 years); and
> SPM 08 (The percent of births resulting from an unintended pregnancy).

Priority 4 - Improve mental health and decrease substance abuse among children, adolescents, and pregnant or parenting women. There are three related performance measures:
> NPM 16 (The rate [per 100,000] of suicide deaths among youths 15-19);
> 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); and
> SPM 04 (The percent of women who reported drinking any alcohol in the 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. There are five related performance measures:
> NPM 02 (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);
> NPM 03 (The percent of CSHCN age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home);
> NPM 05 (Percent of CSHCN age 0 to 18 whose families report the community-based service

systems are organized so they can use them easily);
> SPM 01 (The percent of children birth to 21 years enrolled in the CCS program who have a designated medical home); and
> SPM 07 (The percent of 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. There are nine related performance measures:
> NPM 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);
> NPM 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;
> NPM 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, Hepatitis B);
> NPM 09 (Percent of third grade children who have received protective sealants on at least one permanent molar tooth);
> NPM 12 (Percent of newborns who have been screened for hearing before hospital discharge);
> NPM 13 (Percent of children without health insurance);
> NPM 17 (Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates);
> NPM 18 (Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester); and
> SPM 07 (The percent of 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. There are six related performance measures:
> NPM 03 (The percent of CSHCN age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home);
> NPM 04 (The percent of CSHCN age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need);
> NPM 05 (Percent of CSHCN age 0 to 18 whose families report the community-based service systems are organized so they can use them easily);
> NPM 06 (The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life);
> SPM 01 (The percent of children birth to 21 years enrolled in the CCS program who have a designated medical home); and
> 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).

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. There are three related performance measures:
> NPM 02 (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);
> NPM 03 (The percent of CSHCN age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home); and
> SPM 01 (The percent of children birth to 21 years 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. There are four related performance measures:
> NPM 10 (The rate of deaths to children aged 14 years and younger caused by motor vehicle

crashes per 100,000 children);
> NPM 16 (The rate [per 100,000] of suicide deaths among youths 15-19);
> SPM 05 (The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries); 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).

Priority 10 - Increase breastfeeding initiation and duration. There is one related performance measure:
> NPM 11 (The percent of mothers who breastfeed their 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, the MCAH Program 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 MCAH 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//

Parent and community input has been solicited and 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 more than 2,000 clients, parents and other family members. Sixteen counties reported having conducted focus groups.

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 of the workgroup 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 outcome from workgroup meetings was the development of a general program concept to be further developed and refined by MCAH, UCSF and the workgroup. //2009//

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//

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.

/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//

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//

/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//

/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//

/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//

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	99	99	99.5	100	99.5
Annual Indicator	99.5	100.0	99.2	100.0	100
Numerator	397	391	478	566	
Denominator	399	391	482	566	
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100

Notes - 2007

A manual indicator is reported for 2007 based on 2006.

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.

Notes - 2005
Source: State of California, Department of Health Services, Genetic Disease Branch, 2005 Newborn Screening Records. These data reflect screening for the following six conditions: PKU, congenital hypothyroidism, galactosemia, sickle cell, CAH, and tandem mass spectromety. Data from previous years pertain to only the first four conditions. Screening for the last two conditions began in July 2005.

a. Last Year's Accomplishments
California has effectively achieved universal coverage for newborn screening for genetic, metabolic and hematological disorders. The rate for California in 2006 was 100 percent for all conditions for which screening was performed. The percent receiving timely follow-up to definitive diagnosis and clinical management was also 100 percent. The two sets of screens that were pilot-tested over a period of about six months in 2005 became part of the regular newborn screening program beginning January 1, 2006. These were (1) screening for congenital adrenal hyperplasia (CAH), and (2) tandem mass spectrometry screening (MSMS) for inborn errors of metabolism other than PKU.

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 detected and 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 CCS-eligible; and GDSP and 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 would receive

expeditious diagnostic evaluations and treatment services as needed.

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

Both the prenatal and the newborn screening programs expanded their programs this year (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).

Also July 16, 2007, the Expanded AFP triple-marker Prenatal Screening Program expanded further to include a fourth marker, the analyte Inhibin (Inh). This fourth marker is used in conjunction with the three markers used in the past, 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%. Also on July 16, 2007, 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 screening following these previous screens and/or diagnostic tests.

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 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).

State and local agencies -- including GDSP, the CMS Branch, 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 -- will continue to work collaboratively 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.

There are also plans to expand the Prenatal Screening Program further in January, 2009, by offering first trimester screening in addition to second trimester screening, to allow earlier risk assessment for chromosomal abnormalities.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	48.5	49.5	50.5	51.5	52.5
Annual Indicator	47.6	47.6	47.6	47.6	46.6
Numerator					
Denominator					
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	52.5	52.5	52.5	52.5	52.5

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.

Notes - 2005
The 2005 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 CMS Branch, working with its collaborative partners and a stakeholder group (including parents), has completed a strategic plan for the state priorities for CYSHCN identified through the Needs Assessment process. Family partnership and satisfaction have been important parts of the strategy matrix.

2) The 2007 CRISS Annual Conference, on November 2, 2007, focused on "Hot Topics Arising in the Medical Therapy Program: Safe Transport, Complementary Therapies, and Spasticity Management", and drew more than 100 attendees, including parents, physicians, nurses, physical and occupational therapists, and regional center staff.
3) 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.

4) The FCC Work Group monitored FCC and transition activities, parent liaison services, and medical home projects.

5) The FCC Work Group provided technical assistance for CCS administrators for hiring or contracting a parent liaison.

6) County CCS programs reported on family participation in the CCS program.

7) 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.

8) Family members participated on advisory committees or task forces in many counties, and became involved with in-service training of CCS staff and providers.

9) The CRISS FCC Work Group worked with the results of the FCC survey regarding statewide CCS program family-centered care.
10) Family Voices of CA (FVCA) continued to provide education to the Family Resource Centers and promote development of CCS Parent Health Liaison (PHL) services. Five new PHLs joined the statewide FVCA PHL network increasing participation to 36.)

11) The PHL network developed a questionnaire on "Providing PHL Services to CCS" to address improving and expanding PHL services

12) CCS PHL's met monthly via conference calls for technical support, track emerging issues and statewide trends, identify solutions, and determine training needs.

13) FVCA provided "The Right Question" training to the CCS PHL, to learn how to formulate questions so they can effectively advocate on behalf of their children.

14) FVCA serves as Family Advisory Group to State CCS to find family members (including youth) to serve on additional committees

15) FVCA worked with State CMS staff to provide trainings for PHL, which included "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".

16) FVCA created a youth council. "Kids As Self Advocates" (KASA) that meets once a month via conference call and face to face every other month. State CCS has attended the KASA meetings. KASA has participated on a panel at the annual "CCS Best Practices" conference.

17) FVCA has continued to work on the development of the FVCA Parent Leadership Training Curriculum to prepare families to partner in decision-making.

18) FVCA collaborated to convene a statewide "Health Summit" that brought families, professionals, agency representatives, advocates, insurers, health policy experts and legislators together to discuss access to affordable and appropriate health care for CSHCN and develop strategies to address the challenges families face.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CMS and stakeholders are including family partnership and satisfaction into the strategic plan for the state priorities identified through the Needs Assessment process and Implementation Plan.				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. Children's Regional Integrated Service Systems (CRISS), which comprises 14 CCS county programs, has a Family-Centered Care (FCC) Work Group that meets bimonthly to plan annual conferences, workshops, resource fairs, and address issues regarding FCC.				X
4. The CMS Branch will be reviewing the analyzed results of the FCC questionnaire regarding statewide CCS program family-		X		

centered care.				
5. CCS programs are partnering with Family Resource Centers in their areas.		X		
6. 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		
7. The CMS Branch established a performance measure for family participation in the County CCS programs to evaluate their programs.				X
8. The FCC Work Group is providing technical assistance for CCS administrators for hiring or contracting a parent liaison.				X
9. County agencies and families are collaborating to provide workshops, resource fairs, and conferences for families of CSHCN.		X		
10.				

b. Current Activities
Current activities around this measure include:

1) A Federal MCHB grant was awarded to the USC's University Center for Excellence in Developmental Disabilities (UCEDD) at Children's Hospital LA (CHLA) for collaboration with CRISS, CMS Branch, and FVCA for a 3-year project to implement integrated community systems of care for CSHCN.

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) The CMS Branch continues to work with the results of the FCC survey regarding statewide CCS program family-centered care.
5) FVCA continues to encourage the growth of the PHL Network by providing information and assistance to Family Resource Centers.

6) 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.

7) FVCA continues to work with CMS as the Family Advisory Group to enhance services for families of CSHCN.

8) FVCA KASA (Kids As Self Advocates) youth council continues to meet once a month and provide input to CMS.

9) FVCA continues to develop the FVCA Parent Leadership Training Curriculum to prepare families to partner in decision-making.

c. Plan for the Coming Year
1) The Champions stakeholder group for the MCAH grant implementing integrated community systems of care for CSHCN will meet on a quarterly basis to review and comment on progress in the implementation activities.

2) The CRISS FCC Work Group is planning and developing its annual conference for the fall of 2008 which will focus on diabetes management for children, and model parent-professional collaboration.

3) The CMS Branch will continue to use the analyzed results of the FCC survey regarding statewide CCS program family-centered care to develop strategies to strengthen existing family-centered care activities and to promote additional activities.

4) FVCA will continue to promote the growth of PHL Services and provide trainings to increase the capacity of PHLs to assist families.

5) 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.

6) The results of the questionnaire, "Providing PHL Services to CCS", will be compiled and used as a tool for local Family Resource Centers (FRCs) to use in collaboration with their local CCS agency to improve systems of care for CSHCN.

7)FVCA will continue to meet with CMS as the Family Advisory Group and respond to requests for input on materials and committees.

8) FVCA will continue monthly KASA meetings, both face to face and the phone meetings to ensure their ability to provide input to CMS.

9) FVCA will continue to provide trainings to families and professionals
so families can partner in decision-making.

10) 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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	45.5	46.5	48	50	51
Annual Indicator	44.7	44.7	44.7	44.7	42.2
Numerator					
Denominator					
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	51	51	51	51	51

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.

Notes - 2005
The data reported in 2002 have pre-populated the data for 2005 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". The overall goal of the proposed project was 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. This collaboration is an effort to achieve early detection, diagnosis and best-practices treatment for children and youth (0-18) with epilepsy in California, especially those residing in medically underserved areas, as well as to eradicate the often-associated stigma through increasing public awareness and understanding of the disorder.

Other activities include:

1) County CCS programs assessed whether CCS eligible children have a documented medical home and looked at ways to improve this.

2) CMS finalized the state strategies for increasing the number of FCC medical homes for CSHCN and the number/percent of CCS children who have a designated medical home.

3) In collaboration with federal MCHB grant awardees (USC's UCEDD at CHLA, CRISS, and FVCA) development of a Medical Home Initiative (state strategy) was started to increase the number of FCC medical homes for CSHCN and the number/percent of CCS children who have a designated medical home.

4) FVCA and the PHL Network developed "Hospital Discharge Questionnaire" to assist families in the coordination of care for their child when they come home from the hospital. Four hospitals and three FRCs have incorporated the questionnaire in their work with families and it is available in English, Spanish, and Chinese.

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. FVCA developed "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. CMS and stakeholders are working on the state strategies for increasing the number of FCC medical homes for CSHCN and the number/percent of CCS children who have a designated medical home and an implementation plan.				X
2. CCS is a collaborative partner with Children's Hospital LA (CHLA) for a grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in CA, particularly in a medical home setting.		X		
3. County CCS programs are assessing whether CCS eligible children have a documented medical home and looking at ways to improve this.				X
4. Work continues developing policy for CCS regarding the medical home for CCS clients, authorization of the medical home, including phone consultation and care coordination.				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) Collaborating with CHLA on the grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in California, particularly in medical home settings.

2) Continue to work with USC's UCEDD at CHLA in collaboration with CRISS, CMS Branch, and FVCA to implement the Medical Home Initiative (state strategy).

3) Evaluation continues by county CCS programs to determine if children in the CCS program have a medical home and how to improve on this part of a performance measure regarding effective case management.

4) 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. FVCA agencies will continue to provide a "resource referral pads" to physicians that list local resources for families.

c. Plan for the Coming Year
Plans for the coming year include:

1) Continue to collaborate with CRISS to convene a pilot medical home project for children with epilepsy in rural Northern California.

2) Continue to work with USC's UCEDD at CHLA in collaboration with CRISS, CMS Branch, and FVCA to implement the Medical Home Initiative.

3) CMS will launch a Medical Home Initiative this year, with two components: (1) a policy letter for CCS regarding the medical home for CCS clients, particularly authorization of the medical home, with phone consultation for care coordination, billing codes, and ramifications of this authorization (county-based CCS medical home liaisons will be designated to serve as the single point of contact for primary care providers of CCS children); and (2) a letter to paneled CCS physicians introducing the medical home concept, alerting them to the services and assistance they and their patients can receive from CCS, including the designated CCS medical home liaison, and providing medical home information and tools (e.g. the Center for Medical Home Improvement's abbreviated Medical Home Index).

4) 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.

5) 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. FVCA Agencies will also provide a "resource referral pads" to physicians that list local resources for families.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	60.5	62.5	64.5	65.5	68.5
Annual Indicator	59.3	59.3	59.3	59.3	59.6
Numerator					
Denominator					
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	65.5	65.5	65.5	65.5	65.5

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.

Notes - 2005
The 2005 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 under 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 under 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.

c. Plan for the Coming Year

1) 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.

2) CMS will continue to participate in health care financing discussions at various levels of state government.

3) 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).

4) 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).

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	67	68	69	70	71
Annual Indicator	65.9	65.9	65.9	65.9	85.3
Numerator					
Denominator					
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	85.5	86	86.5	87	87

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.

Notes - 2005
The 2005 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) Family members participated on CMS advisory committees and task forces.

2) CHDP, HCPCFC, and CCS programs reported on a performance measure demonstrating that they provide effective case management.

3) The LA Partnership for Special Needs Children and a CCS stakeholder group, focused on increasing awareness of the need to screen for mental health problems (when necessary) and refer (when appropriate) CCS eligible children.

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) CRISS sponsored a regional workshop in September, 2007 entitled "Implementing Innovative Care Coordination Strategies for Children with Special Health Care Needs", that brought together more than 90 participants in the CRISS 14-county region. The workshop included intensive breakout sessions showcasing three county-wide care coordination models for CSHCN that have been implemented successfully in the CRISS region and provided information and tools for replication of the models.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Work continues 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 coordination of services and education of families for CYSHCN.		X		
2. The CMS Branch has continued collaboration with FVCA, parent representatives, and diverse parent groups through the Interagency Coordinating Council for Early Start.				X
3. CHDP, HCPCFC, and CCS programs continue reporting on a performance measure evaluating whether they are providing effective case management.				X
4. The LA Partnership for Special Needs Children, a CCS stakeholder group, has been focusing on increasing awareness of the need to screen for mental health problems (when necessary) and refer (when appropriate) CCS eligible children.		X		
5. The FCC Work Group continues to meet bimonthly to review county FCC activities, share resources, and plan conferences,				X

trainings, and activities.				
6. The CMS Branch and the Medi-Cal program continue to collaborate on the development of a pediatric palliative care program.				X
7.				
8.				
9.				
10.				

b. Current Activities
Current activities include:

1) Work 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 coordination of services and education of families for CYSHCN continues.

2) CHDP, HCPCFC, and CCS programs continue reporting on a performance measure demonstrating that they provide effective case management; results will be compared with future years.

3) The FCC Work Group continues to meet bimonthly to review county FCC activities, share resources, and plan conferences, trainings, and activities.

4) CRISS has convened regional meetings with members from Family Voices, local family support organizations, CCS programs, regional centers, county children's mental health services, special education, pediatric organizations and children's hospitals to focus on promoting care coordination for children who cross multiple systems.

5) A Palliative Care Stakeholders workgroup had a series of meetings to strategize and obtain input for the development and implementation of a pediatric palliative care model.

6) CMS is developing a universal consent form with parents to facilitate information sharing among agencies.

c. Plan for the Coming Year
Plans for the coming year include:

1) Local CCS offices will conduct regional meetings with family organizations to improve consistency in inter-county interpretation of state laws/regulations/CCS program benefits and eligibility.

2) CRISS Medical Eligibility Work Group, with CCS medical consultants and 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.

3) Continue with the development of a universal consent form with parents to facilitate information sharing among agencies.

4) Develop tools such as a hard copy and/or electronic health record and child health notebooks, to assist families in tracking medical care.

5) FVCA will continue to 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.

6) State CMS and HRSA Project Grant (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.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				5.8	5.8
Annual Indicator	5.8	5.8	5.8	5.8	37.1
Numerator					
Denominator					
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	37.5	37.5	38	38	38

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 the country 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.

Notes - 2005
The data reported in 2002 have pre-populated the data for 2005 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. Due to small sample sizes, the relative standard error for every state except Maine was greater than 30 percent, so the national average is reported, which is 5.8 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) At the bimonthly meetings of the Family-Centered Care (FCC) Work Group, county CCS programs reported on transition activities. A matrix of transition activities of each of the 14 counties represented was maintained and updated.

2) CCS social work consultants continued to meet quarterly and discuss transition issues.

3) The CMS Branch reconvened a Statewide Workgroup on the Transition of Care for Children with Special Health Care Needs. The workgroup developed a five-phase work plan, which included project descriptions, timelines, work plans, and deliverables. The first task of the Workgroup was the development of minimum statewide standards and procedures for the transition of health care for CSHCN.

4) CMS Staff presented at the 2007 Family Voices of California 2nd Bi-Annual Parent Health Liaison Conference. The conference provided training to PHL and FVC members on transition issues facing CSHCN. The presentations included, "Transition to Adulthood", "The State's Vision of Transition and How to Operationalize that Vision", and "Limited Conservatorship and Special Needs Trusts, Living Options, and Employment."

5) CMS met with Kids as Self Advocates (KASA), a group of former CCS clients who provide input to CMS on transition issues for CSHCN, to identify issues they felt were most important when transition planning.

6) The Statewide Workgroup on the Transition of Care for CSHCN developed a CMS Numbered Letter (NL) on the minimum statewide guidelines for local CCS programs for the transition of health care for CSHCN. The NL is expected to be released in 2008.

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				X

evaluation of transition strategies.				
2. The FCC Work Group continues to monitor transition activities in the 14 CRISS counties.		X		
3. The CMS Branch continues to chair the Transition Workgroup to develop statewide guidelines and procedures for transition of care for CSHCN.				X
4. CMS social work consultants continue to meet on transition issues.		X		
5. 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		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Current activities include:
1) The FCC Work Group continues to monitor transition activities in the 14 CRISS counties.

2) CMS social work consultants continue to meet on transition issues.

3) 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.

4) CMS continues to collaborate with Counties, Family voices, and the KASA group on transition issues for CSHCN.

c. Plan for the Coming Year
1) Some counties have Transition Task Forces hosted by their county Developmental Disabilities Council (e.g. Alameda, Contra Costa). Some of these agencies will be hosting transition fairs and other activities to support this population.

2) The CRISS-FCC Work Group will continue to report on the many local activities around improving transition services.

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) The CMS Branch will continue to chair the Transition Workgroup to develop statewide guidelines and procedures for transition of care for CSHCN.

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	2003	2004	2005	2006	2007
Annual Performance Objective	75.8	75.8	78	82	78.4
Annual Indicator	77.4	81.3	77.9	80.3	80.3
Numerator	400715	417804	410274	433605	
Denominator	517719	513904	526667	539981	
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	78.9	79.4	79.9	80.4	80.9

Notes - 2007
A manual indicator is reported for 2007 based on 2006.

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.

Notes - 2005
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, 2005. Available at: http://www.cdc.gov/nip/coverage/nis/05/tab02_antigen_iap.xls Last accessed on February 7, 2007. Data for the 4:3:1:3:3 series used.
Denominator: The number of two-year olds in the given year is from the Department of Finance figures, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004. 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 77.9 percent in 2005, down from 81.3 percent in 2004. In 2006, the rate rebounded to 80.3 percent which is not significantly different from the national rate of 80.6 percent.

The current immunization rate meets 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 - 2006 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 to add Tdap vaccine as a CHDP benefit for purchase for 19 to 21 year clients, and to expand the lower age limit for FluMist™ (VFC) from 5 years to 2 years.

California has 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 53 of 58 California counties. Efforts are underway to improve the electronic exchange of information on patients moving between regions and jurisdictions and also on allowing schools, childcare centers, Medi-Cal, WIC, and Cal-WORKS to link into regional registries. It is anticipated that by 2009, 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 Branches, including 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 for CHDP and Medi-Cal.

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 information for patients moving between regions, and to allow schools, childcare centers, Medi-Cal, WIC, and Cal-WORKS to link into regional registries.			X	
7. The CMS and IZ Branches are collaborating to add Tdap vaccine as a CHDP benefit for purchase for 19 to 21 year clients, and to expand the lower age limit for FluMist™ (VFC) from 5		X		

years to 2 years.				
8. The CMS and IZ Branches are collaborating to expand the lower age limit for Meningococcal Conjugate vaccine (VFC) from 11 years to 2 years, and add preservative free Influenza vaccine for children 6 months through 35 months at increased reimbursement		X		
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 programs, including AFLP and BIH, continue to assess the immunization status of adolescent and women clients and their children on a periodic schedule, and to 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 streamlining and communicating our processes wherever possible.

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/OFP Branch will be working with the IZ Branch in its roll-out of the new adolescent immunizations over the next couple years.

CMS and IZ will be collaborating to adjust the reimbursement rates to equal Medi-Cal's for purchased vaccines Hepatitis A, Hepatitis B, HiB, and Pneumococcal Polysaccharide.

CMS and IZ, and Medi-Cal will be collaborating to increase reimbursement for some vaccines that have not had a rate adjustment since 2000.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	22.3	21.9	20	20.1	20
Annual Indicator	21.1	20.6	20.3	20.0	20.0
Numerator	16193	16263	16740	17208	17208
Denominator	766755	790821	822674	858626	858626
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	19.7	19.4	19.1	18.8	18.5

Notes - 2007
A manual indicator is reported for 2007 based on 2006.

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

Notes - 2005
Numerator: State of California, Department of Health Services, Center for Health Statistics, 2005 California Birth Statistical Master File. Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004. Tabulations were done by the MCAH/OFP Branch.

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, and down further to 20.0 in 2006.

Racial and ethnic differences in the adolescent birth rate persist. In 2006, Asians had the lowest birth rate for women 15-17 years old (5.4 births per 1,000 women), followed by Whites (5.6) Pacific Islanders (12.8), Multiple Race (13.2), American Indians (14.5) and African Americans (19.9). Hispanic adolescents had a birth rate of 35.4 (more than five times higher than the rates for Asians and Whites).

The MCAH and OFP Programs 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 enhancing the psychosocial and economic well-being of the adolescent family.

OFP programs include the Family Planning, Access, Care, and Treatment Program (Family PACT); the Teen Smart Outreach (TSO) Program; the Community Challenge Grant (CCG) Program; the Male Involvement Program (MIP); the Information and Education Program (I&E) and the Domestic Violence Program (DV).

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 as well as 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.

MCAH and OFP staff actively participated on the Preconception Care Council of California (PCCC), a partnership between the MCAH Program 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, including reproductive life planning and pregnancy spacing.

The Adolescent Sexual Health Workgroup (ASHWG), a product of national stakeholder meetings, is comprised of program managers from MCAH and OFP Programs, the STD Control Branch, the Office of AIDS, the CA Department of Education, and private partners. ASHWG is working in two priority areas: Data Integration and Core Competencies. The ASHWG Data Integration Subcommittee has 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. The Subcommittee is still working to resolve confidentiality issues regarding small cell sizes for syphilis, gonorrhea, and HV/AIDS data in age and race/ethnic categories, and to resolve dissemination issues and make the data available to LHJs.

ASHWG has drafted language on Core Competencies for adolescent sexual health providers. They 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 a 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 are being finalized in 2008.

MCAH participated in two national conferences that highlighted the value of ASHWG. At the AMCHP conference, MCAH facilitated a presentation on the evolution of ASHWG and the importance of ASHWG in accomplishing the MCAH mission. At the national STD conference, MCAH was part of a panel of ASHWG members. The presentation outlined the usefulness of each member's participation on ASHWG and the benefit to ASHWG.

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. The Teen Smart Outreach program does outreach to teens and offers counseling related to sexual and contraceptive concerns of adolescents and assists sexually active teens access family planning and reproductive health services through the Family PACT		X		
5. The Information and Education program provides community			X	

based educational services on teen pregnancy prevention.				
6. The Male Involvement Program provides community-based educational services which promote the involvement of young men in the prevention of teen pregnancy and unintended fatherhood.			X	
7. The Cal-SAFE program, 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	
8. MCAH and OFP collaborates with other key stakeholders at the state level, including the Dept of Education, the Office of AIDS, and the STD Control Branch, to better coordinate efforts in HIV, STD, and teen pregnancy prevention.			X	
9. MCAH, OFP and key stakeholders collaborate on data integration to generate STD, HIV, and birth data for 2000-2004.				X
10. 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

b. Current Activities
AFLP provides case management services to pregnant and/or parenting teens, serving about 18,000 teens annually.

The Family PACT Program provides family planning services, testing and treatment of STDs, education and counseling for low-income Californians. Family PACT serves 1.7 million clients a year, including 300,000 adolescents. Family PACT continues efforts in the areas of client outreach; provider recruitment, training, and technical assistance; and the addition of new FDA approved contraceptive methods to the benefits package.

CCG promotes community-based partnerships to develop effective local teen pregnancy prevention programs, to promote responsible parenting, and to involve fathers in the economic, social, and emotional support of their children. CCG funds 116 community agencies and serves about 167,000 teens annually.

MIP promotes the involvement of young men in the prevention of teen pregnancy and unintended fatherhood. MIP funds 21 agencies and serves about 30,000 adolescent boys and young adult males annually. OFP Information and Education (I&E) projects operate in 27 community agencies and serve about 57,000 youth in grades 6 to 12 annually. I&E projects and Male Involvement Programs are currently developing strategies to increase access to Family PACT services.

OFP contracts with the UCSF Bixby Center for Reproductive Health Research & Policy to provide program monitoring and evaluation services for the Family PACT, TSO, CCG, MIP and I&E programs.

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.

AFLP, Family PACT, TSO, CCG, MIP and I&E will continue their teen pregnancy prevention efforts. TSO, CCG, MIP and I&E Programs now require clinical services linkages, i.e., they must demonstrate formal referral mechanisms and collaboration with one or more Family PACT providers. They are currently working to develop and implement teen specific strategies to

increase access to Family PACT services. However, in response to the budget deficit facing California, proposed budget balancing reductions could result in less program evaluation, education, and outreach for teen pregnancy prevention programs.

The recently implemented increase in permissible case load for AFLP case managers from 40 to 50 clients per month is designed to continue to make AFLP services available by lowering program costs due to local budget concerns. As these increased case loads are implemented, it will result in less staff time available per client.

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 Subcommittee is also investigating the possibilities for integration of youth sexual behavior data.

The Core Competencies for providers of adolescent sexual and reproductive health have been finalized, and are ready for dissemination. Using the Competencies as a framework, ASHWG will also pursue opportunities for joint training between agencies. In addition, MCAH will develop a mechanism to determine their implementation and application in MCAH programs.

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.

The PHHI plans to launch a website that will provide information for people working in preconception health and will 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 complete a Teen Birth Rate Resource, which will include detailed maps and tables of teen birth rates by race/ethnicity, for targeting of teen pregnancy prevention efforts.

Through a collaboration between the PCCC and AFLP, a new reproductive life planning tool for teens is being piloted in Sacramento County and will be available for use by MCAH programs.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	19.9	20.2	31	27.6	27.6
Annual Indicator	31.0	27.6	27.6	27.6	
Numerator	157000	132808	130064	129152	
Denominator	506000	481280	471246	467943	
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
	2008	**2009**	**2010**	**2011**	**2012**

Annual Performance Objective	28.1	28.6	29.1	29.6	30.1

Notes - 2007
A manual indicator is reported for 2007 based on 2006

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

Notes - 2005
Source of the percent of third grade children with sealants: Dental Health Foundation, California Smile Survey: An Oral Health Assessment of California's Kindergarten and 3rd Grade Children. http://www.dentalhealthfoundation.org/topics/public/index.shtml. Based on the weighted results from a completed survey of a representative sample of elementary schools in California, 2005. Dental sealant information is based on a one-minute, non-invasive oral health screening of all third graders in selected schools using protocols from the Association of State and Territorial Dental Directors.
Denominator: State of California, Department of Education 3rd graders in 2005-2006 school year (http://data1.cde.ca.gov/dataquest/). Numerators are estimates derived by multiplying the percentage of 3rd graders with identified dental sealants as determined by the 2005 Oral Health Needs Assessment of Children.

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 sealant in California is estimated to be 27.6 percent in 2006. The Healthy People 2010 objective is 50 percent.

The numerator for this performance measure is from the Oral Health Needs Assessment (OHNA), a survey of a representative sample of elementary schools in California in 2005-2006. 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 Program 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.

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 and the Head Start Oral Health Work Group.

To meet the growing demand for technical assistance at both the state and local levels, the MCAH Program contracted with UCSF School of Dentistry for a dental hygienist to serve as the MCAH Oral Health Policy Consultant. Current oral health information has been distributed among MCAH Program staff as well as local jurisdictions. Several presentations were given to local health advocacy groups on maintaining good oral health during pregnancy and the prevention of early childhood caries.

Beginning in June 2006 the application of fluoride varnish by doctors and nurses was added as a reimbursable Medi-Cal benefit for children younger than six years of age. Because many dentists are not willing to see children this young, medical providers offer the best hope for preventing and controlling tooth decay through the application of fluoride varnish. In order to assess the impact for children of this policy change, OHAC, of which MCAH is a member, will be working to identify the extent of provider participation and patient utilization. Identification of provider participation and patient utilization will be critical for future development of targeted provider and patient education strategies.

Beginning in January 2007, California law requires that children receive a dental check-up within the last 12 months and up to May 31 of their first year in public school (kindergarten or first grade). The program will identify children who need further dental examination and treatment, and also identify barriers to receiving dental care.

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 a year and is developing an Oral Health for Infants and Toddlers Provider Training Manual for county programs.		X		
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 Program, with key stakeholders (e.g. Medi-Cal, State First 5 Commission, CMS and APPP), is implementing the "State Team Action Plan" to increase integration of oral health into existing MCAH programs.				X
6. The MCAH Program 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. Beginning in 2007, 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				X

existing CDDPP school-based oral health preventive service programs.				
10. The CA Dental Association Foundation is expanding its Pediatric Oral Health ACCESS Program (POHAP) by offering pediatric dentistry training to 300 dentists statewide to increase their skills to treat young children.				X

b. Current Activities

The MCAH Program continues to meet monthly with key stakeholders (e.g. Medi-Cal, First 5, CMS and AAP) to develop and implement the California State Action Plan as part of the Best Practices for Oral Health Access initiative. This plan will increase the integration of oral health into existing MCAH/OFP programs.

The Dental Health Foundation was awarded a HRSA "Targeted State MCH Oral Health Service Systems" four-year grant. The proposed program will provide screening, health education, fluoride varnish and dental referral resources to WIC families. MCAH has joined the project advisory committee to provide technical assistance.

Ten MCAH programs 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 into MCAH target populations. 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.

In Contra Costa County the Save Our Smiles project, a school-based preventive dental health program, provides oral health education to primary school children, preschool and Head Start teachers, and parents of preschoolers. The program also provides screenings and referrals as well as fluoride treatment and dental sealants for some children.

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. 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.

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 will continue to follow the CDDPP model of screening, preventive treatment and education for 9500 children per year.

The CA Dental Association Foundation is expanding its Pediatric Oral Health ACCESS Program (POHAP). Enhancing general dentists' skills and comfort levels to treat young children, including those with special health care needs, further increases access to the MCAH population.

Given that dental decay is the most common chronic childhood disease, the MCAH Program 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 jurisdiction oral health activities.

Oral health educational materials (in English and Spanish) that address early childhood dental decay prevention for mothers and young children will continue to be distributed through

MCAH/OFP programs. Other health programs within and outside the state have also requested CDPH materials.

As a member of the California State Action Plan, MCAH Program 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) Convening an expert advisory panel to review oral health content of existing programs and make evidence-based content recommendations, including defining what the minimum oral health content of each program should be and metrics that will allow measuring program changes over time.

3) Prioritizing programs needing new or revised oral health content and developing new or revised content for them with consultation from the expert advisory panel.

4) Establishing a procedure for periodic review of oral health content of programs to assure it is current with the latest science.

5) Assisting local MCAH programs 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 programs.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	2.6	2.6	2.9	3	3.1
Annual Indicator	3.6	3.1	3.2	2.6	2.6
Numerator	289	250	257	218	
Denominator	7960784	7951488	7930829	8228513	
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	3	2.9	2.9	2.8	2.7

Notes - 2007
A manual indicator is reported for 2007 based on 2006.

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

Notes - 2005
Source Data: Numerator: State of California, Department of Health Services, Center for Health Statistics, 2005 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. May 2004. Tabulations (by place of residence) were done by the MCAH/OFP Branch.

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. Between 2000 and 2002, the rate was relatively stable, fluctuating between 2.8 and 3.1. In 2003 the motor vehicle death rate jumped to 3.5, then returned to 3.0 in 2004 and has since decreased to 2.6 deaths per 100,000 in 2006.

There is little variation in this measure by race/ethnicity. The rate is lowest for Whites at 2.3 per 100,000, followed by 2.8 for Hispanics, and 5.0 for African Americans. (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 Program, CIPPP has 1) provided technical assistance to local health jurisdictions, 2) organized an annual statewide childhood injury prevention conference, 3) held a bi-monthly injury prevention teleconference with injury prevention professionals, and 4) provided local jurisdictions with regular reviews of the current injury prevention literature.

Due to Title V budget cuts in FFY 2005-06, funding for the MCAH Program contract with CIPPP was reduced. The reduction eliminated funding for the annual statewide conference and the bimonthly injury prevention teleconferences, as well as reducing the level of technical assistance provided to local health jurisdictions.

The MCAH Program provides funding to local health jurisdictions (58 counties and three cities) in support of local efforts to promote maternal and child health; local jurisdictions may use this funding for child injury prevention, among other projects. The Branch has been allocating additional funding for local childhood injury prevention programs in five counties in three-year cycles. However, this funding, specifically for childhood injury prevention, 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, 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 EPIC Branch.

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.

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 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.

AFLP and CPSP provide educational materials on use of car seats and child injury prevention. San Diego County MCAH developed a low literacy curriculum covering health and safety information from pregnancy through age 3, which has been converted to a flip chart format to carry to client homes to provide ongoing education tailored to the needs of the family.

CIPPP provides technical assistance to local health jurisdictions in developing, implementing and evaluating injury prevention programs.

The MCAH Program collaborates with the CDPH Epidemiology and Prevention for Injury Control (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.

The MCAH and OFP Programs continue 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 and OFP Programs, CIPPP and local health jurisdictions will be continued.

The MCAH and OFP Programs 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/OFP and EPIC Branches, the California Highway Patrol (CHP), the California Office of Traffic Safety, the California Alcohol and Beverage Control, the California Department of Education (CDE), and the California Department of Transportation (CalTrans).

The SCOTS task force was established to unite traffic safety stakeholders throughout the state to engage interagency public and private partnerships to employ diverse evidence based interventions to reduce motor vehicle fatalities in California. The MCAH/OFP Branch's participation in SCOTS has lead to an increased awareness among California's motor vehicle injury stakeholders regarding the rise of fatal motor vehicle injuries in California's adolescent and young adult populations and has lead the task force to adopt this particular indicator as a priority area.

As an active partner in the SCOTS coalition, the MCAH and OFP Programs have 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.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				69.6	71
Annual Indicator		69.1	70.2	69.4	69.4
Numerator		361762	369404	377112	
Denominator		523322	526361	543134	
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	71.5	72	72.5	73	73.5

Notes - 2007
A manual indicator is reported for 2007 based on 2006.

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.

Notes - 2005
Percent of mothers breastfeeding at 2 months of age reported. Six month breasteeding data not available. Source: State of California, Department of Health Services, Maternal, Child and Adolescent Health/Office of Family Planning Branch, 2004 Maternal and Infant Health Assessment. Survey data weighted to population of mothers who delivered live infants in survey year. Tabulations were done by the MCAH/OFP Branch.

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 two months of age.

The percentage of California mothers who breastfeed their infants at two months of age is 69.4 percent for 2006. (Data for this performance measure come from California's Maternal and Infant Health Assessment survey, a survey of postpartum mothers that is modeled after the PRAMS.)

There are notable racial/ethnic disparities on this measure. In 2006, Asian women had a higher percentage of women breastfeeding (76.8) than White women (73.6). Latina women (66.8), African American women (60.7), and women of other race/ethnic groups (66.3) had rates of breastfeeding below the state rate.

Last year's accomplishments include:
MCAH, OFP and WIC collaborate on many breastfeeding promotions and share data on breastfeeding. RPPC, CPSP, BIH, CDAPP, AFLP, Cal-SAFE, and Cal-Learn continue to promote exclusive breastfeeding among their constituencies. BIH promotes breastfeeding among African American women. CDAPP promotes breastfeeding as beneficial in reducing the risk for diabetes. AFLP, Cal-SAFE, and Cal-Learn encourage breastfeeding among teen mothers, who are less likely to breastfeed.

The MCAH Local Health Jurisdictions continue to support breastfeeding via their Title V allocation funding. Sample activities include: Alameda County works with moms to improve the number of African American women who breastfeed their infants. Amador County's breastfeeding coalition is educating and providing support for breastfeeding families and promoting breastfeeding as a cultural norm. Calaveras County, with their breastfeeding coalition, promotes a breastfeeding friendly environment in all communities. Del Norte County provides visits to new moms at local hospitals offering public health nursing home visits as well as information regarding services. Kern County oversees the breastfeeding comfort line, a service that answers questions about breastfeeding 7 days a week, 8-10 hours a day. Madera County breastfeeding coalition supports "Heart to Heart" activities and offered a human milk education presentation. Mono County supports home visits by trained lactation assistors that support employees to continue breast feeding when they return to work. Orange County developed and disseminates a county wide breastfeeding directory.

In 2006, only 43 percent of California newborns were exclusively breastfed in the early

postpartum period. Disparities in exclusive breastfeeding rates were found to be lowest for Hispanics (32 percent), African Americans (34 percent), and Pacific Islanders (41 percent), which are well below the rate for whites (64 percent) and the recommended Healthy People 2010 goal of 75 percent. The MCAH Program provided technical assistance to hospital staff using the hospital breastfeeding toolkit at labor and delivery hospitals to improve hospital lactation policies, including the use of quality assurance indicators.

MCAH Program staff provided technical assistance to other partners, such as the Medi-Cal Managed Care Quality Improvement meeting, Office of Women's Health workplace breastfeeding support group, United States Breastfeeding subcommittee, obesity conference, and Medi-Cal breastfeeding benefits workgroup.

The MCAH breastfeeding website expanded to include resources on 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.

Statewide breastfeeding surveillance mapping has been completed. Special attention was given to areas with low breastfeeding rates.

MCAH and OFP staff provided technical assistance to other partners, such as the Medi-Cal Managed Care Quality Improvement meeting, Office of Women's Health workplace breastfeeding support group, United States Breastfeeding subcommittee, and Medi-Cal breastfeeding benefits workgroup.

New breastfeeding websites were developed for CDPH (http://www.cdph.ca.gov/HealthInfo/healthyliving/childfamily/Pages/BreastfeedingandHealthyLiving.aspx) and the MCAH Program (http://www.cdph.ca.gov/programs/BreastFeeding/Pages/default.aspx).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The AFLP, Cal-SAFE, and Cal-Learn promote 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. WIC has conducted peer counseling training at various local BIH sites.		X		
4. The MCAH, OFP and CMS Branches are participating on the CDPH Obesity Prevention Group; breastfeeding promotion is one of the interventions for childhood obesity prevention.				X
5. MCAH and OFP Branch 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, OFP and WIC Branches collaborate on many breastfeeding promotion activities; such as sharing data on breastfeeding, and convening the State Breastfeeding Promotion Advisory Committee.				X
7. The MCAH, OFP Branch and RPPC are providing toolkits and		X		

technical assistance to staff at labor and delivery hospitals to improve hospital lactation policies.				
8. MCAH and OFP staff maintain Branch website information on advocacy groups, hospital-specific data on breastfeeding at hospital discharge, MCAH reports, and model hospital breastfeeding policies.				X
9. CDAPP coordinators are updating Sweet Success Guidelines for care, which should be released by early 2008. The guidelines include the types of birth control that are most suitable for breastfeeding mothers with diabetes.				X
10. MCAH and OFP staff are standardizing information provided to mothers about birth control and breastfeeding, as well as to hospitals about which birth control methods are compatible with in-hospital breastfeeding initiation.				X

b. Current Activities

1) MCAH continues to send annual hospital breastfeeding rates, resources, and an offer of technical support to all labor and delivery hospitals' CEOs and Directors of Nursing.

2) The MCAH nutritionist continues as the alternate for the Association of State and Territorial Public Health Nutrition Directors on the United States Breastfeeding Promotion Committee. She is an active member of the Workplace subcommittee.

3) 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.

4) MCAH staff surveyed women utilizing the East End lactation rooms in 2005, 2007 and 2008 and are providing recommendations to the Director of Public Health.

5) 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.

The Contra Costa County's Breastfeeding Task Force provided a toll-free telephone warm line where callers can get advice from lactation specialists about breastfeeding their babies. Between July 2006 and June 2007, volunteers returned more than 100 calls.

In Los Angeles County eight PHNs that are Certified Lactation Educators serve as consultants for all Nurse Family Partnership, Prenatal Care Guidance and BIH staff.

c. Plan for the Coming Year

Plans for the coming year include the following:

1) CPSP's "Steps to Take" breastfeeding pages will be updated with materials developed by WIC and the National Breastfeeding Campaign to encourage labor and delivery options that promote, protect and support breastfeeding families.

2) CDAPP coordinators are currently in the process of updating Sweet Success Guidelines for Care. The Guidelines will emphasize types of birth control for diabetic mothers that do not negatively affect glycemic control or interfere with breastfeeding.

3) The MCAH Program shares information with its programs during World Breastfeeding Week

held August 1-8 every year. MCAH will send out emails to all county and CBO affiliates encouraging their participation in the celebration.

4) As members of the California Breastfeeding Coalition (CBC), MCAH collaborates with local breastfeeding coalitions, the California WIC Association (CWA) and other CDPH programs to support breastfeeding. MCAH is a cosponsor for the Breastfeeding Awareness Walk, October 15, 2008. In conjunction with the walk, CBC will again honor three outstanding employers; local coalitions are encouraged to celebrate their employer awards simultaneously. CWA will also release a new policy brief that day on Low Wage Worksite Lactation Support.

5) RPPC coordinators will expand their focus on technical assistance and promulgating quality assurance measures to assess each client's breastfeeding success during her hospital stay. Evaluation of their effectiveness will be based on improving exclusive hospital breastfeeding rates.

6) Lactation technical assistance, material development and trainings will continue for the MCAH programs, especially for CPSP, AFLP, RPPC, CDAPP, and BIH.

7) MCAH has created Birth and Beyond California Project to provide technical assistance and training to hospitals in areas of California with the lowest exclusive breastfeeding rates. Beginning in January 2008, hospital administrators in the Central Valley 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 created to assist in maintenance of improvements in the communities. MCAH will be expanding its Birth and Beyond California Project to provide technical assistance and training to Orange County, another area with the lowest exclusive breastfeeding rates.

8) In response to California Senate Bill 22, WIC and the MCAH Program are developing a web based curriculum for hospital administrators to move them towards the model hospital breastfeeding policies.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	60	70	70	75	75
Annual Indicator	56.2	68.6	75.0	75.7	76
Numerator	304469	374096	411162	425638	
Denominator	541760	545329	548216	562157	
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	85	95	95	95	95

Notes - 2007

Section Number: Performance Measure #12
Field Name: PM12
Row Name:
Column Name:
Year: 2007
Field Note:

Manual indicator is reported for 2007 based on 2006 results.

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.

Notes - 2005
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 Health Services, Office of Vital Records, birth certificate data.
Numerator: Number of newborns who have been screened for hearing before discharge for FY 2005.
Denominator: Number of live births by occurrence in California in FY 2005.

a. Last Year's Accomplishments
NPM 12 is the percent of newborns who have been screened for hearing loss before hospital discharge. California legislation was expanded effective January 2008 to require all general acute care hospitals with licensed perinatal services to participate in the Newborn Hearing Screening Program (NHSP). This will increase the number of hospitals that are certified and reporting data from 176 to 272. 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) 2006, 425,638 infants, or 75.7 percent of all California newborns, received newborn hearing screening prior to hospital discharge. This was an increase of 3 percent from CY 2005 and meets the objective of 75 percent. The infants screened in CY 2006 comprise 98 percent of the target population of infants born in certified hospitals.

DHCS has no statewide data management capabilities and 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) One training session for community audiologists was provided on diagnostic audiologic evaluation of infants with hearing loss. This was a three-part training with a 6-week on-line component, a two-day on-site workshop, and a practicum. The workshop, held in November 2006, had twenty-five participants.

2) California was one of eight states that participated in a learning collaborative with the National Initiative for Children's Healthcare Quality (NICHQ) to reduce loss to follow-up. The California team showed significant improvements in the no-show rate for follow-up appointments and in the reporting of primary care provider and additional family contact information.

3) The California NHSP presented results of the NICHQ collaborative as part of a plenary session at the national Early Hearing Detection and Intervention Conference in Salt Lake City in March 2006.

4) The CMS Branch has developed and released a Request for Proposals (RFP) to incorporate the increased workload and funding for the HCCs.

5) The CMS Branch completed regional meetings with staff of the non-CCS approved hospitals to introduce them to the NHSP and the certification process.

6) The CMS Branch negotiated a data use agreement with the Department of Developmental Services to obtain the dates of the Individualized Family Service Plans (IFSP) on infants from the NHSP receiving early intervention services through Regional Centers.

7) 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 participate in the review and selection of contractors to implement the parent support activities in the grant from MCHB.		X		
2. Activities to procure 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) Evaluation and selection of HCC contractors 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) The CMS Branch expects to have more than half of the 95 expansion hospitals certified and participating in the program by June 30, 2008.

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 to present aspects of the program at the International Newborn Hearing Screening Conference in Como, Italy in June 2008.

6) CMS revised the RFP for the data management service to incorporate the program expansion. The RFP was released; a contractor is expected to be selected this year.

7) The CMS Branch collaborates with the DDS to obtain IFSP dates on infants in the NHSP on a quarterly basis.

8) The CMS Branch continues facilitation of the learning collaborative that was initiated as part of the NICHQ collaboration.

9) The CMS Branch participates in the review and selection of contractors to implement MCHB grant parent support activities.

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 assist 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 NICHQ learning collaborative.

5) The CMS Branch plans to develop communication with the California Academy of Audiology, the statewide audiology association, regarding standards of practice and access to pediatric audiology services.

6) The CMS Branch will produce new issues of the Audiology Bulletin to address additional areas of interest to pediatric audiologists.

7) 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	2003	2004	2005	2006	2007

Performance Data					
Annual Performance Objective	15.5	15.5	12.9	13	13.5
Annual Indicator	13.1	13.1	13.6	13.9	13.9
Numerator	1317215	1323850	1443896	1458592	
Denominator	10055080	10105720	10616890	10493468	
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	13.3	13.1	12.9	12.7	12.7

Notes - 2007
A manual indicator is reported for 2007 based on 2006.

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.

Notes - 2005
Source: Estimated percent of uninsured children (age 0-18) is from the Kaiser Family Foundation analysis of the March 2006 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, May 2004. The numerator was derived by multiplying the percent uninsured by the denominator.

a. Last Year's Accomplishments
The percent of children in California aged 0-18 who were uninsured declined from 15.7 percent in 2000 to 13.1 percent in 2004, and increased to 13.9 percent in 2006. This 13.9 percent represents over 1.4 million children. The Healthy People 2010 objective is zero percent uninsured.

California's data for NPM 13 are for children ages 0-18 and are based on the U.S. Current Population Survey. Estimates derived from the 2005 California Health Interview Survey (CHIS), which utilizes a different survey methodology, produce slightly lower numbers [60]. According to the 2005 CHIS, 1.1 million California children age 0 to 18 (11.3 percent) lacked health insurance coverage all or part of the year in 2005. [61]

Insurance coverage rates depend largely on three sources of coverage: job-based insurance, Medi-Cal and Healthy Families. According to the 2005 CHIS, just over half of children aged 0-18 were covered by job-based health insurance, and one-third were enrolled in California's Medi-Cal and Healthy Families programs [62]. Of California's uninsured children, 429,000 (55 percent) were eligible for enrollment in Medi-Cal or Healthy Families. Another 97,000 uninsured children were eligible for one of the 14 county-based Healthy Kids programs in 2005, but not enrolled. The remaining 219,000 uninsured children were not eligible for these public programs because of their family incomes or lived in counties without a Healthy Kids expansion program. [63]

The number of uninsured children in California could be reduced by more than half 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 to enrollment included a shortened joint application for both Medi-Cal and HF, the elimination of quarterly status reports under Medi-Cal, and an on-line enrollment system. 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 old 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 is given a temporary Medi-Cal Benefits Identification Card. With this card, a child has access to no-cost, full-scope fee-for-service Medi-Cal benefits for up to 60 days. From July 2003 through December 2007, 3.2 million children were pre-enrolled in the Gateway, and 77 percent requested a joint application for Medi-Cal and HF.

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. The WIC Gateway 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 Healthy Families and to 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 for enrolling tens of thousands of uninsured children into Medi-Cal and Healthy Families.

Many counties (Humboldt, Santa Clara, San Mateo, Los Angeles, Mendocino, etc.) have created Children's Health Initiatives (CHI) to locally fund insurance programs for children in families that are not eligible 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 CHIs emphasize streamlined enrollment into Health Families, 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.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCAH 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 and OFP programs, including AFLP, BIH, BWSP, 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.

Local CHDP programs inform new providers about the Gateway and direct these providers to CHDP Gateway resources. Modifications, effective June 1, 2004, revised the Gateway pre-enrollment process allowing the Gateway transaction to identify and "deem" certain infants under one year of age as eligible for ongoing, full scope, no cost Medi-Cal at the time of a CHDP assessment.

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 to navigate the complex eligibility structures of Medi-Cal and HF.

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 who are served at local WIC agencies.

c. Plan for the Coming Year
MCAH and OFP programs, including AFLP, BIH, BWSP, and CPSP, will continue to encourage and facilitate enrollment in Medi-Cal and HF and CHI.

The CMS Branch will continue to analyze CHDP Gateway data reports to monitor program operations and the needs of CHDP local programs and CHDP providers.

DHCS and MRMIB will continue to implement and support improvements in the process of eligibility determination and enrollment for Medi-Cal and HF.

Over the next year, DHCS and the WIC Program will conduct a feasibility study report (FSR). The FSR will determine the viability of the WIC gateway and help guide its development and implementation.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				33.7	33.6
Annual Indicator		33.8	33.7	33.2	33.2

Numerator		114071	111876	112867	
Denominator		337488	331975	339961	
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	33.6	33.5	33.5	33.4	33.4

Notes - 2007
A manual indicator is reported for 2007 based on 2006.

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.

Notes - 2005
Data Source: Centers for Disease Control and Prevention, Pediatric Nutrition Surveillance System (PedNSS) Annual Reports for Calendar Year 2004. Table 16C, children age 24-59 months. 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.dhs.ca.gov/pcfh/cms/onlinearchive/pdf/chdp/informationnotices/2005/chdpin05d/contents.htm. Last accessed on March 28, 2006.

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 2006 Pediatric Nutrition Surveillance System (PedNSS) revealed that 33.2 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.

Prevalence rates differ by race/ethnicity. For 2006, Pacific Islander children were most likely to have a BMI at or above the 85th percentile (43.8 percent), followed by American Indians/Alaska Natives (39.9 percent), Hispanics (34.8 percent), Whites (28.8 percent), African Americans (27.9 percent), Filipinos (27.5 percent) and Asians (26.6 percent).

The MCAH Program took the lead in promoting early intervention to reduce childhood obesity. It focused on 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.

MCAH and CMS assisted in the development and delivery of the 2007 California Childhood Obesity Conference. Many MCAH local health jurisdictions and other MCAH contractors were able to attend.

Cholesterol and fasting blood glucose screening tests for children at risk for obesity and/or cardiovascular disease were added as CHDP program benefits.

Health departments in mid-size counties, such as Santa Barbara County, worked closely with medical providers to ensure BMI documentation by creating a follow-up system which includes referral and intervention. Health departments in larger counties, such as Santa Clara County, met with local HMOs to share PedNSS data and collaborate on intervention approaches. Five counties are participating in the California Endowment's four-year project to demonstrate Healthy Eating and Active Communities (HEAC). There are six Healthy Tomorrow grants in California. Topics include: school health, obesity, oral health, SCHIP and medical home.

Blue Cross of California and the CHDP program collaborated to provide BMI training for office medical staff including CHDP providers and their staff. One-hour BMI workshop luncheons/dinners were held from May to December 2006 throughout California. CHDP providers were encouraged to use the tools provided at the workshop to measure and document BMI in their medical offices.

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. AFLP and the oral health programs are promoting healthy food choices and physical activity.		X		
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 proper nutrition by encouraging healthy eating through discussions on how to cut fat and lower calories.		X		
7. CDAPP promotes breastfeeding and optimal nutrition and provides counseling to women to encourage optimal pregestational weight, optimal pregnancy weight gain, and		X		

glycemic control during pregnancy.				
8. The MCAH Program 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 Program and CMS Branch 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.				

b. Current Activities
The MCAH Program's main approach to preventing overweight among children 2-5 years is to focus on modifying risk factors which are independently related to the later risk of obesity, including risk factors before pregnancy, in-utero, and in infancy.

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 to related programs.
MCAH collaborates with multiple partners to promote healthy lifestyles (healthy food choices, physical activity and breastfeeding) and thus reduce the prevalence of obesity and its associated health risks. Partners include: the Network for a Healthy California, California Project LEAN, the California Obesity Prevention Initiative (COPI), the California Center for Physical Activity, WIC, and the CDPH Director's Coordinating Office for Obesity Prevention (CO-OP).

The MCAH Program is working with counties to address the preconception period as it affects obesity. Two examples are: 1) San Luis Obispo County developed a curriculum on nutrition and exercise for the preschool population, and 2) Alameda County Faith Initiative collaborative launched a community gardening project to provide hands-on training for setting up an edible back yard garden.

c. Plan for the Coming Year
The MCAH Program continues to 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 Program and CMS Branch will continue to participate on the Obesity Prevention Group (OPG), chaired by CO-OP, which aims to integrate obesity prevention into CDPH programs, develop an action plan, and obesity-related proposals and plans for funding opportunities.

Similar to previous years, MCAH and CMS will be partners in planning for the 2009 Childhood Obesity Conference.

MCAH is rewriting a cookbook for teens planned for distribution next year. The book will utilize basic cooking information and recipes from a previously developed MCAH cookbook. Options for substituting seasonal fruits and vegetables and recommendations for physical activity will be included.

The PCCC is developing a curriculum with a component on healthy weight and optimal glycemic control prior to pregnancy for integration into existing MCAH programs.

The MCAH Program continues to provide nutrition, physical activity, breastfeeding resources and

intervention ideas to MCAH health jurisdiction directors. Local health jurisdiction activities include (but are not limited to) the following:

Amador County MCAH is a member of connecting HANDs which supports educational efforts in hope to change nutritional habits of adults and their children. This includes nutrition information in the baby welcome wagon parent kit; participation on the Healthy School Committee and media pieces on nutrition and fitness for adults and children.

Colusa County MCAH collaborates in county planning activities that increase the awareness, knowledge and behaviors that support healthy weight of children; their health service advisory committee shares and exchanges nutritional data; and they participate on their school nutrition action council and physical activity committee.

Modoc County has a Health through Nutrition and Activity Development Project (Modoc H.A.N.D project).

Orange County is working to decrease prevalence of childhood overweight through training providers e.g. WIC and MCH clinics.

Santa Clara has a model Black Infant Health Program that addresses nutrition and physical fitness including participation in walk to school day.

Sonoma County has a family nutrition and physical activity task force. Santa Barbara County is providing home visits by PHN's to provide nutrition information, physical activity suggestions and appropriate medical referrals to families with an identified overweight child.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				3.4	3.7
Annual Indicator		3.4	3.8	3.0	3
Numerator		18154	20218	16544	
Denominator		530756	532721	555604	
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	3.6	3.5	3.4	3.3	3.2

Notes - 2007
A manual indicator is reported for 2007 based on 2006.

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.

Notes - 2005
Source: State of California, Department of Health Services, Maternal, Child and Adolescent Health/Office of Family Planning Branch, 2004 Maternal and Infant Health Assessment survey. Survey data weighted to population of mothers who delivered live infants in survey year. Tabulations were done by the MCAH/OFP Branch.

a. Last Year's Accomplishments
In 2006, 3.0 percent of women who gave birth reported smoking during the last trimester of pregnancy. Smoking during pregnancy has declined by 47 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 2006, American Indian/Other women were most likely to smoke during the last trimester (7.4 percent), followed by White women (5.3 percent) and African American women (4.7 percent). This differs in comparison to 2005 in that there is a significant decline for White women (from 7.8 percent to 5.3 percent) and African American women (7.0 percent in 2005 to 4.7 percent) and a 24 percent increase for American Indian/Other women (from 5.6 percent in 2005 to 7.4 percent in 2006).

Most recently, the percentage of all women in California who smoke decreased by 18 percent from 11.1 percent to 9.1 percent between 2005 and 2006. 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 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 Program's Preconception Health and Healthcare Initiative (PHHI) and is critical to the work of the Preconception Care Council of California (PCCC). The PCCC 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.

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 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 Care Council of California (PCCC) was developed under the leadership of MCAH/OFP and the CA Chapter of MOD and is composed of organizations committed to creating and providing preconception care 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 now includes links to the CDPH California Tobacco Control Section's tobacco prevention efforts.				X
10. CDAPP 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 at entry and annually for past smoking habits, current smoking habits, and exposure to second hand smoke. Case managers discuss the risks of smoking for the mother and baby during pregnancy and after birth.

BIH clients, individually or in small groups, receive education about smoking and health. The BIH Scope of Work includes smoking cessation to reduce low birthweight rates.

CPSP guidelines "Steps to Take" assist providers and practitioners with health education, nutrition, and psychosocial intervention guidelines. "Camera ready" handouts, in English and Spanish, are available for CPSP to educate women about smoking cessation.

The CDPH Tobacco Control Section supports multiple statewide, regional, county, and community smoking cessation projects.

The California Smokers' Helpline provides intensive tobacco cessation counseling, which includes tailored counseling for teens, adults, and pregnant women. Perinatal Services Coordinators from local MCAH health jurisdictions have consulted with educational experts at the Helpline for outreach educational materials.

The PCCC is developing a curriculum on preconception health with a module that focuses on helping women (and their partners) to stop smoking in the event that they may have a baby in the future.

The Los Angeles Collaborative to Promote Preconception/Interconception Care held a successful train-the-trainers event for 135 public health providers in March 2008.

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. There are plans to include this presentation at an MCAH/OFP Branch meeting later this year.

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 PCCC and the Los Angeles Collaborative will continue to include smoking cessation as an important component of their work to improve the health of women of childbearing age. The MCAH Program's PHHI plans to launch a website that will connect people working in preconception health and will feature links to tools and resources such as the CDPH Tobacco Control Section's tobacco prevention efforts, the California Smokers Helpline and other smoking cessation programs.

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	2003	2004	2005	2006	2007

Data					
Annual Performance Objective	4.7	4.6	4.8	5.6	4.7
Annual Indicator	5.0	5.7	4.9	5.2	5.2
Numerator	131	153	135	150	
Denominator	2617630	2689492	2762949	2865987	
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	4.7	4.6	4.6	4.5	4.4

Notes - 2007
A manual indicator is reported for 2007 based on 2006.

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

Notes - 2005
Source Data: Numerator: State of California, Department of Health Services, Center for Health Statistics, 2005 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. May 2004. Tabulations (by place of residence) were done by the MCAH/OFP Branch.

Provisional 2005 data submitted for last year's Title V report have been updated (July 2008).

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 2005, the rate fluctuated around 5.0. In 2006, the rate was 5.2.

Due to Title V budget cuts in FY 2005-06, the contract with AHC for adolescent health improvement was eliminated; it is being reinitiated in 2008 with redirected funding.

The MCAH Program collaborated with the Medi-Cal Managed Care (MCMC) Division on their Interagency Work Group for the Behavioral, Emotional, and Social Screening and Treatment for Primary Care Providers (BEST-PCP) Project, which ended at the end of 2006. BEST-PCP focused on a discrete set of policy and structural issues at the state and county levels to facilitate meaningful change at the practice level. The project developed and implemented a model for changing provider practice as the basis for broader collaborative quality improvement efforts. The

target population was age 0-3 years. By addressing the behavioral, emotional, and social health of very young children, this model has the potential for improvements in social, emotional, and mental health of children as they get older.

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 Program 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.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

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 and OFP 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 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 as well.

In the fall of 2004, California voters passed the Mental Health Services Act (MHSA), 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 now begun, and the availability of county mental health services is gradually improving. The first counties to receive MHSA grants were Stanislaus, Mendocino and Los Angeles. Grants to other local jurisdictions have followed. 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.

c. Plan for the Coming Year

The MCAH and OFP Programs will continue to look for opportunities to incorporate positive youth development into its programs and coordinate with others in the State to work to increase the assets of our youth. MCAH and OFP will continue to work with AHC and others to promote best practices in mental health and to investigate best practices in suicide prevention. This will include particular attention to the foster youth population.

The MCAH and OFP Programs 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), and the Department of Health Services to address systemic barriers and create pathways to service delivery. The Branch 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.

The MCAH and OFP Programs 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 contracted with the California Adolescent Health Collaborative to develop adolescent health indicators and process for needs assessment to identify "hot spots" (jurisdictions with poor health indicators), and "cold spots" (jurisdictions with good health indicators and effective adolescent health programs). The indicators will include suicide rates.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	68.7	69.6	68.5	68.2	67.2
Annual Indicator	67.3	68.0	67.1	66.9	66.9
Numerator	3970	4360	4546	4471	
Denominator	5900	6411	6770	6679	
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	67.5	67.8	68.1	68.4	68.4

Notes - 2007
A manual indicator is reported for 2007 based on 2006 data.

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.

Notes - 2005
Source: State of California, Department of Health Services, Center for Health Statistics, 2005 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/OFP Branch.

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 65.6 in 2001 and the highest point was 68.7 in 2002. The percent decreased from 67.1 in 2005 to 66.9 in 2006, 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 2006, Pacific Islanders and American Indians had the lowest percentages of these deliveries, 56.7 and 60.0, respectively. Asians had the highest percent (71.5), followed by African-Americans (67.2), Hispanics (66.6) and Whites (65.1).

The California figures are based on data from hospitals designated by the CCS program as Regional or Community NICU facilities. There are currently 118 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).

Based on information from the 2004-2005 RPPC statewide survey, the RPPC and CCS developed strategies to improve inter-hospital transport of high-risk pregnant women and newborns to hospitals with high-risk services. Recently completed RCCP Toolkits are: "Neonatal Hyperbiliruminemia; Screening, Assessment, Management & Prevention of Kernicterus" and "The Late Preterm Infant: Assessment, Management & Prevention of Morbidity and Mortality". These toolkits were developed by Workgroups of the Community Perinatal Network & Orange County Perinatal Council for RPPC.

The MCAH Program 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. 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 goal is to provide interactive presentations including awards for improved data collection to birth clerks.

CPQCC has convened a Perinatal Transport Sub-committee to develop and implement a web-based perinatal transport data collection system. The Sub-committee includes an expert panel of providers with experience in perinatal transport to identify data elements to guide perinatal transport quality improvement processes.

Data collected in 2007 using the web-based Perinatal Transport Data Collection Form totaled 4245 forms which are in the process of final evaluation. 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.

Funding for emergency preparedness efforts was cut in September 2007. The importance of

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 its "Hot Topics" annual meeting.

The importance of reporting NICU bed availability continues to be an important part of CPeTs. Presently there are 150 participating hospitals. On a daily basis they demonstrate available or non-available NICU beds throughout the state.

CMQCC will identify and validate appropriate indicators that will be used to guide quality improvement projects for maternal, perinatal and neonatal care in California.

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 aid continuous quality improvement to all maternity hospitals.				X
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 in matching high-risk patients with the appropriate level of care. Bed availability for regional neonatal intensive care units, updated daily, is reported on the CPeTS website (www.perinatal.org). CPeTS also facilitates meetings of the Regional Transport Quality Improvement Committees.

The RPPCs review all birth outcomes data, including IPODR and Perinatal Profiles data, with each hospital in their region to identify areas for improvement. RPPCs also provide technical assistance for implementation of the CPQCC toolkits to perinatal providers. The RPPCs, with the CDPH OVR, convene regional meetings with local Birth Clerk and County Registrars to improve the collection of data on birth certificates.

The CMS Branch continues to collaborate with CPQCC in retrieval, analysis and development of NICU data for CCS-approved NICUs. This collaboration offers CCS a useful, uniform reporting scheme for comparative assessment of hospitals for level of care provided for neonates. All CCS approved NICUs are now required to submit data annually to CPQCC. The number of CPQCC member hospitals has increased from 80 in May 2004 to over 120 in May 2006.

The RPPC Branch Nurse Consultant participates with representatives from EPO and Licensing and Certification to review Title 22 of the California Code of Regulations and purpose revisions specific to emergency preparedness and response.

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. RPPC continues to collaborate with OVR through Birth Clerk trainings across the state.

The tool kit, "Agreements for Provision of Perinatal and Neonatal Care: A Step-by-Step Guide" was completed in 2006 and is being disseminated through seven Regional Cooperative Agreement Workshops in 2007. These workshops are hosted by RPPC in collaboration with CMS.

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. CPQCC is collaborating to evaluate the toolkit's impact.

CPSP will continue to strengthen ongoing collaboration between CPSP providers and Sweet Success, affiliates of the CDAPP, to ensure that CPSP clients, who have diabetes or who develop gestational diabetes have access to expert care in diabetes management.

The CMS Branch and CPQCC will continue to 1) respond to CPQCC membership questions, and 2) review data element selection in an effort to decrease any unnecessary data element collection for hospitals. The CMS Branch will continue to analyze CPQCC data reports for CCS-approved NICUs, addressing outliers and concerns about quality of care. The MCAH Program and CMS Branch will continue participation on the CPQCC Executive Committee and the Perinatal Quality Improvement Panel (PQIP). (The PQIP is an executive subcommittee of CPQCC which oversees data analysis and quality improvement efforts and develops and distributes toolkits on quality improvement topics.)

The CMS Branch has begun and will continue collaboration with CPQCC to develop 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.

The MCAH Program will continue 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.

The RPPC Branch Nurse Consultant will work with a group from OEP and Licensing and Certification to propose revisions to sections of Title 22 regulations for responding to emergencies. Once funding for emergency preparedness to CPeTS was cut in September 2007, there has been no continued communication from OEP to request collaboration to modify Title 22 regulations.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	87.4	88.4	89.4	87.1	86.7
Annual Indicator	87.3	87.1	86.6	85.9	85.9
Numerator	464157	466463	470955	478973	
Denominator	531508	535633	544118	557642	
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
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	86.9	87.1	87.3	87.5	87.5

Notes - 2007
A manual indicator is reported for 2007 based on 2006 data.

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.

Notes - 2005
Source: State of California, Department of Health Services, Center for Health Statistics, 2005 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH/OFP Branch. Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

a. Last Year's Accomplishments
Improving access to first trimester prenatal care has been a long-term MCAH and OFP priority. California made steady progress on NPM 18 between 1998 and 2003, with the rate increasing about one percentage point a year. Since 2004, NPM 18 has been decreasing slightly each year from 87.1 to 86.6 in 2005 and 85.9 in 2006. The Healthy People 2010 objective is 90 percent.

The rate was down slightly across all racial/ethnic groups in 2006. Only White women met the statewide annual objective for 2006. White and Asian women were more likely to receive prenatal care in the first trimester (89.9 percent and 89.2 percent, respectively) than women who were Hispanic (83.8 percent), African American (81.8 percent), American Indian (72.7 percent), or Pacific Islander (71.0 percent).

Several strategies have been used in California to improve prenatal care utilization, including expansion of Medi-Cal eligibility criteria, improved access to Medi-Cal through presumptive and continuous eligibility, a waived assets test, and reduced application paperwork. These were accomplished in California in the late 1980s.

CPSP, AFLP, BIH, WIC, and the American Indian Infant Health Initiative (AIIHI) support improvements in adequate 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.

The primary goal of the BIH program is to reduce barriers to care. In addition to case management, the BIH staff collaborates with obstetricians and family practitioners in activities such as "Adopt A Doctor" in Pasadena and "Doctors in the House" in Sacramento County to improve access for at risk African American pregnant women. Mentor programs such as "Sister-Friends" and the "Angel Club" in Pasadena provide support to encourage BIH clients to keep medical appointments.

The MCAH and OFP Programs work to provide ethnically diverse staff for recruiting clients into care, and local MCAH jurisdictions employ a variety of methods to target diverse populations. The MCAH program in Orange County works with Latino Health Access, a local non-profit organization, to operate the Promotores Program. Promotores are trained community health workers, recruited and hired from the communities where they live, who provide wellness education and act as role models for their peers. Promotores, in conjunction with public health professionals, work with pregnant Hispanic women and their families to promote early prenatal care and access to other appropriate healthcare services.

In Los Angeles, the Probation-Prenatal Outreach Project (P-POP) identifies high-risk pregnant minors who are detained in local juvenile detention facilities to refer them to an appropriate provider and care system upon their release. The "Probation Liaison PHN" (LPHN) assessed 250 (68%) minors and referred 126 (50%) to the Nurse Family Partnership (NFP) and Prenatal Care Guidance (PCG) case management programs for continuous prenatal care follow up upon release.

It is estimated that about 40 percent of all births in California are unintended. [64] California's Family PACT Program provides 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 increased utilization of prenatal care.

The Preconception Care Council of California (PCCC), a partnership between MCAH, OFP and the March of Dimes California Chapter, has played a pivotal role in relaying the message of the importance of intended pregnancy, pregnancy spacing and preconception care to local communities. PCCC is composed of organizations and programs that are stakeholders in the development of preconception care services. It provides information, tools and resources to local communities focusing on the importance of achieving optimal health before pregnancy.

In spite of efforts to increase the number of women who receive prenatal care in the first trimester, the following obstacles remain: delays due to lack of awareness of Medi-Cal Presumptive Eligibility Program, delays due to the Medi-Cal enrollment process, 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 and OFP Programs 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 to reduce the rate of unintended pregnancy, and contribute indirectly to increased utilization of prenatal care.				
7. The PCCC plays a pivotal role in relaying the message of the importance of intended pregnancy, pregnancy spacing and preconception care to local communities.				
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.				
9.				
10.				

b. Current Activities
CPSP, AFLP, WIC, BIH, and AIIHI continue to provide case management services and linkages to medical care for their target populations.

Through participation in CPSP, providers receive a bonus for each woman receiving three assessments and the initial pregnancy office visit provided within the four weeks of entry into care, and CPSP providers are eligible for payment of one additional obstetrical visit to ensure continuity of care for each CPSP patient.

The MCAH Program is working on consolidating data (beneficiaries, paid claims, birth outcomes, and hospital discharge data) to develop baseline data on the efficacy of CPSP services.

Community Health Workers from the BIH program provide assessment, education and linkage to services for pregnant African American women.

The PCCC is developing a curriculum with a reproductive life planning component that will help women take charge of their reproductive lives--decreasing unintended pregnancies, achieving optimal pregnancy spacing and early prenatal care.

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 federal poverty level.

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.

c. Plan for the Coming Year
CPSP, AFLP, WIC, BIH, and AIIHI will continue to provide case management services and linkages to medical care for their target populations.

Plans for the coming year for CPSP include continuing provider recruitment; monitoring and strengthening the utilization of CPSP's scope of benefits through provider and practitioner training, including documentation training; material development; and development of evaluative reports on the efficacy of services. In addition, CPSP is in the process of identifying the sociodemographic and medical-diagnostic characteristics of its client populations and their patterns of service utilization that will help in future program planning and administration. These activities are undertaken in an effort 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 PHHI 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.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				50	70
Annual Indicator			57.9	76.4	84.2
Numerator			92903	123748	146423
Denominator			160499	162023	173850
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	84.2	84.2	84.2	84.2	84.2

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.

Notes - 2005
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 55 counties and data from local county CCS programs for the remaining 3 counties for FY 2005-06.

a. Last Year's Accomplishments
SPM 01 was a new California State Performance Measure in 2006.

SPM 01 is 84.2 percent in FY 2007-2008. There has been an increase of 8 percent since 2006-2007. It is believed that this increase is due to improved reporting of this indicator. County CCS programs assessed whether CCS eligible children had a documented primary care physician/medical home and worked at improving this documentation.

This measure is from a field on CMS Net for "medical home", and from a data system field for LA and Sacramento Counties (not on CMS Net). This SPM is similar to the 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.

Currently the CCS program is interchanging terminology for medical home and primary care physician (PCP) in the data captured for this measure. The aim is to work on the data definition and the data collected so that ultimately the field "medical home" will reflect where the child, enrolled in the CCS program, receives comprehensive and coordinated, ongoing medical care.

This is a goal for the coming years as this change will take time. As the definition is refined, the anticipation is that the percent of CCS enrollees with medical homes may actually decrease for a few years since some previously designated PCPs will not meet the criteria for providing a medical home. Also, LA County receives a direct transfer of data from Medi-Cal Managed Care plans regarding the medical home/PCP for each child. When LA County converts to CMS Net in 2009, this direct transfer will no longer occur, resulting in a decrease in the number of medical homes/PCPs reported.

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 Needs Assessment identified having a medical home for children enrolled in the CCS program as one of the top three state priorities over the next five years. The priority is to increase the number of FCC medical homes for CSHCN and the number/percent of CCS children who have a designated medical home.

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.
CMS finalized the state strategies for increasing the number of FCC medical homes for CSHCN and the number/percent of CCS children who have a designated medical home.

In collaboration with federal MCHB grant awardees (USC's UCEDD at CHLA, CRISS, and FVCA) development of a Medical Home Initiative (state strategy) was started to increase the number of FCC medical homes for CSHCN and the number/percent of CCS children who have a designated medical home.
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 work on data definition and the data collected for the CMS Net “medical home” field to reflect where the child receives comprehensive and coordinated, ongoing medical care.				X
2. Work continues developing policy for CCS regarding the medical home for CCS clients, authorization of the medical home, including phone consultation and care coordination.				X
3. Continue to collaborate with CHLA on the grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in California.		X		
4. CMS and stakeholders are working on the state strategies for increasing the number of FCC medical homes for CSHCN and the number/percent of CCS children who have a designated medical home and an implementation plan.				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 “resource referral pads” to physicians that list local resources for families.				X
7. There will be continued evaluation by county CCS programs of whether children in the CCS program have a medical home and how to improve on this part of a performance measure regarding effective case management.				X
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. Work continues on 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. Work continues on a policy letter for CCS regarding the medical home for CCS clients, particularly authorization of the medical home and ramifications of this authorization.

4. Evaluation continues by county CCS programs to determine if children in the CCS program have a medical home and how to improve on this part of a performance measure regarding effective case management.

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. FVCA agencies will continue to provide a "resource referral pads" to physicians that list local resources for families.

c. Plan for the Coming Year
Plans for the coming year include:

1. Continue to work with USC's UCEDD at CHLA in collaboration with CRISS, CMS to Branch, and FVCA to implement the Medical Home Initiative and increase the number/percent of CCS children who have a designated medical home.

2. CMS will launch a Medical Home Initiative this year, with two components: (1) a policy letter for CCS regarding the medical home for CCS clients, particularly authorization of the medical home, with phone consultation for care coordination, billing codes, and ramifications of this authorization, and designation of county-based CCS medical home liaisons to serve as the single point of contact for primary care providers of CCS children; and (2) a letter to paneled CCS physicians introducing the medical home concept, alerting them to the services and assistance they and their patients can receive from CCS, including the designated CCS medical home liaison, and providing medical home information and tools (e.g. the Center for Medical Home Improvement's abbreviated Medical Home Index).

3. 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.

4. 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. FVCA Agencies will also provide a "resource referral pads" to physicians that list 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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				0	0
Annual Indicator			0.0	0.0	0.0
Numerator			137	130	137
Denominator			67267	57865	56034
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	0	0	0	0	0

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.

Notes - 2005
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 2005-06.

The result is a ratio for 2005 of 1:491. This is the annual indicator for 2006, 2007, 2008; the indicator is 1:475 for 2009 and 2010.

a. Last Year's Accomplishments
SPM 02 was a new California State Performance Measure in 2006.

SPM 02 for FY 2007-08, there is a 5% increase in the number of cardiologists and a 3% decrease in the number of children being seen by these cardiologists. Of note is that there was an error in the reporting of this measure for FY 2006-07 and the number of active cases (extrapolating for LA and Sacramento Counties) should have been 23,416 (and not 28,416) and the ratio corrected to 1:445. SPM 02 addresses provider capacity for the CCS program for the subspecialty of pediatric cardiologists. There are growing concerns over the shortage of pediatric subspecialty care providers throughout the state, and particularly for CSHCN with complex medical conditions. The subspecialty of pediatric cardiologists has been selected for this measure because children with diagnoses related to congenital heart disease make up the largest group of children enrolled in CCS, and because it is perceived that pediatric cardiologists are decreasing in numbers throughout the state. Some reasons for the latter include that the pool of pediatric cardiologists in the country is insufficient, and recruiting to California is difficult due to the high cost of living, lower salaries, and lower reimbursement.

The ratio for this measure was obtained by determining the number of active cases in CMS Net with any of the following 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 (22413) was the result of extrapolating for LA and Sacramento Counties. The assumption was then made that CCS cases represent approximately 40 percent of pediatric cardiologists' caseloads. Hence, pediatric cardiologists are responsible for an estimated 56,034 children birth through 14 years of age in California. The number of pediatric cardiologists at all the CCS approved Cardiac Special Care Centers (SCCs) was then determined (137) and the ratio obtained of one pediatric cardiologist per 409 children birth through 14 years of age.

The CCS program (for the past 2-3 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. Though small, it is at least a positive upturn in the number of pediatric cardiologists at the CCS approved SCCs.

Because internists specializing in cardiovascular diseases are seeing an unknown number of the children over 14 years, the CCS children 15 to 21 years with cardiac ICD-9 codes were not included. However, some pediatric cardiologists continue to see an unknown number of these children over 14 years, making the ratio of 1:409 an underestimate of the caseload. A benchmark for this ratio has not been found in the literature.

Work was finalized on identifying the activities that will be needed over the next few years to attain the objectives for the goal of expanding the number of qualified providers participating in the CCS program.

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.				X
2. Improve CCS program capacity to serve older teens and YSHCN who are transitioning to adult services.				X
3. Advocate for enhanced physician training regarding CYSHCN.		X		
4. CMS will work on a method to annually update the core team members at the Pediatric Cardiac SCCs so that the CMS Branch can best evaluate the numbers of pediatric subspecialty physicians in the state available to CSHCN.				X
5. Explore strategies used by other states that have successfully attracted and retained pediatric and sub-specialty providers.		X		
6. Collaborate with the AAP, Children's Specialty Care Coalition, the CCS Transition Workgroup, and other partners in order to evaluate and implement strategies to address provider capacity.				X
7.				
8.				
9.				
10.				

b. Current Activities

Administer the Federal MCHB grant awarded to USC's University Center for Excellence in Developmental Disabilities (UCEDD) at CHLA for collaboration with CRISS, CMS Branch, and FVCA to implement the objectives through identified activities for the goal of expanding the number of qualified providers participating in the CCS program. Strategies used by other states to attract and retain pediatric and sub-specialty providers have been explored superficially to date. Implementation plans and evaluation tools will also be developed in a collaborative method. Collaboration will continue with the state CMS expert committee and the Cardiac Technical Advisory Committee, to analyze this performance measure and to explore ways to increase provider capacity.

c. Plan for the Coming Year

1. CMS will work on a method to annually update the core team members of CCS approved Special Care Centers, particularly the Pediatric Cardiac Special Care Centers so that the number of active pediatric cardiologists is accurate and the CMS Branch can best evaluate the numbers of pediatric subspecialty physicians in the state available to CSHCN.

2. Continue to work with USC's University Center for Excellence in Developmental Disabilities (UCEDD) at CHLA in administering the Federal MCHB grant awarded for collaboration with CRISS, and FVCA to implement the objectives through identified activities for the goal of

expanding the number of qualified providers participating in the CCS program.

3. Explore strategies used by other states to attract and retain pediatric and sub-specialty providers. Implementation plans and evaluation tools will also be developed in a collaborative method.

4. Continue to collaborate with the state CMS expert committee and the Cardiac Technical Advisory Committee, to improve on the methodology for determining the ratio for this performance measure if possible, and to explore ways to increase provider capacity.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				13.6	12.8
Annual Indicator		13.7	12.9	13.4	13.4
Numerator		941842	877547	918931	
Denominator		6858643	6822505	6870676	
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	12.7	12.6	12.5	12.4	12.4

Notes - 2007
A manual indicator is reported for 2007 based on 2006.

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.

Notes - 2005
Source: California Department of Health Services, California Women's Health Survey (CWHS), 2005. 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 population data for 2000 (file name Race/Ethnic Population with Age and Sex Detail, 2000-2050).

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 2006, up from 12.9 percent in 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 promoting mental health and of early detection and treatment of mental health problems. MCAH and OFP 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 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 as well.

Since the inception of the California Mental Health Services Act (MHSA) in January 2005, implemented as a result of Proposition 63 which imposes a one percent tax on incomes in excess of $1 million, the availability of mental health services for the MCAH population in the local health jurisdictions is gradually improving. The first counties to receive grants from the California Department of Mental Health were Stanislaus, Mendocino and Los Angeles. Grants to other LHJs have followed. While the grants are not specifically administered by MCAH programs within the counties, 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.

Further efforts and collaborations at the county and regional level have occurred as a result of the MHSA. Marin County identified maternal depression as a priority area and devoted Title V augmentation funds to the issue. The county contracted with a local agency to provide a parenting support group, in-home visits and bilingual psychotherapy for women referred by the CPSP program who were experiencing postpartum depression. Marin County continued to address the mental and behavioral health needs of its citizenry, incorporating an increasing emphasis on the MCAH population into its strategic plan.

The City of Pasadena, in conjunction with a local junior college, researched and developed a project to establish the Pasadena Youth Radio. Radio 626 Broadcast was initiated in 2007 for teens by teens. The goal of the program is to give youth a voice in their community about issues that concern them and to stimulate creative and intellectual growth. Lessons learned as a result of this program were incorporated into a Pasadena Strategic Plan devoted to promoting the health and well-being of its citizenry. Collaboration among diverse agencies resulted in a comprehensive approach to adolescent social and behavioral issues.

MCAH and OFP Program staff actively participated on the PCCC, a partnership between MCAH, OFP and the March of Dimes California Chapter. The PCCC 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, for women before pregnancy.

The MCAH Program continues to inform 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.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCAH and OFP programs - 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 because of increased resource availability and program capacity due to 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		X		

prevention, including education and counseling to overcome client emotional barriers to testing.				
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. The behavioral/emotional findings of a forthcoming demonstration site assessment of early childhood systems of care will be applied to our current year's Early Childhood Comprehensive Systems efforts.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
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.

The PCCC is developing a curriculum 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 Program is a key collaborator in the University of California Berkeley (UCB), School of Public Health Maternal and Child Health Program's Bright Beginnings Grant, funded by HRSA. The project aims to improve the California MCAH workforce's capacity to address maternal mental health issues in a timely and effective manner through continuing education courses.

Maternal mental health was one of the selected measures discussed in the MCAH publication "Preconception Health: Selected Measures, California, 2005" 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 show that the most frequent diagnosis for the cohort of women who had births in 2003 and were hospitalized for selected chronic conditions during 2000-2002 was Mental Disorders (ICD 9-CM codes 295-301.9).

c. Plan for the Coming Year
General plans for the next several years include:

1. Establishing and maintaining 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), and the Department of Health Services to address systemic barriers and create pathways to service delivery;

2. Building capacity of the provider network that delivers comprehensive perinatal services, including psychosocial assessment and reassessment each trimester and post-partum, development of a care plan, efficacious referrals, and client follow-up;

3. Collaborating with DMH, DSS, Office of Emergency Services, and Medi-Cal to enhance the

Domestic Violence Program in the area of preventing and treating domestic violence and improving mental health in preconception/pregnant/parenting women;

4. The MCAH and OFP Programs 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. 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.

More specific plans include:
1. 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 and counseling to overcome client psychological barriers to HIV/AIDS testing.

2. A demonstration site assessment of early childhood systems of care is forthcoming. The behavioral/emotional health findings will be applied to our current year's Early Childhood Comprehensive Systems efforts.

3. A preconception website, launched by the MCAH Program's Preconception Health and Healthcare Initiative (PHHI), featuring links to information, tools and resources related to mental health and well-being for women of childbearing age.

4. The UCB Bright Beginnings project is planning a conference on maternal mental health for primary care providers in Northern California in Fall 2008.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				16.4	17.1
Annual Indicator		16.5	17.3	15.8	15.8
Numerator		87461	92534	87117	
Denominator		530470	534314	552433	
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	16.9	16.7	16.5	16.3	16

Notes - 2007
A manual indicator is reported for 2007 based on 2006.

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.

Notes - 2005
Source: 2005 Maternal and Infant Health Assessment Survey, Maternal, Child and Adolescent Health/Office of Family Planning Branch, California Department of Health Services. 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.

In 2006, 15.8 percent of women who gave birth reported drinking any alcohol in the first or last trimester of pregnancy, down from 17.3 percent in 2005. The 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 were most likely to drink any alcohol (28.3 percent), followed by Other race (20.5 percent), African American (16.3 percent) and Asian/Pacific Islander (14.9 percent). Latina women were least likely to report drinking in the first or last trimester of pregnancy (8.2 percent).

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 Program 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 year, the MCAH and OFP Programs have 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 Program's PHHI and representatives from other MCAH and OFP Programs actively participated on the Preconception Care Council of California (PCCC), a partnership between the MCAH, OFP and the March of Dimes California Chapter (MOD). Formed in 2006, the Council is a state-wide collaborative that provides information, tools and resources to local communities about 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.

MOD funded the development of a provider/patient resource packet to assist health care providers. Use of alcohol is one of the covered topics. The packet is available on-line and has been adopted by several other states. Plans are currently in place to update the California version of the packet.

The 4 P's Plus is a nationally-recognized screening tool developed by Dr. Ira Chasnoff that helps medical staff identify women who may be at risk and need additional evaluations by certified alcohol and drug counselors. Many 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 abuse and FASD. Strategies include incorporating substance abuse avoidance education into preconception care, schoolbased 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.

The MCAH Program conducted a survey of local MCAH directors from April to July 2006 to assess the availability and format of local MCAH data on prenatal substance abuse. A report on the survey results was completed in September 2006.

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 and OFP Programs 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 and OFP Programs participates in the Statewide FASD Task Force, which meets quarterly and consists of representatives from state agencies and local communities.				X
4. Results of a MCAH and OFP Programs survey of local MCAH directors assessing the availability and forms of local MCAH prenatal substance abuse data showed that 21 of the 46 local health jurisdictions use 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

The MCAH and OFP Programs participate in the Statewide FASD Task Force. The Task Force meets quarterly and consists of representatives from state agencies and local communities. A five-year Strategic Plan was approved in 2005, to be carried out by 2010.

The PCCC is developing a curriculum with a module that alerts women to the risks of having an unintended pregnancy while engaging in alcohol use.

The MCAH Program has contracted with Dr. Ira Chasnoff to write a perinatal substance report on perinatal substance use screening data; specifically findings on use of the 4 P's Plus tool. The

report is currently under review.

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.

Plans are under way to set up a preconception health and health care website which will contain valuable information such as educational materials and lecture templates for health professionals, as well as links to other helpful websites. Perinatal substance use is one of the important topics.

Alameda County's Perinatal Substance Abuse Task Force is developing a strategic plan: Children's Screening, Assessment, Referral and Treatment (SART). The aim is to improve pediatric care for substance-exposed children and other children at risk.

c. Plan for the Coming Year

The MCAH and OFP Programs and local health jurisdictions will continue and 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 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 aims at providing for the infant's optimal cognitive, emotional, and physical development, and ensuring comfort and competency of family members in parenting and care-taking roles.

The MCAH and OFP Programs 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, establish a statewide FASD Registry, and establish a public policy agenda.

The PCCC will guide the planned revision and reprinting of the preconception provider/patient resource packet, including the section on alcohol use.

The MCAH Program's PHHI plans to launch a 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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	20.7	20.7	19.5	18.2	16.6

Annual Indicator	19.7	18.4	17.1	16.9	16.9
Numerator	516	494	474	485	
Denominator	2617630	2689492	2778214	2865987	
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	16.4	16.2	16	15.8	15.8

Notes - 2007
A manual indicator is reported for 2007 based on 2006.

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

Notes - 2005
Source Data: Numerator: State of California, Department of Health Services, Center for Health Statistics, 2005 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. May 2004. Tabulations (by place of residence) were done by the MCAH/OFP Branch.

Provisional 2005 data submitted for last year's Title V report have been updated (July 2008).

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 increases in 2001 and 2002 (to 17.3 and 20.2, respectively), the rate declined slightly in each subsequent year to 17.2 in 2005, and to 16.9 in 2006. (Denominators are based on the number of adolescents, not the number of miles driven.)

The highest rates of adolescent motor vehicle deaths were to Hispanics (19.5), and Whites (17.6). 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 1) provided technical assistance to local health jurisdictions in developing, implementing and evaluating injury prevention programs, 2) organized an annual statewide childhood injury prevention conference, 3) held bi-monthly injury prevention teleconferences with injury prevention

professionals from local health jurisdictions, and 4) provided local health jurisdictions with regular reviews of current injury prevention literature.

Due to Title V budget cuts in FFY 2005-06, funding for the MCAH contract with CIPPP was reduced. The reduction eliminated funding for the annual statewide conference and the bimonthly injury prevention teleconferences, as well as reducing the level of technical assistance provided to local health jurisdictions.

The MCAH Program 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. Funding will be discontinued after June 2007. Counties are expected to address injury prevention issues with their general funding allotment. Counties obtained grants from several sources which augment their ability to address issues related to injury prevention.

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 the Epidemiology and Prevention for Injury Control Branch.

The MCAH Program has served as a member of the UC Berkeley Center for Traffic Safety's Teen Traffic Safety Task Force, whose purpose is to put together a document summarizing both 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: 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.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The MCAH Program 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 Program-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 Program 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 Program Branch participates in the Statewide Coalition on Traffic Safety, which focuses on seat belt use and				X

prevention of speeding and driving under the influence.				
6. The MCAH Program 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
Since the 2006 reduction in the MCAH Program contract with CIPPP, Center staff continue to provide data updates and technical assistance to local health jurisdictions, but in a reduced capacity.

The MCAH Program collaborates with the CDPH Epidemiology and Prevention for Injury Control (EPIC) Branch to coordinate activities to 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. The MCAH Program works with EPIC and other agencies to promote adolescent injury prevention through MCAH programs.

Local health jurisdictions undertake various activities to promote adolescent injury prevention, including participation in Safe Kids Coalitions, traffic safety education, bicycle helmet distribution and education, and education regarding appropriate use of automobile seat belts. Humboldt County implemented a Youth Safe Driving Program, conducted focus groups on driving attitudes and behavior, DUI prevention and seat belt campaigns and convened a Youth Driving Subcommittee. The staff of local health jurisdictions conduct home safety evaluations when performing home visits to clients and provide guidance for corrective actions when perilous situations are identified. Counties are also using the Child Death Review data to identify trends and to raise awareness.

c. Plan for the Coming Year
Current activities of the MCAH and OFP Programs, the EPIC Branch, CIPPP and local health jurisdictions will be continued.

The MCAH Program 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.

The Statewide Coalition on Traffic Safety (SCOTS) is a task force containing representatives from more than 20 state and national agencies including the CDPH MCAH Program and EPIC Branch, the California Highway Patrol, the Office of Traffic Safety, Alcohol and Beverage Control, the Department of Education, the Department of Transportation (CALTRANS), the State Sheriff's Association, the Police Chiefs Association, the Emergency Medical Services Authority, the

Department of Alcohol and Drug Programs, the Department of Motor Vehicles (DMV), Mothers Against Drunk Driving (MADD), the American Automobile Association (AAA), and the UC Berkeley Traffic Safety Center.

The SCOTS task force facilitates interagency public and private partnerships to employ interventions to reduce motor vehicle fatalities in California. The MCAH Program's participation in SCOTS has led to an increased awareness among California's motor vehicle injury stakeholders regarding the rise of fatal motor vehicle injuries in California's adolescent and young adult populations and has lead the task force to adopt this particular indicator as a priority area.

The MCAH Program is also participating in the development of California's Statewide Strategic Highway Safety Plan (SHSP), an effort led by the California Department of Transportation (Caltrans). In addition to identifying key safety needs and providing a structure for data-driven decision-making, the SHSP provides a framework for California safety agencies to collaborate in aligning and leveraging collective resources to work toward reductions in fatalities and injuries involving motor vehicles.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	7	7	7	5.2	6.4
Annual Indicator	7.7	5.2	6.7	7.0	7
Numerator	49	34	45	49	
Denominator	63305	65484	67365	70382	
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	6.2	6	5.8	5.6	5.6

Notes - 2007
A manual indicator is reported for 2007 based on 2006.

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.

Notes - 2005
Source: State of California, Department of Health Services, 2005 California Birth Defects Monitoring Program Registry (CBDMP). Numerator: Confirmed cases of NTD in fetal deaths plus live births reported to monitored counties. Denominator: Fetal deaths plus live births among counties participating in California Birth Defects Monitoring Program Registry. The number of counties included in the registry was reduced beginning in 1998. Data since 1998 are from eight counties in the Central Valley. An analysis carried out by CBDMP of the neural tube defect incidence data from 1991-97 suggests the comparability of the 8 county sample with the larger sample used through 1997. The eight counties were deemed sufficient by CBDMP for surveillance purposes in this state.

a. Last Year's Accomplishments
Between 2001 and 2005, the incidence of neural tube defects, calculated for spina bifida and anencephaly only, fluctuated between 5.2 and 8.1 per 10,000 (using the corrected number for 2003 (see Field Note to Form 11). The final incidence for 2005 was 6.7 for spina bifida and anencephaly only. The provisional incidence for 2006 is 7.0, again based on only those two NTDs. 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, and back up to 7.7 in 2005. The incidence data, which is provided by the California Birth Defects Monitoring Program (CBDMP), is based on eight counties in the Central Valley.

The MCAH Program continues its long-standing efforts to improve folic acid intake before and during pregnancy, because folic acid intake around the time of conception is associated with a number of perinatal benefits especially lower rates of neural tube defects (NTDs). MCAH continues to collaborate with, and provide technical assistance regarding folic acid use to local MCAH programs, including AFLP, BIH, CDAPP, and CPSP; other CDPH programs, including WIC, and the Genetic Disease Screening Program (GDSP) and outside groups such as the March of Dimes. 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.

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 Branch. A folic acid document has been posted to the MCAH website providing information on folic acid needs, sources, recommendations, and resources.

MCAH participated in monthly conference calls with CDC to plan and implement strategies to fortify corn tortillas with folic acid. The goal was to increase folic acid consumption among Latina women, who have a lower rate of folic acid use and a higher rate of neural tube defects than the general population. MCAH encouraged CDC, MOD and others to work to expand this fortification effort to whole grains.

Information on the third National Folic Acid Week (in January 2007) was distributed to all MCAH programs, state nutritionists, and CDPH nutrition networks. This included educational materials on the importance of taking folic acid, along with information for ordering free brochures, posters, bookmarks, etc.

MCAH staff participated in planning for the 2007 Second National Preconception Conference, which included folic acid as one if it's main messages.

MCAH staff actively participated on the Preconception Care Council of California (PCCC), a

partnership between the MCAH Program, OFP and the March of Dimes California Chapter (MOD). Formed in 2006, the Council is a state-wide collaborative that 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.

MOD funded the development of a provider/patient resource packet to assist health care providers. Folic acid consumption is one of the covered topics. The packet is available on-line and has been adopted by several other states. Plans are currently in place to update the California version of the packet.

MCAH hosted the Second National Preconception Conference, October 29-31, 2007 in Oakland California. Folic Acid was highlighted in posters and presentations produced by MCAH. A MMWR: Trends in Folic Acid Supplement Intake Among Women of Reproductive Age -- California, 2002--2006 (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5642a3.htm?s_cid=mm5642a3_e) produced by MCAH in conjunction with CDC and released on October 26, 2008, was highlighted at the conference. The MMWR shared findings from the California Women's Health Survey that 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.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The MCAH Program 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 Program 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.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCAH has posted Folic Acid Resources at the new CDPH webpage: http://www.cdph.ca.gov/healthinfo/healthyliving/nutrition/Pages/FolicAcidResources.aspx

In February 2008 a group of 30 stakeholders met to strategize on targeted and evidence based interventions to increase folic acid intake among California Latinas and women with lower educational attainment. An additional meeting with members of EAPD, Program Standards, and Policy Development Branches of MCAH 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 was re-introduced into California's MIHA survey in both 2005 and 2006. These data were analyzed and 2006 data was published on our MIHA web site:
http://ww2.cdph.ca.gov/data/surveys/Pages/StatewideTablesfromthe2006MaternalandInfantHealthAssessment(MIHA)survey.aspx.

The PCCC is developing a curriculum with a module that emphasizes folic acid consumption for women of reproductive age.

MCAH and the MOD California Chapter co-hosted the Second National Preconception Summit in Oakland in October 2007.

Plans are under way for a preconception health and health care website with valuable information such as educational materials and lecture templates for health professionals, and links to other helpful websites. Folic acid consumption is one of the important topics.

c. Plan for the Coming Year

The MCAH and OFP Programs will continue their 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.

MCAH Program will be implementing its strategic plan to promote folic acid. Folic acid education materials will continue to be distributed across the state via local MCAH, OFP, WIC and GDSP programs, as well as by the March of Dimes.

The PCCC will guide the planned revision and reprinting of the preconception provider/patient resource packet, including the section on folic acid.

The importance of folic acid intake is part of the "Sweet Success: Guidelines for Care" State Program Guide for the California Diabetes and Pregnancy Program. It is also stressed during affiliate trainings.

MCAH continues to encourage the MCAH Health Jurisdictions to work on folic acid. Examples of their activities include:
Madera County is focusing on enhancing preconception care by: 1) Ensuring that women experience good nutrition by adequate and appropriate food intake, through WIC services, and 2) educating women about neural tube defects and the importance of daily vitamin supplement containing 400 mg of folic.

Mono County provides pregnant women with prenatal vitamins and folic acid via the PHNs.

Plumas County MCAH Clinics distribute folic acid supplement information to all women of child bearing age.

San Francisco County conducts a preconception health awareness campaign targeting reproductive age women with high rates of infant morbidity and mortality.

Sonoma County's features folic acid week on the news and alerts section of their web site.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				76	72
Annual Indicator			75.7	70.4	76.2
Numerator			20638	34053	37977
Denominator			27269	48387	49871
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	77	77.5	78	78.5	79

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.

Notes - 2005
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 55 counties and data from LA County for FY 2004-05. Sacramento and Orange Counties are not collecting comparable data and so are not included in this measure.

a. Last Year's Accomplishments
SPM 07 was a new California State Performance Measure in 2006.

SPM 07 is 76 percent for FY 2006-07. That is, 76 percent of new referral cases were opened within 30 days compared to 70.4 percent in 2005-06. This improvement is believed to be due to the Counties collecting and evaluating their processes. 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 are opened within 30 days of referral.

The 56 counties using CMS Net are opening 68.7 percent, compared to 60.3 percent in 2005-2006, of their cases within 30 days; Los Angeles County, not yet on CMS Net, is stable and

opening 96.5 percent of their cases within 30 days. Sacramento County, not yet on CMS Net, is not collecting comparable data, so this county is not included in this measure. The 57 counties collectively are opening 76 percent of their cases within 30 days.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CCS program will be identifying areas in the process of determining program eligibility where improvements can be made.		X		
2. Identifying factors influencing the length of time from CCS referral to authorization and to receipt of services.		X		
3. Considering strategies to reduce the length of time from referral to receipt of services that would include stationing CCS workers in hospitals.				X
4. Facilitating provision of medical and financial information from families and providers to expedite eligibility determinations and service authorizations.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

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 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

These include evaluating 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.

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.

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.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				42.1	40.9
Annual Indicator		42.4	41.3	43.2	43.2
Numerator		228085	222148	239285	
Denominator		538020	537394	554168	
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	40.5	40.1	39.7	39.3	39.3

Notes - 2007
A manual indicator is reported for 2007 based on 2006.

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.

Notes - 2005
Source: 2005 Maternal and Infant Health Assessment Survey, Maternal, Child and Adolescent Health/Office of Family Planning Branch, California Department of Health Services. 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 was one of California's new state performance measures, beginning in 2006. Data on pregnancy intentions have been collected via California's Maternal and Infant Health Assessment Survey (an annual, population-based survey modeled on PRAMS) since 1999.

In 2005, it was estimated that 41.3 percent of all births to California women (age 15 and over) resulted from unintended pregnancies. This proportion increased slightly to 43.2 percent in 2006. The proportion of unintended pregnancy among women giving birth in California had been steadily declining from 1999 (when it was estimated at 49 percent), through 2005. By comparison, in 2002 (the most recent year for which data are available), 35 percent of recent births in the United States were unintended. [68]

There are notable disparities by race/ethnicity. The proportion of unintended pregnancy among women giving birth in California in 2006 was highest for African American women (60 percent), compared to 48 percent for Hispanic women, and 34 percent for White women and for Asian/Pacific Islander women. Data for the United States suggests that the differences between African American and other women are somewhat larger in California than in the nation as a whole. In 2002, 51 percent of recent births to African American women in the U.S. resulted from unintended pregnancy, compared to 44 percent of births to Hispanic women and 29 percent of births to White women. [69]

Unintended pregnancy rates are highest for adolescents. Adverse consequences of unintended pregnancy are more severe for teens than for adults, and may include lower educational prospects and a greater risk of living in poverty. Adverse consequences of unintended pregnancy for women of any age and their babies include: the lost opportunity to receive preconception counseling to improve the health of the fetus (such as by increasing folic acid intake or controlling diabetes prior to pregnancy); less likely to receive early or adequate prenatal care, more likely to smoke or drink during pregnancy, and more likely to have low birth weight babies. [70] Costs to society include increased health care and welfare expenditures and increased risk of child abuse and neglect. [71]

The MCAH and OFP Programs support several programs which help women avoid unintended pregnancy by decreasing risky behavior, increasing access to and promoting the use of effective contraceptive methods, and improving the effectiveness with which all methods are used. OFP programs include Family PACT; the TSO Program; the CCG Program; the MIP; and the I&E. (See the following sub-section for a description of these programs.)

MCAH Program staff actively participate on the PCCC, a partnership between the MCAH Program and the March of Dimes California Chapter. The Council plays a pivotal role in relaying the message of the importance of reproductive life planning, pregnancy intendedness and preconception care to local communities.

OFP contracts with the UCSF Bixby Center for Reproductive Health Research & Policy for Family PACT, TSO, CCG, MIP and I&E program monitoring and evaluation services. The Bixby Center estimated that in 2002 alone averted approximately 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 participates in the ASHWG, a collaborative effort between the California Department of Public Health, 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 youth in California. One key component in sexual and reproductive health is family planning which will reduce the rate of unintended pregnancy.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The MCAH and OFP Programs 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 reproductive health services, information, education, and counseling, including comprehensive clinical exams and access to contraception.		X		
3. The Teen Smart Outreach Program offers in-depth reproductive health counseling to adolescent Family PACT clients.		X		
4. CCG promotes community-based partnerships to develop effective local teen pregnancy prevention programs and to promote responsible parenting.		X		
5. MIP promotes the involvement of young men in the prevention of teen pregnancy and unintended fatherhood.		X		

6. AFLP assesses and addresses the risks and resources of adolescent clients related to pregnancy prevention, birth outcomes, child health and safety, and health care issues.		X		
7.				
8.				
9.				
10.				

b. Current Activities
The Family PACT Program provides family planning services, testing and treatment of sexually transmitted diseases, and education and counseling for low-income Californians. Family PACT serves 1.7 million clients a year, including about 350,000 adolescents. Family PACT undertakes ongoing efforts in the areas of client outreach; provider recruitment, training, and technical assistance; and the addition of new FDA-approved contraceptive methods to the benefits package.

CCG promotes community-based partnerships to develop effective local teen pregnancy prevention programs and to promote responsible parenting. CCG funds 117 community agencies and serves approximately 200,000 teens annually.

MIP promotes the involvement of young men in the prevention of teen pregnancy and unintended fatherhood. MIP funds 21 agencies and serves about 25,000 adolescent boys and young adult males annually.

OFP I&E projects operate in 27 community agencies and serve approximately 75,000 youth in grades 6 through 12 annually.

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, and enhancing the psychosocial and economic well-being of the adolescent family. AFLP provides services to about 17,000 teens a year.

The PCCC is developing a curriculum with a reproductive life planning component to help women decrease unintended pregnancy and achieve optimal pregnancy spacing.

c. Plan for the Coming Year
In spite of the success in recent years in reducing the proportion of births that result from an unplanned pregnancy, 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.

The MCAH Program EAPD Branch will produce a Teen Birth Rate Resource, which will include detailed maps and tables of teen birth rates by race/ethnicity, for targeting of teen pregnancy prevention efforts.

The MCAH Program's PHHI plans to launch a website that will feature links to information, tools and resources related to reproductive life planning and connect people working in preconception health.

Family PACT, TSO, CCG, MIP, I&E, and AFLP will continue their teen pregnancy prevention

efforts. CCG, I&E, TSO and MIP Programs now require clinical services linkages, i.e., they must demonstrate formal referral mechanisms and collaboration with one or more Family PACT providers. They are currently working to develop and implement teen specific strategies to increase access to Family PACT services.

Family PACT undertakes to reduce unintended pregnancy through ongoing efforts in the areas of client outreach; provider recruitment, training, and technical assistance; and the addition of new FDA-approved contraception methods to the benefits package. The Family PACT Medicaid Demonstration Project Section 1115 Waiver has been extended by the Centers for Medicare and Medicaid Services through April 2007 and may be further extended on a month-by-month basis.

During this period, California is in negotiations with the Centers for Medicare and Medicaid Services for renewal of the Waiver.

MCAH will continue participation on ASHWG.

LHJs' activities include:
Alameda County's Healthy Passages program continues to promote comprehensive health and well-being of adolescents and young adults. The program addresses all aspects of adolescent health including unintended pregnancy, obesity, relationship violence and mentorship for a healthy and productive life.

Contra Costa County continues implementation of the Teen Age Program to promote adolescent health and reduce the incidence of teenage pregnancy. The program is designed to provide countywide comprehensive services to address the physical, social, and emotional needs of youth ages 12 to 21.

Santa Cruz County uses a combination of teen outreach, collaborations, and special projects toward reducing births to teens age 17 and younger. Activities continue to be implemented through several community/school-based programs including the MIP, CCG, AFLP, and the Pregnant and Parenting Teens Network.

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	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				32.8	32.9
Annual Indicator		32.9	33.1	32.0	32
Numerator		136011	147308	144156	
Denominator		413409	445038	450488	
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	32.7	32.5	32.3	32.1	31.9

Notes - 2007
A manual indicator is reported for 2007 based on 2006.

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.

Notes - 2005
Source: California Department of Education. 2005 California Physical Fitness Testing: Report to the Governor and the Legislature. Sacramento, CA: California Department of Education, December 2005. http://www.cde.ca.gov/ta/tg/pf/documents/govreport2005.pdf . Last accessed on February 7, 2007.

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 09 was added in FY 2006-2007. For the previous five years, California reported on the percent of low-income children 0-12 years that were overweight using the body mass index (BMI) for age (former SPM 02). SPM 09 reports on the prevalence of 9th graders who are outside the healthy fitness range for body composition.

The percent of 9th grade students not within the Healthy Fitness Zone (HFZ) for Body Composition decreased to 32 percent in 2006 compared to 33.1 percent in 2005. Since 2000, this percentage has fluctuated between 32.3 and 35.3 percent. These data are from the California Department of Education's Annual Physical Fitness Test, which is administered to all 9th grade students.

There are some differences in this measure by race/ethnicity. Forty four percent of Pacific Islander 9th grade students were not within the HFZ for Body Composition, compared to 39.1 percent of Hispanics, 37.6 percent of American Indian/Alaskan, 35.5 percent of African American, 26.8 percent of Filipino, 24.5 percent of White and 19.9 percent of Asian students. A gender difference in rates has also been observed. A higher proportion of 9th grade male students (33.9%) are not within the HFZ compared to females (30.1%).

Problems associated with body composition scores below the HFZ are associated with menstrual irregularity, infertility, and osteoporosis while body composition scores above the HFZ are associated with high blood pressure, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems, and some types of cancer.

The MCAH Program and CMS Branch have been involved with program planning, implementation and evaluation in the CDC-funded California Obesity Prevention Initiative (COPI). In addition, the MCAH Program and CMS Branch actively participated in the Physical Activity and Nutrition Coordinating Committee (PANCC), the Inter-Agency Nutrition Coordinating Council (IANCC) and the Primary Care and Family Health Nutrition Coordinating Committee.

Local MCAH health programs work with school districts to introduce healthy food choices into school cafeterias and increase opportunities for physical activities in the school curricula. Advocacy at the local level has resulted in a legislative mandate to remove soda from schools. Further accomplishments resulting from MCAH local program activities have been the development of collaborations between multiple agencies. As a result of jurisdiction-wide collaboration, local restaurants have modified menus to indicate healthier food choices. In addition to attendance increasing at farmers markets, more fruits and vegetables were made available at farmers markets, and community knowledge about the components of a healthy diet

and the benefits of regular physical activity has improved.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCAH Program and CMS Branch participate in the CDPH Obesity Prevention Group, the Inter-Agency Nutrition Coordinating Council, and the Primary Care and Family Health Nutrition Coordinating Committee.				X
2. The MCAH Program and CMS Branch have been involved with program planning, implementation and evaluation in the CDC funded California Obesity Prevention Initiative (COPI).				X
3. The AFLP and BIH Programs 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.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCAH and OFP Branch actively participated in the planning of the 2007 Childhood Obesity Conference held in Anaheim, California. MCAH and OFP facilitated conference sessions, presented two posters and showcased resources at a conference booth.

The MCAH in Schools Program (formerly called School Health Connections) promotes healthy food choices and physical activity in schools through the endorsement of nutritional assessment tools, including the CDC's School Health Index.

San Francisco established County Nutrition Action Plan (CNAP), a collaboration among United States Department of Agriculture Food and Nutrition Service at the community level with the goal to improve nutrition among low-income families in San Francisco.

The Alameda County Faith Initiative collaborative launched a community gardening project to provide hands-on training on setting up an edible back yard garden. Other activities include a 2007 summer series on nutrition education and physical activity, and a farmer's market weekly.

Yuba County MCAH staff was able to establish and implement a series of nutritional lectures throughout the community comprised of 62 classes reaching 558 participants. In addition, six Diabetes classes were conducted including nutrition for the entire family as well as the need for increased physical activity as prevention for the disease and other aspects of this chronic disease.

c. Plan for the Coming Year
The MCAH and OFP Programs and CMS Branch will continue to actively participate in coalitions and committees promoting nutrition and activity.

The MCAH Program will continue to provide nutrition and physical activity resources and intervention ideas to MCAH Action, which is the self-directed organization of the 61 California MCAH health jurisdiction directors.

The MCAH Program will be assessing MCAH resources and supporting efforts in its local health jurisdictions in the areas of policy development, coordination of services and provision of enabling services that are geared towards stemming the epidemic of obesity in children.

Most MCAH local health jurisdictions are addressing the issue of adolescent obesity, in part by networking with each other and the MCAH Program to share available resources and information. The local health jurisdictions will continue to include healthy lifestyles education within local school health clinic activities. Activities include outreach, education and guidance to children and parents 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.

Local MCAH health programs will continue to work with school districts to introduce healthy food choices into school cafeterias and increase opportunities for physical activities in the school curricula.

Existing MCAH, OFP 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 which is targeted to teens.

The Preconception Health Initiative will continue its collaborations with organizations and programs that reach adolescents with information about healthy eating and active living. A website is planned which will feature links to information and resources related to preconception health, including healthy food choices and physical activity for adolescents.

An ongoing activity for the CMS Branch is the collection of data from CHDP nutrition assessments by CHDP providers for infants, children, and adolescents. In another ongoing activity, 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.

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	2003	2004	2005	2006	2007
Annual Performance Objective				9.6	8.4
Annual Indicator		9.7	8.5	7.6	7.6
Numerator		1026644	896672	856984	
Denominator		10546784	10549890	11298656	
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	8.3	8.2	8.1	8	7.9

Notes - 2007
A manual indicator is reported for 2007 based on 2006.

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%.

Notes - 2005
Sources: California Department of Health Services, California Women's Health Survey (CWHS), 2005. 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) responding either 'yes' or 'no' to any of the nine CWHS questions (in 2004) about intimate partner abuse. Numerator and denominator weighted using the California Department of Finance population data for 2000 (file name Race/Ethnic Population with Age and Sex Detail, 2000-2050).

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 abuse, including sexual and psychological abuse. For this year and all previous years to 2003, the reporting of this measure is being expressed as the percent of intimate partner abuse among all adult women, regardless of whether these women were involved in an intimate partnership.

Over the past three years, SPM 10 has fluctuated between 8.1% and 9.2%. SPM 10 was 7.6 percent in 2006, down from 8.5 percent in 2005. (These data are from the California Women's Health Survey.)

To combat the serious health threat of domestic violence (DV), 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.

MCAH and OFP continue to inform the research and program communities by analyzing and presenting data on intimate partner violence from the California Women's Health Survey (CWHS) and from the MIHA survey. Early this year, the Office of Women's Health (OWH) published a Data Point contributed by MCAH and OFP entitled Frequent Mental Distress and Desire for Help Among California Women Experiencing Intimate Partner Violence. A similar report was presented

in December, 2006 by MCAH at CDC's annual MCH-Epi conference in Atlanta, and supplied the content of a section entitled Intimate Partner Violence and Mental Health in the forthcoming report from OWH entitled California Women's Health, 2007.

MCAH Program staff actively participated on the Preconception Care Council of California (PCCC), a partnership between the MCAH Program and the March of Dimes California Chapter (MOD). PCCC 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 shelterbased 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.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OFP Program currently funds 94 shelter-based grantees to provide direct services to battered women and their children.

July 1, 2008 marks the start of the third year of a five-year funding cycle for 94 BWSP grantees. All grantees continue to incorporate domestic violence prevention activities and outreach to unserved/underserved populations into their ongoing shelter-based services. In a further effort to increase access to shelter services for unserved/underserved populations, the OFP Program incorporates Cultural/Linguistic Competency as a 14th Core Service Standard. Agencies are required to develop and submit a policy statement and implementation plan to provide services to women from varying cultural and linguistic backgrounds.

Via contracts with domestic violence expert programs, the Program has developed a curriculum to conduct regional training and technical assistance (TAT) for BWSP shelter staff in three priority unserved/underserved (U/U) areas: Mental Health and Substance Abuse; Disabled and Developmentally Disabled; and Lesbian, Gay, Bisexual, Transgender, and Questioning populations. Training has begun in this year with technical assistance to begin during next year.

The grantees also continue to provide direct services to U/U populations as part of their ongoing grants with OFP.

The PCCC is developing a curriculum with a healthy relationships module to help women of childbearing age be free of family violence.

c. Plan for the Coming Year

Throughout the coming year, the OFP Program will be conducting regional statewide U/U technical assistance for BWSP shelter staff. The DV-experienced contractors will be providing telephone, video/teleconference, or on-site technical assistance to the 94 agencies.

In September 2008, the OFP Program will convene its annual statewide meeting for BWSP grantees. The meeting agenda includes a wide variety of topics geared toward state and agency identified needs including a Statewide Advisory Council update, access to state funding, grants administration, panels on best practices, and a presentation on the impact of violence on children presented from a differential response model.

The OFP will continue ongoing development and maintenance of its domestic violence website, called SafeNetwork, to facilitate the sharing of information, to promote networking among providers, and to offer resources for providers and victims of domestic violence. The webpage can be accessed at www.safenetwork.net.

The MCAH Program's Preconception Health and Healthcare Initiative (PHHI) plans to launch a website that 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 PCCC will guide the planned revision and reprinting of the preconception provider/patient resource packet, including the section on intimate partner violence.

E. Health Status Indicators

Health Status Indicators (HSI) 01-02: Low Birth Weight (LBW)

HSI 01 and 02 are the percent of live births weighing less than 2,500 grams and 1,500 grams, respectively. HSI 01a and 02a are for all live births, and HSI 01b and 02b are for all live *singleton* births. (Live births with unknown birth weight were excluded from the analysis.)

Births weighing less than 2,500 grams are classified as low birth weight (LBW). LBW births are divided into two categories: Births weighing less than 1,500 grams are classified as very low birth weight (VLBW), and births weighing between 1,500 and 2,499 grams are classified as moderately low birth weight (MLBW).

/2008/ In 2005, the percent of live births which were LBW (HSI 01a) was 6.9 percent, up slightly from 6.7 percent in 2004. This is higher than the Healthy People 2010 goal of 5.0 percent.

The percent of live singleton births which were LBW (HSI 01b) remained the same as last year at 5.2 percent.

Among racial and ethnic groups, African American infants were twice as likely as infants of most other groups to be LBW (HSI 01 a). In 2005, 12.8 percent of African American live births were

LBW. Comparatively, Asians and Pacific Islanders had approximately 7 percent LBW births. Whites, American Indians, and Hispanics had between 6.2 and 6.6 percent LBW births.

The percent of live births which were VLBW (HSI 02a) was 1.2 percent; there was no change from the previous year. This is slightly higher than the Healthy People 2010 goal of 0.9 percent.

The percent of live singleton births which were VLBW (HSI 02b) was 0.9 percent.

Among racial and ethnic groups, African American infants were twice as likely as infants of most other groups to be VLBW (HSI 02a). In 2005, 3.0 percent of African American live births were VLBW. Comparatively, all other racial and ethnic groups had between 1 and 1.5 percent VLBW births. //2008//

/2009/ The percent of live births which were LBW (HSI 01a) in 2006 remained the same as 2005 at 6.9 percent. The percent of live singleton births which were LBW (HSI 01b) also remained the same as the previous year at 5.2 percent.

African American infants were nearly twice as likely as infants of most other groups to be LBW (HSI 01 a). In 2006, 12.3 percent of African American live births were LBW. Comparatively, Asians and Pacific Islanders had 7.7 and 7.5 percent LBW births respectively. Whites, American Indians, and Hispanics had between 6.3 and 6.7 percent LBW births.

The percent of live births which were VLBW (HSI 02a) was 1.2 percent; there was no change from the previous year. This is slightly higher than the Healthy People 2010 goal of 0.9 percent.

The percent of live singleton births which were VLBW (HSI 02b) was 0.9 percent.

Among racial and ethnic groups, African American infants were twice as likely as infants of most other groups to be VLBW (HSI 02a). In 2006, 2.8 percent of African American live births were VLBW. Comparatively, all other racial and ethnic groups had between 1 and 1.5 percent VLBW births. //2009//

LBW rates are important indicators of the health of California. LBW rates among populations within our society reflect not only differences in the health of the mother, access to risk appropriate care before and during her pregnancy and delivery, but also socio-economic status and lifestyle issues.

LBW is most commonly associated with prematurity and intrauterine growth restriction. These complications can lead to significantly increased risk of mortality and morbidity. Within the LBW group are two distinct populations of infants -- MLBW and VLBW. The cause, outcomes and potential strategies for improvement are different.

> Moderately Low Birthweight (MLBW)

Birth weights between 1,500 and 2,499 grams are most commonly associated with infants with intrauterine growth restriction or those delivered between 32 and 37 weeks gestation, called Late Preterm Infants /Near Term Infants (LPI/NTI). Few data are available on the intrauterine growth restriction group, as size for gestational age is not consistently available via birth certificate data.

More is known about the LPI/NTI infants. LPI/NTI may be associated with factors such as: lower order multi-fetal pregnancies (twins), mothers less than 17 years of age, 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 and hypertension as well as life style issues such as tobacco, alcohol and drugs also contribute to

the risk of LPI/NTI.

Outcomes of infants born at MLBW include: nearly three fold increase in neonatal and postneonatal mortality; excess hospital costs of up to six times that of infants born between 37-40 weeks gestation, increased risk of neonatal complications including hypoglycemia, hyperbilirubinemia, Respiratory Distress Syndrome, suspected infection or sepsis and feeding difficulties. These complications lead to significantly greater medical intervention and utilization of neonatal intensive care resources.

Interventions aimed at stemming the increase in the LPI population will require public health interventions, collaboration with professional medical associations, commitment to preconception and interconception health and wellness programs. Ensuring the quality of neonatal care for LPI will require leadership in developing a greater understanding of the medical risks these infants face and facilitating health care system changes necessary to prevent complications and optimize outcomes.

/2008/ The California Perinatal Quality Care Collaborative (CPQCC) is developing and disseminating a toolkit, "The Late Preterm Infant" in order to assist hospitals' treatment for late preterm infants (LPI) 34-36 + 6/7 weeks. LPI comprise a unique population requiring enhanced awareness and sensitivity to issues of transition, infection, nutrition, discharge readiness, and parent education that needs to begin after birth. //2008//

/2009/DVD copies of "The Late Preterm Infant Toolkit" have been widely distributed at professional meetings and made available to hospitals during site visits by RPPC Regional Representatives.

In late 2007 CPQCC hosted workshops covering Successful Strategies for Implementing Neonatal Practice Improvements. Presentations included: Care Planning for Evaluation and Education for the Later Pre-term Infant; and the issues of Respiratory Compromise; At Risk for Sepsis; Nutrition. Along with those presentations was an update on Nosocomial Infection Prevention.//2009//

Public health interventions such as tobacco cessation, perinatal substance abuse treatment and prevention of domestic violence provide key support to minimize risk. Targeted programs such as AFLP, BIH, CDAPP, and CPSP, work to improve outcomes in specific populations.

MCAH/OFP Branch encourages professional medical associations to develop and use guidelines for practice regarding labor induction and augmentation, cesarean delivery, as well as assisted reproductive therapies.

MCAH has taken a leadership role along with the March of Dimes in identifying priorities and funding for preconception care that has significant potential to reduce the risk of LBW infants.

/2009/The most recent issue of "Perinatal Profiles, 2004 and 5 Year Cohort" issued in March 2008 reflected that Low Birthweight rates have increased from 6.1% to 6.6% in the 5 year period. This illustrates the need to continue to be vigilant in identifying and addressing related factors.//2009//

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, will focus on the LPI as well as causes of maternal complications such as hemorrhage and infection. Other partners working with MCAH/OFP 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.

> Very Low Birthweight (VLBW)

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. Emphasis on improved prepregnancy health and wellness by providing access to preconception care are vital to these efforts. MCAH/OFP offers the optimal collaboration of state programs to address preconception care provision and funding sources.

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, MCAH/OFP 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.

/2009/ MCAH Program and CMS Branch staff participated in the March of Dimes-funded California Perinatal Summits which were held to achieve consensus among key stakeholders on the development of guidelines for maternal risk appropriate care. //2009//

Health Status Indicators 03-04: Child Injury Rates

Health Status Indicators 3A and 4A describe fatal unintentional injury and nonfatal (both intentional and unintentional) injury rates per 100,000 children aged 14 years and younger. Health Status Indicators 3B and 3C describe fatal motor vehicle injury rates and Health Status Indicators 4B and 4C describe nonfatal motor vehicle injury rates per 100,000 children aged 0-14 and per 100,000 young adults aged 15-24, respectively.

Injury data for these indicators are currently obtained from the California death file and the California Hospital Discharge file. Given the nature of overall injury data, only the most severe cases ending in death or requiring hospitalization are recorded. This results in an under estimation of the true magnitude of injuries suffered by children and young adults in California.

In both children aged 0-14 and young adults aged 15-24, injury is the leading cause of death. Among fatal injuries those due to motor vehicle collisions are most frequent.

Death rates from unintentional injuries due to motor vehicle collisions in children under age 14 (HSI 3B) fell significantly from 5.4 deaths per 100,000 in 1990 to 2.9 deaths per 100,000 in 2000. Since 2000, rates have oscillated between 2.9 per 100,000 (2000) and 3.5 per 100,000 (2003) with no directional trend. Statewide data for 2004 and 2005 fall within this range at 3.0 and 3.1 deaths per 100,000 children, respectively, for each year.

Death rates from unintentional injuries due to motor vehicle collisions in adolescents and young adults aged 15-24 (HSI 3C) have been less stable. Fatal motor vehicle collision injury rates in this group increased significantly from 14.4 per 100,000 in 2000 to 21.0 per 100,000 in 2003, representing an excess of 383 deaths in 2003 for this population. The rate was slightly lower at 19.9 in 2004 and 19.6 in 2005. Although this decrease is a positive sign, overall, deaths due to motor vehicle injuries in this age group continue to be elevated and remain greater than the HP 2010 objective of 15 deaths per 100,000 for the entire population. (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.)

/2009/ Death rates from fatal accidental/unintentional injuries to children aged 0-14 (HIS 3A) show no directional trend. The rate increased from 5.5 per 100,000 in 2002 to 6.2 per 100,000 in 2003. This rate then dropped to 5.8 in 2004 and increased again in 2005 to 6.2 per 100,000. For 2006, this rate is back at 5.5 per 100,000.

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. Hospitalization rates for all nonfatal injuries among children aged 0-14 years (HSI 4A) have decreased since 2000. The rate for nonfatal injury hospitalizations decreased from 284.9 per 100,000 in 2000 to 250.7 per 100,000 in 2004. This downward trend continued in 2005 and 2006 with rates of 229.2 and 210.9, respectively.

Death rates from unintentional injuries due to motor vehicle collisions in children under age 14 (HSI 3B) fell significantly from 5.4 deaths per 100,000 in 1990 to 2.9 deaths per 100,000 in 2000. Since 2000, rates have oscillated between 2.9 per 100,000 (2000) and 3.6 per 100,000 (2003) with a slight downward trend to 3.0 in 2004, 3.1 in 2005, and 2.6 per 100,000 in 2006.

Death rates from unintentional injuries due to motor vehicle collisions in adolescents and young adults aged 15-24 (HSI 3C) have been less stable. Fatal motor vehicle collision injury rates in this group increased significantly from 14.4 per 100,000 in 2000 to 21.3 per 100,000 in 2003. The rate was slightly lower in 2004 and 2005 with 20.2 per 100,000 and increased to 20.3 in 2006. (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.)

Motor vehicle 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. Hospitalization rates for nonfatal injuries due to motor vehicle crashes among children aged 0-14 (HSI 4B) decreased from 39.6 per 100,000 in 2000 to 35.9 in 2001. However, in 2002 the rate increased to 36.4 and then again decreased to 35.4 in 2004. The rate continued to decrease to 29.6 in 2005 and to 26.5 in 2006.

Motor vehicle crashes are the leading cause of hospitalized nonfatal injuries among youth aged 15-24 in California. Hospitalization rates in this population (HSI 4C) increased overall from 147.7 per 100,000 in 2000 to 164.5 per 100,000 in 2004. The rate decreased in 2005 and 2006 with rates of 156.0 and 146.7, respectively. (Numerators are based on principal diagnoses codes in hospital discharge data.) //2009//

The Branch continuously participates in public and private partnerships and actively seeks involvement of key state, local and community-based stakeholders to reduce the burden of injury in our youth. The Branch's current injury control partnerships include the Center for Injury Prevention Policy and Practice, the CDHS Epidemiology and Prevention for Injury Control (EPIC)

Branch, local health jurisdictions, the Statewide Coalition on Traffic Safety, and the working group on the California Statewide Strategic Highway Safety Plan, all of which are described below.

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 and provides training and technical assistance in the development, implementation and evaluation of state and local injury prevention programs. CIPPP has worked with the MCAH/OFP Branch to organize the annual childhood injury prevention conference, administers the 'Kids Plates' injury prevention grant program for the EPIC Branch, and also produces Safety Literature updates with weekly references of current injury prevention articles to 1404 California subscribers.

Due to Title V budget cuts in FFY 2005-06, funding for the MCAH/OFP contract with CIPPP was reduced. The reduction eliminated funding for the annual statewide conference and the bimonthly injury prevention teleconferences, as well as reducing the level of technical assistance provided to local health jurisdictions.

The MCAH/OFP Branch collaborates with the CDHS Epidemiology and Prevention for Injury Control (EPIC) Branch to coordinate activities to address joint areas of interest, including the Statewide Coalition on Traffic Safety, the Statewide Strategic Highway Safety Plan, and various child passenger safety programs.

/2009/ The CIPPP continues to provide support to local health departments to identify and prioritize injury problems, select appropriate interventions, and conduct program evaluation. The Center's weekly SafetyLit Update Bulletin delivered summaries of 1457 recently published reports and journal articles on child and adolescent safety issues to 1530 email and RSS subscribers in California. Each week the SafetyLit website receives more than 50,000 unique visitors from around the world, including more than 200 from the U.S. Department of Health and Human services. //2009//

/2008/ The MCAH/OFP Branch provides funding to local health jurisdictions (58 counties and three cities) in support of local efforts to promote maternal and child health; local jurisdictions may use this funding for child injury prevention, among other projects. The Branch has been allocating additional funding for local childhood injury prevention programs in five counties in three-year cycles. However, this funding, specifically for childhood injury prevention, 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, which have enabled them to expand childhood injury prevention programs. //2008//

/2009/ Funding for local childhood injury prevention programs was discontinued beginning July 2007, however some counties continue their programs with local funding and working collaboratively with local agencies. //2009//

The MCAH/OFP Branch also supports regular injury prevention teleconferences available to all local MCAH jurisdictions and injury stakeholders enabling statewide networking, joint planning, and skill development as well as an injury prevention list serve used to give updates, alert programs of funding sources, and share information.

The Statewide Coalition on Traffic Safety (SCOTS) is a task force containing representatives from more than 20 state and national agencies including the CDHS MCAH/OFP and EPIC Branches, the California Highway Patrol (CHP), the California Office of Traffic Safety (OTS), the California Alcohol and Beverage Control (ABC), the California Department of Education (CDE), the California Department of Transportation (CALTRANS), the California State Sheriff's Association, the California Police Chiefs Association, the California Emergency Medical Services Authority (EMSA), the California Department of Alcohol and Drug Programs (ADP), the California Department of Motor Vehicles (DMV), Mothers Against Drunk Driving (MADD), the American Automobile Association (AAA), SafeKids West Coast, the UC Berkeley Traffic Safety Center, the

Federal Motor Carrier Safety Administration (FMCSA), the Federal Highway Administration (FHWA), and the National Highway Traffic Safety Administration (NHTSA).

The SCOTS task force was established to unite traffic safety stakeholders throughout the state to engage interagency public and private partnerships to employ diverse evidence based interventions to reduce motor vehicle fatalities in California. The MCAH/OFP Branch's participation in SCOTS has lead 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 and has lead the task force to adopt this particular indicator as a priority area.

The MCAH/OFP Branch has also participated in the development of California's Statewide Strategic Highway Safety Plan (SHSP) spearheaded by CALTRANS 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 will provide 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.

/2009/ The MCAH Program participated in the 2008 California Strategic Highway Safety Summit as well as continued work with the statewide group addressing public awareness and education. //2009//

As active partners in both the SCOTS and SHSP coalitions, the MCAH/OFP Branch 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.

Health Status Indicator 05: Chlamydia Rates

Health Status Indicators (HSI) 05a-b describe Chlamydia trachomatis (CT) rates per 1000 women aged 15-19 years and 20-44 years, respectively. For 2004, the CT rate for women aged 15-19 years was 22.3 per 1000. Among women aged 20-44, the chlamydia rate was considerably lower at 8.6 per 1000.

/2008/ CT rates for both age groups increased between 2004 and 2005. Rates for women aged 15 through 19 increased from 22.3 in 2004 to 22.8 in 2005. Rates for women aged 20 through 44 increased from 8.6 in 2004 to 9.1 in 2005. //2008//

/2009/ For 2006, the CT rate for women aged 15 to 19 years is 22.8 per 1000; among those aged 20-44 the rate is 9.7 per 1000. CT rates are highest among young African American females at 62.8 per 1000, compared to Whites (7.9 per 1000), Latinas (17.3 per 1000) and Asian/Pacific Islanders (6.0 per 1000) aged 15-19. //2009//

Data are currently obtained from the California STD surveillance systems operated by local and state STD control programs mandated by Title 17 reporting regulations. To augment case-based surveillance and to address inconsistent patterns of STD screening and reporting, prevalence monitoring of women is conducted at sentinel sites. These sites include family planning clinics, STD clinics, managed care clinics and juvenile halls.

California is concerned about the large number of CT infections in women. With over 120,000 cases in 2004, CT is the most commonly reported communicable disease in California and nationally. Given the asymptomatic nature of the disease, these cases represent only a fraction of the true number of infections that occurred. CT is also costly due to the long term reproductive

health consequences which include infertility, potentially fatal ectopic pregnancy, chronic pelvic pain, and poor perinatal/neonatal outcomes including prematurity, pneumonia and conjunctivitis.

Among females, more than 61,000 cases of chlamydia were reported among those aged 15- 24 years, representing almost 70 percent of all reported female cases. African Americans age 15-19 years have the highest CT rate at 50.1 per 1000 compared to the 22.3 per 1000 statewide. This heightened vulnerability to CT infection in females is observed in both case-based reporting data as well as in prevalence monitoring data gathered from the sentinel sites.

/2009/ There were over 136,000 cases of CT infection in 2006, accounting for 76 percent of reported STD cases in the state. Of these, more than 67,000 were reported among females aged 15-24 years. Female African Americans aged 15-19 continued to have the highest CT rate at 62.8 per 1000, compared to 22.8 per 1000 among females for the same age group statewide. //2009//

Trends in case-based CT rates show consistent increases over time. However, this may be due to increased screening of young women, targeted screening of older women, and the use of more sensitive screening tests. The interpretation of trends should be based on additional information, including screening coverage and access to health care. Additional 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 in family planning clinics, managed care organizations and STD clinics, chlamydia prevalence was relatively stable from 1999-2005.

HSI 05b (CT rates for women age 20-44 years) is not particularly useful for monitoring populations at risk for CT: More specific age groups should be used. Case-rates in women 20-24 and 25-29 are significantly higher than rates among women age 30 and older.

HSI 05a is preferable for focusing CT control strategies. With effective public and private partnerships and involvement of key community stakeholders, STD Control Branch resources, coordinated with resources from CDPH partners, focus CT control strategies in the following areas:

1) Community and Individual Behavior Change Interventions aim to increase both awareness and screening. In particular, it aims to increase awareness of CT screening for adolescent girls.

2) Medical/Clinical and Laboratory Services support these goals by increasing CT screening among sexually active women age 25 and younger in managed care, family planning, and juvenile detention settings.

3) Partner Services intend to increase the number of CT cases who receive timely partner referral and treatment services for CT.

4) Leadership and Partnership Development efforts strive to create and implement a strategic plan in partnership with public and private stakeholders. In particular, planning efforts will include developing innovative strategies to reduce disparities in CT infection rates among populations of special emphasis, specifically among adolescents and African Americans.

5) Surveillance and Data Management efforts aim to enhance timeliness and completeness of CT case data and prevalence monitoring test result data through electronic transmission.

6) Quality Improvement (QI) Initiative to enhance CT screening among women age 25 and younger: This intervention, targeting individual providers, will include the analysis of individual provider screening data, provider feedback via provider-specific letters, and possibly chart audits performed on a subset of low performers in order to validate screening estimates.

As indicated above, 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.

/2008/ The STD Control Branch attempts to reduce chlamydia prevalence by working in the domains of behavior change, clinical and laboratory services, surveillance, quality improvement, and leadership. On the individual level, the STD community intervention program supports youth organizations educating adolescent girls about CT screening. On the clinical level, the Branch works to increase screening in private settings including managed care, Medi-Cal, family planning, and juvenile detention settings. The Branch has released guidelines for expedited partner therapy and field therapy for chlamydia, to address infections among partners. Surveillance efforts aim to enhance timeliness and completeness of chlamydia reporting. Leadership and partner development efforts include initiatives such as 1) working with outside partners to address inequities in chlamydia rates associated with race/ethnicity, and 2) partnering with medical groups to provide chlamydia screening rates to individual providers. //2008//

Health Status Indicators 06-12: Demographics

The categorization of race/ethnicity requested by HRSA for Health Status Indicators (HSI) 06-12 is different from that commonly used in California. Because neither the race nor the ethnicity classification alone provides a complete picture of the California population, little attention has been focused on the narrative for HSI 06-12.

/2009/
The population of California age 0-24 was 13,733,693 in 2006. Of these, 6,282,257 were of Hispanic ethnicity. By race, 10,903,727 were White, 1,368,473 were Asian, 867,486 were African American, 471,326 had More Than One Race Reported, 72,482 were American Indian or Alaska Native (AIAN), and 50,199 were Native Hawaiian or Other Pacific Islander (NHPI). The population was evenly distributed among five-year-interval age categories.

The number of live births to California women in 2006 was 562,084. The mother's ethnicity for 293,267 of these births was Hispanic. Mother's race for 439,296 births was White, for 63,334 it was Asian, for 30,653 it was African American, for 12,228 More Than One Race was Reported, for 2,777 mother's race was AIAN, and for 2,600 it was NHPI. For 11,196 births, mother's race was Other or Unknown.

By age, 17,208 of these births were to women age 15-17, 35,562 to women age 18-19, 410,849 to women age 20-34, and 97,784 to women age 35 or older.

The number of deaths of children age 0-24 in California in 2006 was 7,970. Of these, 3,901 were of Hispanic ethnicity. By race, 5,994 of the deaths were White, 1,039 were African American, 539 were Asian, 259 were More Than One Race Reported, 58 were AIAN, and 47 were NHPI. For 34 child deaths, race was Other or Unknown.

The 2006 population of California age 0-19 was 11,094,500. Of these, 5,237,459 were of Hispanic ethnicity. By race, 8,845,014 were White, 1,057,369 were Asian, 687,390 were African American, 410,942 had More Than One Race Reported, 54,764 were AIAN, and 39,021 were NHPI .

Of the population age 0-19, 26.2 percent lived in a household headed by a single parent (2007). For children of Hispanic and non-Hispanic ethnicity, 27.0 percent and 25.4 percent lived in households headed by a single parent, respectively. The proportion living in households headed by a single parent, by race, were 54.8 percent for African American (down from 60 percent), 30.3 for More Than One Race Reported, 29.0 percent for AIAN

(down from 46 percent), 24.4 percent for White, and 15.7 percent for Asian.

Of the population age 0-19, 9.1 percent received benefits from Temporary Assistance for Needy Families (TANF) in 2006. By ethnicity, 9.9 percent of Hispanic children, and 8.3 percent of children who were not Hispanic, received TANF. By race, 28.4 percent of African American, 19.6 percent of AIAN, and 18.3 percent of NHPI children received TANF, while 8.1 percent of White children, 6.6 percent of Asians, and 1.4 percent of children with More Than One Race Reported received TANF.

The number of children (0-19 years) enrolled in Medi-Cal (Medicaid) in 2006 was 3,341,224. Of those enrolled, 2,057,348 were of Hispanic ethnicity. By race, the number of children enrolled in Medi-Cal was 2,564,990 White, 351,848 African American, 206,999 Asian, 14,541 AIAN and 576 children with More Than One Race Reported. For 202,270 Medi-Cal children, race was Other or Unknown.

In 2007, 866,031 children were enrolled in Health Families (SCHIP). Of these, 489,510 were of Hispanic ethnicity. By race, 582,469 White children, 94,019 Asians, 19,500 African Americans, 2,517 AIANs, and 167,526 children of Other or Unknown race were enrolled in Healthy Families.

The January 1, 2007 caseload for children living in foster home care was 75,862. Of these, 32,665 were of Hispanic ethnicity. By race, 52,036 White children, 21,006 African Americans, 1,753 Asians, 1,021 AIANs, and 46 children whose race was Other or Unknown were living in foster home care.

In 2006, 1,391,156 children ages 0-19 were enrolled in the Food Stamp Program. Of these children, 840,533 were of Hispanic ethnicity. By race, 1,035,139 White children, 234,486 African American, 107,819 Asian, 5,312 AIAN, and 8,400 children of Other and Unknown race received Food Stamps.

Of the population aged 0-19, 2,009,050 were enrolled in WIC (2007). Of these, 1,534,347 were of Hispanic ethnicity. The numbers of children enrolled in WIC by race were 1,720,710 White, 135,998 African American, 97,611 Asian, 26,715 More Than One Race Reported, 21,343 AIAN, and 6,723 Other and Unknown.

In 2006, there were 3,177 arrests per 100,000 population for juvenile felony and misdemeanor offenses among those 19 years old and younger. The arrest rate for Hispanic juveniles was slightly higher than for non-Hispanic juveniles (3,199 vs. 3,001 per 100,000), the reverse of last year. By race, the arrest rates for juvenile offenses per 100,000 children were 8,707 for African Americans, 4,195 for NHPI, 3,055 for White, 2,325 for AIAN, and 978 for Asian. All rates increased from the previous year.

For the 2005-2006 school year, the percentage of high school dropouts (grades 9-12) was 3.5 percent. By ethnicity, 4.5 percent of Hispanic students dropped out of high school, compared to 2.6 percent of non-Hispanic students. By race, 6.1 percent of African American, 4.1 percent of AIAN, 4.0 percent of NHPI, 2.1 percent of White, and 1.5 percent of Asian students dropped out of high school. 3.6 percent of students whose race was Other and Unknown dropped out. All rates increased from the previous year.

Of the 11,094,500 million children less than 20 years old, only 255,174 lived in rural areas in 2006. The majority of children lived in metropolitan or urban areas.

In 2006, 5.1 percent of the total California population of 36,160,432 were living below 50 percent of the federal poverty level (FPL). In addition, 12.2 percent were living below 100 percent FPL, and 32.2 percent were living below 200 percent FPL. Of children less than twenty years old, 7.1 percent were living below 50 percent FPL, 17.8 percent were living

below 100 percent FPL, and 41.3 percent were living below 200 percent FPL. //2009//

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//

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//

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//

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.

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//

/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//

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//

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//

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//

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.

/2009/ Title V dollars have not been used to support staff in the CMS Branch. //2009//

"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//

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.