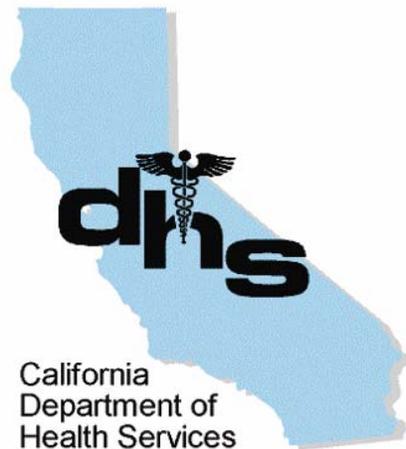


**California Five Year Needs Assessment
for the
Maternal and Child Health Services
Title V Block Grant Program**



**Maternal, Child and Adolescent Health/
Office of Family Planning Branch
Children's Medical Services Branch
Primary Care and Family Health Division
Department of Health Services
State of California**

**July 15, 2005
Needs Assessment**

State of California
Department of Health Services
Title V Five Year Needs Assessment
Maternal, Child and Adolescent Health/Office of Family Planning (MCAH/OFP) Branch
Children’s Medical Services (CMS) Branch

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EXECUTIVE SUMMARY

As a recipient of the federal Title V Maternal and Child Health Block Grant, California is required to complete a statewide needs assessment every five years. The needs assessment for the 2006 to 2010 cycle has resulted in the identification of priorities for the maternal, child, and adolescent health population over the next five years.

The Maternal, Child and Adolescent Health/Office of Family Planning Branch (MCAH/OFP) and the Children's Medical Service (CMS) Branch are two of five branches within the Primary Care and Family Health Division (PCFH) of the California Department of Health Services (DHS). The other branches include Genetic Disease Branch, Primary and Rural Health Care Systems, and WIC (Women, Infants and Children Supplemental Nutrition). MCAH/OFP and CMS within DHS coordinate the needs assessment and administer Title V funds. The mission of the MCAH/OFP Branch is to "develop systems that protect and improve the health of California's women of reproductive age, infants, children, adolescents, and their families," and the mission of the CMS Branch is to "assure the health of California's children."

Each Branch undertook inclusive efforts to produce this comprehensive needs assessment. From 2003 to 2004, the MCAH/OFP Branch took a multi-level approach to conduct the current needs assessment. This involved collaborations with the University of California San Francisco (UCSF) and the state's 61 local health jurisdictions, including various state and local programs, professional groups, provider organizations, community citizens, parents, and former clients. Fifty-five of the 61 jurisdictions (90 percent) submitted needs and capacity assessments in 2004, and the Branch closely analyzed this rich data on local-level needs and process methodology. In April 2005, 46 stakeholders from a range of organizations involved in the maternal, child, and adolescent health arena participated in a stakeholder meeting where the participants discussed the data and issues and, based on an agreed criteria for ranking, provided recommendations for setting state priorities. The Branch also analyzed statewide quantitative data and examined capacity at the state level. From the results of the local needs assessments, the Stakeholder Meeting, statewide data, and capacity assessment the MCAH/OFP Branch identified priority needs for two of the Title V maternal, child and adolescent health population groups: Pregnant Woman and Infants, and Children and Adolescents.

The CMS Branch invited 37 stakeholders to participate in the identification and prioritization components of the needs assessment process for Children with Special Health Care Needs (CSHCN). Stakeholders included representatives from local CMS and MCAH programs, California Children's Services (CCS) Technical Advisory Committees, State agencies, professional and provider organizations, and parents. 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 third Title V population group.

California's Title V priority needs for 2006-2010 are as follows:

- Enhance preconception care and work toward eliminating disparities in infant and maternal morbidity and mortality. (MCAH)
- Promote healthy lifestyle practices among MCAH populations and reduce the rate of overweight children and adolescents. (MCAH)

- Promote responsible sexual behavior in order to decrease the rate of teenage pregnancy and sexually transmitted infections. (MCAH)
- Improve mental health and decrease substance abuse among children, adolescents, and pregnant or parenting women. (MCAH)
- Coordinate to develop and implement a system of timely referral between mental health, developmental services, social services, special education services and CCS. (CSHCN)
- Improve access to medical and dental services, including the reduction of disparities. (MCAH)
- Expand the number of qualified providers participating in the CCS program, e.g., medical specialists, audiologists, occupational and physical therapists, and nutritionists. (CSHCN)
- Increase the number of family-centered medical homes for CSHCN and the number/percent of CCS children who have a designated medical home. (CSHCN)
- Decrease unintentional and intentional injuries and violence, including family and intimate partner violence. (MCAH)
- Increase breastfeeding initiation and duration. (MCAH)

The MCAH/OFP Branch will begin to draft specific strategies for addressing each priority need in August, 2005. The CMS Branch will continue working with the stakeholder group in partnership with the Champions for Progress grant to develop strategies, activities, and performance measures to implement these objectives.

The California Title V Five Year Needs Assessment is the first step in a cycle for continuous improvement of maternal, child and adolescent health. Between 2005 and 2010, actions and strategies will be implemented, results will be monitored and evaluated, and adjustments will be made as necessary to continue to enhance the health of California women, children and adolescents.

INTRODUCTION

The Title V Block Grant is a federal grant sponsored by the Health Resources and Services Administration (HRSA). Originally implemented as part of the Social Security Act of 1935, Title V is a federal-state partnership, giving federal support to state efforts to extend and improve health and welfare services for mothers and children. In 1981, the Title V program was converted to a block grant, and in 1989 the program began to require increased accountability in order to insure that states' use of these federal dollars were consistent with national health objectives. The new accountability standards required measurable goals, reported annually, and linked funding decisions to performance.

With a target population of women of childbearing age (15-44), pregnant and parenting women, children and adolescents and children with special health care needs, Title V is the primary source of federal support for improving the health and well-being of mothers and children. In 2005 California received approximately \$48 million in federal Title V funds, and put up state matching funds of over \$750 million. These funds are allocated to the MCAH/OFP Branch and the CMS Branch.

One of the requirements of Title V is that all grant recipients prepare a comprehensive statewide needs assessment every five years. It was decided that the California 2006-2010 Title V Five Year Needs Assessment process would be conducted by population group. The MCAH/OFP Branch was responsible for assessing the needs of pregnant women, mothers, infants, children, and adolescents. The children with special health care needs (CSHCN) component was completed by the CMS Branch.

MCAH/OFP began development of the needs assessment in 2002. The first step in the process was a series of planning meetings among Branch staff as to the direction and goals of the needs assessment. California is unique among the states in terms of its size and diversity of population, geography, and maternal, child and adolescent health needs. The goal was to design a process capable of encompassing all of the variation in this large, diverse state.

It was decided that the needs assessment should be driven by the state's 61 local MCAH jurisdictions. The challenge was to develop a local needs assessment approach that gathered information from local jurisdictions that revealed the diversity among them, yet standardized enough to compare them on common measures. Over the next year, MCAH/OFP Branch staff developed a set of needs assessment guidelines that led local jurisdictions through all aspects of the report. In order to gain as much insight as possible into unique community needs, jurisdictions were strongly encouraged to gather information from local stakeholders, community organizations, clients, and the local staff of MCAH and related programs.

The MCAH/OFP Branch's Five Year Needs Assessment process was a three-way collaboration between the Branch, local MCAH jurisdictions, and the Family Health Outcomes Project (FHOP) at UCSF. Working with FHOP, the Branch developed a set of 27 indicators and report guidelines for the local jurisdictions. The guidelines were distributed to local MCAH Directors in August, 2003. During the following year, FHOP provided the jurisdictions with indicator data, technical assistance, training sessions, and, in some cases, one-on-one assistance. Each jurisdiction selected priority needs for their community. Jurisdictions submitted their reports to the Branch one year later, in August, 2004.

MCAH staff read and synthesized the local jurisdiction reports, examining the frequency of selected priority needs and any qualitative data. The synthesized results of the local reports were presented, along with statewide data, to a statewide stakeholder meeting in April, 2005. Stakeholders considered the data and results of the local reports, discussed and selected ranking criteria, and made recommendations for priority needs. The Branch reviewed statewide surveillance data and analyzed capacity as well. The priority needs were chosen based on the input from local MCAH jurisdictions, stakeholders, statewide data, and the assessment of capacity. The selected priority needs represent the experience and input of individuals and organizations from across the state and from a broad range of MCAH policy and practice. Over the next year, the MCAH/OFP Branch will develop state performance measures (SPMs) and action plans for addressing the priority needs.

The CMS Branch utilized a two-pronged approach in the needs assessment process. The Branch staff completed an internal capacity assessment tool to identify its strengths and weakness to meet the challenges of the next five years. As part of that process, the group identified several potential strategies to address the areas that need improvement.

The external needs assessment for CSHCN in California was facilitated by FHOP, which also analyzed the available data for this population. Thirty-seven (37) stakeholders were identified to be integral partners in this process. The stakeholder group included representatives from local CMS and MCAH programs, CCS Technical Advisory Committees, State agencies, professional and provider organizations, and parents.

Two meetings were held with the stakeholders in January and April 2005. Based on the analysis of data and the first stakeholder meeting, 15 indicators were selected for prioritization at the April 2005 meeting. The prioritized list that resulted will guide the activities of the CMS Branch over the next five years. The top three objectives on the list are incorporated into the State's ten priority needs for the Title V 5-year plan.

The CMS Branch will be partnering with the Champions for Progress project to develop an action plan to address the priority areas identified in this process. The stakeholder group will develop a strategic plan for serving CSHCN, identify resources in California to carry out the activities, and develop a monitoring and evaluation strategy to assure continued improvement and progress toward achievement in the priority areas.

STATE OF CALIFORNIA MATERNAL, CHILD AND ADOLESCENT HEALTH OVERVIEW

Demographics

California is the most populous of all US states, with 36.6 million residents as of July 2004, and is the third largest state in terms of land area ¹. The state's population has increased annually since 1940 and currently makes up 12 percent of the nation's total. Though the population in the state continues to increase, the rate of increase has slowed each year since 2000, from 2.0 percent in 2000-2001 to 1.7 percent in 2003-2004 ².

The population increase is the result of a net increase of births minus deaths plus net migration to the state. Foreign immigration to the state far exceeded domestic migration for the period 1999-2004, with net foreign immigration totaling 1,228,673 and net domestic migration totaling 435,290 ³.

California residents are younger on average than the nation as a whole. The median age for the state in 2003 was 34, which is significantly lower than the median age in the US of 36 ⁴.

In 2003, there were almost 7.8 million women of childbearing age (15-44) in California ⁵. 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) ⁶. Nationally, children under age 19 make up 28 percent of the population, and those under 5 make up 7 percent. 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 ⁷.

The number of live births in California increased from 518,073 in 1999 to 540,827 in 2003 ⁸. While the overall number of births in California has been increasing, the number of teen births declined from 56,577 in 1999 to 49,330 in 2003. The rate of teen births (per thousand females age 15-19) has dropped from a peak of 72.9 in 1991 to 38.9 in 2003.

Although the overall teen birth rate declined steadily between 1991 and 2003, the decline among Hispanic teens was slower, and Hispanics are disproportionately represented in the number of California's teen births. Hispanics account for 69 percent of teen births⁹, while only accounting for 41 percent of the total teen population (age 15-19) ¹⁰.

In 2001, California had significantly fewer children identified as CSHCN when compared to national statistics (10% vs. 13%). This difference persisted in all age groups under 12 years of age. For children 0-3 years of age, 4% of those in California have been identified as CSHCN as compared with 7% nationally. Only 8% of California children 4-7 years of age were designated as having special health care needs compared with 11% nationally. For children 8-11 years of age, the difference remains significant (13% vs. 16%).¹¹

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 2000¹². By the year 2040 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 counties¹³. 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).

California is home to 28 percent of the nation's foreign-born population. In 2002, 27 percent of the nation's immigrants 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 Asia¹⁴.

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 2003 was 26, eight years younger than that of the total population (34). Among Whites, the median age was 40, and for Asian and Pacific Islanders, the median age was 34¹⁵. Hispanic children comprised the largest proportion of school children during the 2003-2004 school year, making up 46 percent of students in California¹⁶.

Racial/ethnic diversity and a large immigrant population contribute to linguistic diversity in California. In 2003, 41 percent of California residents over the age of five spoke a language other than English at home, compared to 18 percent nationwide. Most often this language is Spanish, however, a variety of Asian and Pacific Island languages are also spoken. Of those who speak a language other than English at home, 47 percent believe that they speak English less than "very well"¹⁷. This poses a linguistic barrier to access to health services in California. Nearly half of Medi-Cal and Healthy Families recipients in 2003 spoke a language other than English¹⁸. To increase access, Medi-Cal and Healthy Families publish materials in ten different languages.

The race/ethnicity of the CSHCN population in California is significantly different from that of the United States as a whole. It parallels that of the race/ethnic distribution in the state general population. Based on the National Survey of CSHCN in 2001, 32% of California CSHCN were Hispanic, compared with 12% nationally. Whites accounted for 48% of CSHCN in California, significantly less than the 68% for the United States, followed by Blacks (10% vs. 14% nationally). The race/ethnicity of Multiracial (3.1% vs. 2.9%) and Other children (6.8% vs. 2.6%) were not significantly different.¹⁹

Geography

California is comprised of 61 local health jurisdictions, including 58 counties and three incorporated cities. These local health jurisdictions 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 had the smallest population, with about 1,200 residents.

Most of the state's population (94 percent) resides in urban areas. 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 2000-2004, although the rate of growth appears to be slowing ²⁰. Riverside and Placer Counties grew at the highest rate, increasing in population by at least 4 percent each year. Other counties projected to experience large increases in population include San Joaquin, Merced, and Madera ²¹. From 1999-2004, Sierra was the only county with a net loss in population, but Alpine and Marin Counties were at or close to a zero growth rate ²².

In addition to the variation in population size among counties, there are abundant differences in geographic terrain. Rural counties may be agricultural, mountainous, desert, forested, or any combination thereof. Some counties contain pockets of population in certain areas that can readily access health services, while those residing in other parts of the county may face significant barriers to access. Impassability of roads, due to weather conditions, may also make access to services impossible during parts of the year in some counties. Rural counties' community assessments provide many illustrations of geographic barriers to healthcare.

Other counties noted deficiencies in, or a complete lack of, public transportation, making access time-consuming and complicated for those without their own means of transportation. Mendocino County, for example, reported that some transit routes from remote areas to services in larger towns such as Ukiah or Fort Bragg could take over an hour in each direction, and may only run one round trip per day, providing little flexibility for residents who rely on them for access to services.

Economy

In 2003, the State of California's gross product ranked seventh in the world ²³. 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 2004 was 6.1 percent, compared to the national rate of 5.5 percent. The drop in the unemployment rate in Fiscal Year (FY) 2003-04 was the first drop in unemployment since FY1999-2000 ²⁴. The forecast through 2007 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 ²⁵.

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 2003, 13.4 percent of California residents lived below the FPL. This is worse than the national rate of 12.7 percent and ranks California as the 19th worst state in terms of residents in poverty²⁶. Two counties in California's Central Valley ranked among the ten most impoverished counties in the nation: Tulare, with 22.9 percent of residents living below the federal poverty level, and Fresno, with 21.8 percent²⁷.

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 2003 California ranked 48th in the nation for home ownership among residents. It ranked second in the nation for cost of a home or rental contract²⁸. Of those families with children in California whose income falls below 150 percent poverty level, 33 percent are headed by a single female parent²⁹. Of the 4.6 million households with one or more children under 18 in California, 20 percent are headed by a single female parent³⁰. These households are more likely to struggle to support themselves with less than adequate income.

Housing costs present an increasing challenge in California, both for those who rent and for those who hope to own their home. The population growth occurring in California only compounds this problem, as the construction of new housing units cannot keep up with increasing demand. While the actual cost of housing varies between different regions in California, the problem exists throughout the state.

In high-cost Orange County, 48 percent of renters and 32 percent of owners spent more than the recommended 30 percent of their household income on housing. Among low-income (less than \$20,000/household) residents, this proportion balloons to 89 percent of renters and 80 percent of those who own their homes. In San Francisco, to afford a two-bedroom apartment at fair market rent (as deemed by the Federal Housing and Urban Development Office), a family needed to earn \$71,000, the equivalent of five minimum wage jobs³¹.

Orange and San Francisco Counties are notoriously high-cost areas; however, even in lower-cost areas, affordable housing is becoming increasingly scarce. In California's rural counties, a family would need to earn \$10/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)³².

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 children³³.

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 force³⁴. In California, 52 percent of children were in families headed by a single working parent or in which both parents worked³⁵.

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 25 percent of children with parents in the

labor force. The cost of childcare for a preschooler typically consumes 48 percent of a parent's income if the parent is working full time at minimum wage ³⁶.

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) ³⁷.

Income level correlates with education level in California, as it does nationally. The median number of years of education completed by California's residents 25 years or older is 13.5. Among California residents, 81 percent have a high school diploma, and 32 percent have a Bachelor's degree or higher. Asians have the highest rate of college completion among California residents, at 50 percent, followed by Whites at 40 percent, African-Americans at 23 percent, and Hispanics at 10 percent. The high school graduation rate was 94 percent for Whites, 87 percent for African-Americans, 85 percent for Asians, and 54 percent for Hispanics ³⁸.

There are currently more than 6 million school-aged children in California and more than 9,000 schools ³⁹. Hispanic students comprise the largest and fastest growing racial/ethnic groups 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 ⁴⁰.

Health Care Status

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 ⁴¹. 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. It is estimated that 40 percent of the undocumented immigrants are women⁴². 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 ⁴³.

Most of the undocumented families lack employer-based health insurance, and many are prevented from accessing publicly funded insurance due to legal and regulatory restrictions.

Providing MCAH services to this population presents a unique challenge which is made even more difficult by the different eligibility requirements for available public programs. Some services, such as Women, Infants and Children Supplemental Nutrition Program (WIC), are available to undocumented immigrants. Others, such as Medi-Cal, are available to undocumented immigrants on a limited basis. Still others, such as Food Stamps, are not available to undocumented immigrants, but are available to their children born in the United States.

It is not surprising, given the complicated nature of eligibility for public assistance, coupled with fear of the consequences of having to reveal one's status as undocumented, that 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 expensive⁴⁴. Other complications arise for undocumented immigrants who seek services in one county, then move on to another region for work. This makes it difficult to provide consistent and comprehensive services and to track services rendered to this population.

Challenges in meeting the diverse needs of mothers and children also arise as a result of increasingly varied family and household structures that exist in California. For example, in addition to the large proportion of female-headed households with children, a growing proportion of children are living with grandparents. In 2003, over 860,000 grandparents stated that grandchildren were living in their home. In 31 percent of these households, the grandparents reported that they were the primary caretakers for the grandchildren living in the household. Of those responsible for grandchildren, 55 percent were working, and 16 percent were living in poverty⁴⁵.

The aging of the state's population also has 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. About half of California caregivers reported they were employed, 35 percent full-time. One third of caregivers reported high emotional stress due to providing care⁴⁶. 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 increase in size.

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.

LOCAL MCAH JURISDICTION FIVE YEAR NEEDS ASSESSMENT PROCESS

California is the most populous state in the nation, and has extreme demographic and geographic diversity. In order to best reflect the variations among the state's 61 MCAH jurisdictions, a guiding principle in the design of the California MCAH/OFP Branch's Title V Five Year Needs Assessment (5YNA) was that it be a "bottom-up" approach. The goal was to mine the rich experience and subject knowledge of MCAH staff throughout the state in order to have the best possible understanding of the range of MCAH needs and capacity. It was also realized that in a state as large as California, one of the best ways to obtain stakeholder and consumer input in the development of the statewide needs assessment was to have the local jurisdictions obtain this information from their constituents.

Guideline Development

Each MCAH jurisdiction was required to develop a needs assessment of their Title V populations and develop a set of priority areas based upon identified needs and consideration of local capacity. The MCAH/OFP Branch and FHOP collaborated on the development of the needs assessment guidelines (see "Guidelines and Indicator List for MCAH Jurisdictions," in Appendix 1), which specified the standardized needs assessment format to be used by all jurisdictions. It was important that the jurisdictions provide consistently formatted needs assessments so that the MCAH/OFP Branch could synthesize the findings from the many reports into one cohesive document.

The guidelines specified that each needs assessments should be comprised of seven sections. Specific descriptions of what the sections should include, along with recommended page lengths, were provided. The seven sections included:

- Summary/Executive Report (1-2 pages)
- Description of the MCAH Community Health Assessment Process (1-3 pages)
- MCAH Planning Mission Statement and Goals (1 page)
- MCAH Community Assessment
 - Community Health Profile (2-5 pages)
 - Community Resources Assessment (1-4 pages)
 - Review of Required MCAH Indicators (2-7 pages)
 - Optional Topics (1-4 pages)
 - Assessment of MCAH Capacity (1-4 pages)
 - Identification of Problems/Needs of MCAH Populations (1-3 pages)
- Priority MCAH Problems/Needs in the Jurisdiction (1-2 pages)
- Preliminary Problem Analysis for the Identified Priority Problems (2-3 pages)
- Appendices

A suggested "process" followed the detailed section descriptions, describing how the jurisdictions might want to go about collecting data, conducting interviews and stakeholder meetings, and setting priorities among identified health problems. Throughout the Guidelines, the importance of receiving input from local stakeholders was strongly emphasized.

Health Status Indicator Data

A key component of the local needs assessment process was the requirement for each jurisdiction to review 27 different indicators of population health status in their jurisdiction. Selection of the indicators was based upon a number of criteria. The first step was to conduct a survey of local MCAH Directors and obtain their input regarding what they viewed as core indicators of MCAH population health status. In February 2003 a list of approximately 75 possible indicators, including those from Title V, were sent to the 61 MCAH local jurisdictions for them to rank. These results were then summarized and the health status indicators ranked. Another consideration in choosing the indicators was whether county-level data were available. The final list of selected indicators also had to cover the primary MCAH Title V populations as well as cover major domains of health.

The final list of indicators fell into several groups, including: birth, death, prenatal/postnatal care, health, injuries, and other. The data sources used for the 27 required local indicators included:

1. Birth file
2. Fetal death file
3. Death file
4. Genetic Disease Branch data
5. California Health Interview Survey (CHIS)
6. Child Health and Disability Prevention Program (CHDP)
7. Office of Statewide Health Planning and Development—hospital discharge data (OSHDP)
8. Sexually Transmitted Disease (STD) Branch data
9. Department of Social Services (DSS)
10. Census 2000 from Department Of Finance (DOF)
11. California Women's Health Survey (CWHS)

To decrease local jurisdiction burden and ensure standardized analyses, jurisdiction-level data were compiled and posted on the FHOP website. When possible, the data were stratified by race/ethnicity and trended over time. Jurisdictions were required to compare their rates to the State rate and/or Healthy People (HP) 2010 objectives. Local jurisdictions were also instructed to review their data for significant differences among subgroups and trends over time. Indicators that were significantly worse than a standard or that had a significant downward trend were to be included in the list of MCAH problems for consideration as a local priority area.

A number of “optional topics” were suggested that are of MCAH interest, but for which data were limited or not available at the county level. Some of the recommended “optional” topics included perinatal substance abuse, physical activity, gestational diabetes, oral health, etc. Jurisdictions were encouraged to use locally developed data sources and/or qualitative data for these measures.

Local Capacity Building and Provision of Technical Assistance to Jurisdictions

FHOP staff provided technical assistance and other capacity-building activities that were critical to the completion of the local MCAH jurisdictions' comprehensive needs assessments. Services provided included the development and dissemination of surveillance data, data analysis tools, assistance with data analysis, technical assistance by phone and through local site visits, trainings, and other activities as needed or requested by the local MCAH jurisdictions.

To assist with the data analysis on the required indicators, FHOP created several automated products. A set of EXCEL spreadsheets, were created that allowed local jurisdictions to compare their data to State data and HP 2010 targets for each of the required indicators. The local jurisdiction needed only to enter the numerator and denominator data (extracted from the spreadsheets provided for them) for up to 10 years of data and the spreadsheet automatically calculated the rates and confidence intervals and then created a chart comparing local data to State level data and HP 2010 targets. This enabled local MCAH staff, many of whom do not have a background in statistics, to easily determine whether their county was doing significantly better or worse than the State or HP 2010 target. They were also able to examine longitudinal changes in their jurisdiction for a particular indicator because the data templates allowed them to enter data for multiple years. FHOP staff were available to assist local MCAH staff with the use of the data templates by phone, and also had several in-person meetings with local jurisdictions to help with the interpretation of their indicator data.

FHOP held trainings and provided ongoing technical assistance to local jurisdictions on EpiBC and EpiHOSP. Both programs are based on the CDC's EpiINFO software and are available for free download off the FHOP website. EpiBC uses birth certificate data files while EpiHOSP allows analysis of hospital discharge data files. These software products allow local jurisdictions to generate reports, tables, maps, and graphs that provide more detailed information about indicator data and associated risk factors and co-morbidities. For example, a county noticing a high rate of late entry into prenatal care can use EpiBC to examine the relationship between insurance payor source and time of entry into prenatal care.

Many counties in California have small populations, which makes it difficult to perform extensive quantitative analysis on many of the required indicators using existing data sets. Existing statewide surveys do not collect enough data from the smaller counties to provide a statistically valid sample. As a result, the Rural Caucus of MCAH Action (the statewide coalition of local MCAH jurisdictions), requested that FHOP work to develop a survey tool that could be used by local jurisdictions to identify key problems that affect the MCAH population in their communities. The survey tool could be used either to collect quantitative data on a representative sample or to supplement existing quantitative data with qualitative information.

FHOP worked collaboratively with a Rural Caucus workgroup to develop the survey tool. The workgroup met several times through teleconferences and chose to develop a core set of health questions as well as additional supplementary modules on specific health areas as decided upon by the committee. These modules included Adolescent Health, Oral Health, Perinatal Substance Use, Family Violence, Asthma, and Childhood Obesity. FHOP staff identified

potential survey questions, using already tested surveys/questionnaires as sources. These questions were compiled, and the group met to determine criteria for question selection. Some members of the workgroup volunteered to pilot the survey in their communities. Based on the pilot test, FHOP staff developed guidelines for the administration of the survey and posted these with the survey modules on its website.

The FHOP website was used extensively as a tool for disseminating information about the needs assessment process and applicable products and tools. A section of the website was designed exclusively for local MCAH jurisdictions to access resources for the needs assessments, including indicator data and each of the other products described above. In addition, the website included sections containing links to useful data and resources for use in developing the Community Health Profile and the Community Resources Assessment sections required in the Title V Needs Assessment report. Both sections contained links to local data and suggested information sources that could be used to gather some of the information necessary to complete these sections.

FHOP developed tools that were recommended for use by local jurisdictions for the completion of their needs assessment reports. These included a Capacity Rating tool, which guided MCAH staff through a process of assessing the capacity of their local MCAH agency to address problems in their community and carry out programs effectively. FHOP also developed a tool to assist local MCAH staff in working with stakeholders to prioritize problems identified during the Needs Assessment process. Both of these tools were available, along with instructions for their use, on the FHOP website.

FHOP's monthly newsletter, the *FHOP Express*, which contains training announcements, information about new products, and other resources relevant to local MCAH staff and their communities, helped to keep local MCAH staff abreast of needs assessment-related resources. When data or resources were added or updated on the FHOP website, an additional "Data Alert" was sent to newsletter recipients to inform them of the update.

Following the July 31, 2004 deadline, FHOP followed up with those jurisdictions that had not yet submitted their Needs Assessment reports, and offered additional assistance. As reports were submitted, FHOP staff reviewed each one and sent a feedback report to each MCAH Director to discuss highlights of their report, alert them to any required item that may have been missing, and to provide information about the steps they would take in developing an Action Plan to address their priority problem areas.

SUMMARY OF LOCAL MCAH JURISDICTION NEEDS ASSESSMENT REPORTS

METHODS USED FOR REVIEWING LOCAL MCAH NEEDS ASSESSMENTS

Needs assessment reports were completed by 55 of the 61 local health jurisdictions in California. These jurisdictions represent 91 percent of all births to California residents, 95 percent of children and adolescents 1-17 years of age, and 93 percent of women 18-44 years of age.

Both qualitative and quantitative data in the local assessments were reviewed. Data were collected on the planning process – the number and type of participants recruited for their efforts as well as the number and type of partnerships, collaborations, and community inputs. Data were also collected on the sources of information. These sources were identified in the narratives and references, and then grouped into one of three categories – empirical research data, local program data, or community resident input data.

Data were collected on the stated gaps and needs (including barriers), as identified in the community assessment, community profile, and priority sections of each assessment. This type of data was analyzed for their content and theme according to techniques commonly used in the sociological and social science traditions.⁴⁷ No inferences were made on what other issues these problems might have also encompassed, unless they were specifically discussed in the body of the text. In other words, only issues detailed in the narratives regarding each concern were recognized as being part of that problem.

The data on the gaps and needs were analyzed from two perspectives – as individual topics and as broad categorical subjects. Individual topics were distinguished from categorical subjects by the idea that single topics help show the specific area of focus to be targeted, whereas broad subjects help show where the problem fits within the context of the larger health care arena.

Microsoft Excel was used to tabulate the results by state totals and by individual jurisdictions. With regard to the tallying method, each jurisdiction received a count of one when it identified a specific problem, regardless of how often that issue was reiterated in the report. This method of counting would result in showing how many jurisdictions identified an issue as being a problem rather than how often that issue was restated by the same jurisdiction. Therefore, the unit of analysis was the jurisdiction.

Most individual topics and categorical concerns represented stand-alone subject matters. A few represented subjects that were expressed only in connection to another subject. In general, the issues that were discussed along with another problem included special populations, education, and basic needs. For example, a jurisdiction that named low birth weight, particularly among Hispanics, as a priority received a count of one for the priority dealing with low birth weight and another count of one for the priority dealing with the ethnically diverse population. This method of counting would capture the various concerns that might be covered by a single statement of priorities.

RESULTS

Rich Sources of Data Supported Local Needs Assessments

In addition to the required quantitative surveillance data for the 27 indicators provided to the health jurisdictions, local jurisdictions used many sources of data to describe the problems in

their regions. Table 1 provides a breakdown of the different data sources. Overall, there were 676 sources of data with an average of 12 citations per jurisdiction.

Table 1: Documented Sources of Data, by Data Type

Data Type	County	Volume
	# (%)	# (%)
Total Documented Data Sources	54 (98)	676 (100)
Empirical Research Data	54 (98)	483 (71)
Academic Journals	17 (31)	45 (07)
Think Tanks	18 (33)	28 (04)
Academic Institutions	44 (80)	76 (11)
State Governmental Agencies	42 (76)	105 (16)
Federal Governmental Agencies	45 (82)	82 (12)
Advocacy groups	34 (62)	68 (10)
Other Empirical Research Sources Not Identified Above	37 (67)	79 (12)
Local Program Data	41 (75)	116 (17)
Community Input Data	48 (87)	77 (11)
Local Surveys	27 (49)	27 (04)
Community Representatives in the Assessment Process	34 (62)	34 (05)
Focus Groups to Community Representatives	16 (29)	16 (03)

Empirical research data were cited by 98 percent of all jurisdictions and accounted for 71 percent of all sources. Most of these data were generated by state and federal agencies, such as the Department of Health Services or the Centers for Disease Control and Prevention. Other sources of data came from academic institutions and advocacy groups. Works from the University of California campuses at San Francisco and at Los Angeles were the most frequently cited academic sources. Papers by advocacy groups came from a variety of organizations, such as the First Five Commission or the American College of Obstetrics and Gynecology. A number of publications also came from think tanks, such as the Medi-Cal Policy Institute. Other sources of data were generated by miscellaneous organizations, such as private research consulting firms or professional newsletters.

Local program data accounted for 17 percent of all sources. Examples included the local Black Infant Health programs or the local Departments of Education. Recent needs assessments conducted by other organizations, such as the First Five Commission, were also a frequent source of local data.

Community input data made up 11 percent of all sources. This form of data came in three ways – as participants in local surveys, as invited members to the local needs assessment process, or as participants in focus group or other public meetings. Although local surveys accounted for only 4 percent of all sources, the questionnaires from these surveys were distributed to 4,959 individuals across the state, including clients, family members, and adolescents.

Local Stakeholder Input

Local jurisdictions relied on residents in the community as well as professionals involved in the MCAH field to identify problems and priorities. However, in reporting this part of the process, the jurisdictions varied in their level of specification. Some jurisdictions named each individual participant, whereas others named each organization or type of organization.⁴⁸ A few provided a total number of participants without additional details. More than two out of five provided facts about the individuals, such as their professional titles or organizational affiliations. Table 2 provides an overview of participants who assisted in the identification of needs.

Table 2: Participant Group Representation in the Naming of Local Needs and Priorities, by Participant Type

Participant Type	County	Volume
	# (%)	# (%)
Total	55 (100)	1655 (100)
Local Governmental Agencies or Local Programs	55 (100)	239 (14)
Social Service Organizations	41 (75)	99 (06)
Health Care Providers	43 (78)	131 (08)
Elementary, Middle, or High School Administrators	23 (42)	24 (01)
University or College Academicians	8 (16)	10 (-)
Local Residents as Community Representatives	39 (71)	62 (04)
Advocacy Groups and Other Organizations	46 (84)	137 (08)
Unaccounted or Unknown Affiliations	19 (35)	953 (58)

Taken as a whole, all jurisdictions had community representation. Some groups were more heavily represented in this assessment process than others. For example, over 70 percent of all jurisdictions reported having representation from health care providers, social service agencies, advocacy groups, and local resident communities. However, as an aggregate total for each group, there were greater numbers of representatives from health care providers and advocacy organizations than from school administrators or local community residents. In mentioning the participation of community residents, it should be re-emphasized that this form of input made

up only a fraction of all residents who participated in the assessment – the most common form of input was from local surveys.

About 35 percent of all jurisdictions reported a total number of local participants without identifying additional details about them, such as their group affiliations. As a result, these unnamed participants were tallied as unaccounted or unknown. The unaccounted group totaled 953 individuals and made up 58 percent of all participants throughout the state.

Qualitative Information Supplemented Issues with Limited Data

One inherent nature of needs assessments is that data describing problems are not always available in existing databases. This is particularly true with emerging issues and previously unidentified problems. For example, most of the sources for perinatal substance abuse came from testimonies of various individuals, such as parents, social service administrators, and medical professionals. Some came from secondary data sources that touch on issues that could suggest a potential problem, such as surveys involving providers of the Comprehensive Prenatal Care Program or case reviews by the Child Death Review Team or from the Fetal Infant Mortality Review. Many of these qualitative data sources also came from the partnerships developed by the local jurisdictions, such as those involved work with the various child and family-oriented commissions, the various local medical or health societies, and the other existing local collaborations.

Frequency of Problems and Priorities

At the local level, the task of identifying needs consisted of two parts – the identification of major problems in the region and the prioritization of those problems that will be addressed over the next five years. In all, the jurisdictions identified 122 individual problems and named 81 of them as priorities. Table 3 shows the concerns organized by broad categorical subjects, while Table 4 shows the most frequently identified concerns by individual topics. The rankings shown in these tables reflect the number of jurisdictions that identified an issue as a local problem or priority.

Table 3: Categorical-Level Problems and Priorities, Ranked by Number of Jurisdictions

Broad Categorical Subjects	Rankings	Jurisdictions	Rankings	Jurisdictions
	Problems	Problems	Priorities	Priorities
		# (%)		# (%)
Access to Care/Services	1	52 (95)	2	38 (69)
Special Populations	1	52 (95)	5	29 (53)
Basic Needs *	2	48 (87)	12	11 (20)
Substance Abuse **	2	48 (87)	3	37 (67)
Health Conditions	2	48 (87)	1	41 (75)
Prenatal Care	3	45 (82)	4	34 (62)
Other Topics ***	4	44 (80)	10	17 (31)
Mental Health	5	42 (76)	8	19 (35)
Education	5	42 (76)	13	10 (18)
Violence	6	39 (71)	7	23 (42)
Oral Health	7	37 (67)	6	25 (45)
Birth Outcomes	8	35 (64)	6	25 (45)
Mortality	9	30 (55)	11	13 (24)
Breastfeeding	10	29 (53)	6	25 (45)
Injuries	11	26 (47)	9	18 (33)

* The category basic needs encompasses issues dealing with income, food, clothing, and shelter.

** The term substance abuse is used broadly throughout this report to refer to any alcohol or drug use that was identified as being a problem, including tobacco use. This includes any discussion of substance use, substance abuse, and substance dependence.

*** The category other topics encompass all issues not identified as falling clearly within the scope of the other 14 categorical topic areas, such as access to care, substance abuse, health conditions, or mental health.

Table 4: Most Frequently Identified Individual Problem and Priority Topics, Ranked by Number of Jurisdictions

Specific Individual Topics	Rankings	Jurisdictions	Rankings	Jurisdictions
	Problems	Problems	Priorities	Priorities
		# (%)		# (%)
Lack of Health Insurance	1	42 (76)	4	23 (42)
Ethnically Diverse Population	1	42 (76)	10	13 (24)
Adolescent At-Risk Population	2	38 (69)	3	25 (45)
Lack of Transportation	3	37 (67)	--	--
Obesity in Children & Adolescents	3	37 (67)	1	33 (60)
Early or First Trimester Prenatal Care	4	34 (62)	4	23 (42)
Low Birth Weight or Prematurity	4	34 (62)	3	25 (45)
Perinatal Substance Abuse	5	32 (58)	2	29 (53)
Poverty or Low Wages	5	32 (58)	--	--
Lack of Bilingual Professional Staff	6	30 (55)	--	--
Oral or Dental Health Care	7	29 (53)	7	18 (33)
Cost of Housing or Cost of Living	8	28 (51)	--	--
Adequacy of Prenatal Care	8	28 (51)	6	19 (35)
Lack of Specialty Providers	9	27 (49)	--	--
Substance Abuse in General	9	27 (49)	9	14 (25)
Domestic, Family, or Partner Violence	9	27 (49)	--	--
Lack of Dental Insurance	10	26 (47)	--	--
Low Education or Health Literacy	10	26 (47)	--	--
Health Education & Promotion	10	26 (47)	--	--
Program Funding	10	26 (47)	--	--
Breastfeeding in General	--	--	5	20 (36)
Asthma	--	--	8	16 (29)
Infant, Neonatal, Post Neonatal	--	--	10	13 (24)
Deaths & SIDS	--	--	10	13 (24)
Unintentional Injuries Among Teens	--	--	10	13 (24)

The remaining tables in the section focus on each categorical subject, detailing the individual topics within each grouping. These tables are presented here in order of their frequencies for being named as a local priority.

Table 5 shows that childhood obesity was the most frequently identified health problem as well as the most frequently named priority under this subject heading. It was viewed as a problem by 67 percent of all jurisdictions and ranked as a priority by 60 percent. On the other hand, although diabetes was recognized as a problem by nearly a quarter of all jurisdictions, this issue was viewed as a MCAH priority by only 5 percent of the jurisdictions.

Table 5: Health Conditions Issues as Problems and Priorities, Ranked by Number of Jurisdictions

Health Conditions: Individual Topics	Rankings Problems	Jurisdictions Problems	Rankings Priorities	Jurisdictions Priorities
		# (%)		# (%)
<i>Total Jurisdictions</i>		48 (87)		41 (75)
Obesity in Children & Adolescents	1	37 (67)	1	33 (60)
Obesity in the General Population	2	22 (40)	3	11 (20)
Asthma	3	19 (35)	2	16 (29)
STI in the General Population *	4	14 (25)	5	4 (07)
STI Among Adolescents *	4	14 (25)	4	7 (13)
Infectious Diseases & Miscellaneous Conditions	5	12 (22)	--	--
Diabetes or Gestational Diabetes	5	12 (22)	6	3 (05)
Heart Diseases	6	6 (11)	--	--
Anemia	7	5 (09)	7	2 (04)
HIV/AIDS **	7	5 (09)	8	1 (02)
Cancer	8	4 (07)	--	--

* STI is abbreviated for sexually transmitted infections.

** HIV is abbreviated for human immunodeficiency virus; AIDS is abbreviated for acquired immune deficiency syndrome.

Access to care was the second most frequently named priority by 69 percent of all jurisdictions. Table 6 in the following page distinguishes between issues that were recognized as a problem and those that were named as a priority. Specifically, 14 out of 23 identified access-related problems were named as priorities. The top three most commonly identified concerns included the lack of health insurance, the lack of transportation, and the lack of bilingual staff members. Each of these issues was mentioned by over half of all jurisdictions. However, as a priority topic, only the lack of health insurance and the lack of transportation made it as one of the top three priorities. The lack of specific services, such as family planning services for teenagers, was the fourth most commonly named access-related priority.

As a subject matter, access to care was the most frequently identified categorical problem among the most frequently named individual concerns. Notably, as shown in Table 4, access to

care-related topics appeared five times, whereas topics from most other categorical issues appeared once or twice.

Table 6: Scope of Access to Care Issues as Problems and Priorities, Ranked by Number of Jurisdictions

Access to Care/Services: Individual Topics	Rankings Problems	Jurisdictions Problems	Rankings Priorities	Jurisdictions Priorities
		# (%)		# (%)
<i>Total Jurisdictions</i>		52 (95)		38 (69)
Lack of Health Insurance	1	42 (76)	1	23 (42)
Lack of Transportation	2	37 (67)	7	1 (02)
Lack of Bilingual Professional Staff	3	30 (55)	6	2 (04)
Lack of Specialty Providers	4	27 (49)	--	--
Access to Health or Dental Care	5	25 (45)	2	12 (22)
Lack of Nurses, Physicians, Dietitians, & Dentists	6	24 (44)	--	--
Lack of Dental Insurance	7	23 (42)	3	10 (18)
Lack of Providers in General	7	23 (42)	7	1 (02)
Cost of Health Care or Insurance	8	22 (40)	--	--
Lack of Specific Services	8	22 (40)	4	4 (07)
Complexity and Bureaucracy of System	9	21 (38)	7	1 (02)
Lack of Information or Awareness About Services	10	20 (36)	7	1 (02)
Language and Cultural Communication Barriers	11	19 (35)	6	2 (04)
Lack of Providers Who Accept Medi-Cal	12	18 (33)	7	1 (02)
Lack of Cultural Sensitivity	13	16 (29)	5	3 (05)
Access to Care in General	14	15 (27)	2	12 (22)
Access to Mental Health Care	15	14 (25)	6	2 (04)
Hours and Location, Including Long Waiting	15	14 (25)	--	--
Fear of Seeking Care or Lack of Trust	16	10 (18)	--	--
Lack of Non-Physician Providers	16	10 (18)	--	--
Underutilization	17	7 (13)	--	--
Culture in General	18	4 (07)	--	--
Lack of Motivation to Seek Care	19	2 (04)	--	--

Substance abuse was the third most frequently named priority topic by 67 percent of all jurisdictions. As shown in Table 7, most of the priorities were focused on perinatal substance abuse. Other priorities under this heading included substance abuse among the general population as well as substance abuse among children and adolescents. Although treatment programs for specific population groups were identified as a problem by over one-third of all jurisdictions, this issue was named as a priority by only 5 percent of the jurisdictions.

In a separate calculation not shown, several jurisdictions named more than one substance abuse topic as a priority for them. For example, four jurisdictions identified three different topics as priorities, along with their interest in perinatal substance abuse. These topics included the lack of drug treatment programs, the use of drugs and alcohol by parents, and the concern over newborn drug exposure. It should be noted that the concerns about the lack of treatment programs were focused primarily on two population groups – women and teenagers.

Table 7: Substance Abuse Issues as Problems and Priorities, Ranked by Number of Jurisdictions *

Substance Abuse: Individual Topics	Rankings Problems	Jurisdictions Problems	Rankings Priorities	Jurisdictions Priorities
		# (%)		# (%)
<i>Total Jurisdictions</i>		48 (87)		37 (67)
Perinatal Substance Abuse	1	32 (58)	1	29 (53)
Substance Abuse in General	2	27 (49)	2	14 (25)
Substance Abuse Among Children & Adolescents	3	22 (40)	3	11 (20)
TX Programs or Gender/Age Specific TX Programs **	4	21 (38)	4	3 (05)
Substance Abuse Among Parents, Adults, or Women	5	12 (22)	5	1 (02)
Newborn Exposure to Substances & Testing	6	8 (15)	5	1 (02)
Drunk Driving	7	2 (04)	--	--
Drug Manufacturing	8	1 (02)	--	--

* The substance abuse category covers all concerns related to the use of different substances as well as use described as abuse or dependence.

** TX is abbreviated for treatment.

Prenatal care was the fourth most frequently named priority. As with the category on substance abuse, the issues related to prenatal care were concentrated in two main topics – first trimester care and the adequacy of that care. However, although these issues were the primary areas of focus, nearly one out of three jurisdictions continued to see the lack of prenatal care and the need for prenatal care education as local problems. Most of these concerns about education were geared toward women. Nearly one out of six named these problems as priorities for their regions.

Table 8: Prenatal Care Issues as Problems and Priorities, Ranked by Number of Jurisdictions

Prenatal Care: Individual Topics	Rankings Problems	Jurisdictions Problems	Rankings Priorities	Jurisdictions Priorities
		# (%)		# (%)
<i>Total Jurisdictions</i>		45 (82)		34 (62)
Early or First Trimester Prenatal Care	1	34 (62)	1	23 (42)
Adequacy of Prenatal Care	2	28 (51)	2	19 (35)
Lack of Prenatal Care	3	10 (18)	3	4 (07)
Prenatal Care Education	4	5 (09)	5	2 (04)
Continuous Care or Case Coordination	5	3 (05)	4	3 (05)

The category special population summed up the top five categorical subjects that were named as a local priority. These top five subjects were health conditions, access to care, substance abuse, prenatal care, and special population. As previously stated, special populations consisted of specific groups that were expressed in connection with other priorities. The individual topics for this category are shown in Table 9. The two most frequently identified groups were the adolescent population and the ethnically diverse population, which will be further detailed at the end of this section.

Table 9: Special Population Issues as Problems and Priorities, Ranked by Number of Jurisdictions

Special Populations: Individual Topics	Rankings Problems	Jurisdictions Problems	Rankings Priorities	Jurisdictions Priorities
		# (%)		# (%)
<i>Total Jurisdictions</i>		52 (95)		29 (53)
Ethnically Diverse Population	1	42 (76)	2	13 (24)
Adolescents At-Risk Population	2	38 (69)	1	25 (45)
Low Income or Medi-Cal Population	3	13 (24)	3	3 (05)
Single Mother Population	4	7 (13)	4	1 (02)
Advanced Maternal Age High-Risk Population	5	3 (05)	4	1 (02)

Each of the next three tables highlights a different category of concern – birth outcomes, oral health, and breastfeeding. As shown in these tables, most of the priorities focused on one or two topics within each category. For example, the primary focus for birth outcome priorities was low birth weight and the primary focus for oral health priorities was oral health care.

Table 10: Birth Outcome Issues as Problems and Priorities, Ranked by Number of Jurisdictions

Birth Outcome: Individual Topics	Rankings Problems	Jurisdictions Problems	Rankings Priorities	Jurisdictions Priorities
		# (%)		# (%)
<i>Total Jurisdictions</i>		35 (64)		25 (45)
Low Birth Weight or Prematurity	1	34 (62)	1	25 (45)
Short Interval Pregnancies *	2	4 (07)	--	--
Multiple Pregnancies	2	4 (07)	--	--
Birth Outcomes in General	3	1 (02)	--	--

* Short interval pregnancies include repeat births.

Table 11: Oral Health Issues as Problems and Priorities, Ranked by Number of Jurisdictions

Oral Health: Individual Topics	Rankings Problems	Jurisdictions Problems	Rankings Priorities	Jurisdictions Priorities
		# (%)		# (%)
<i>Total Jurisdictions</i>		37 (67)		25 (45)
Oral or Dental Health Care	1	29 (53)	1	18 (33)
Lack of Dental Insurance	2	26 (47)	2	10 (18)
Limited Dental Visits	3	17 (31)	4	2 (04)
Dental Diseases	4	12 (22)	3	3 (05)

Table 12: Breastfeeding Issues as Problems and Priorities, Ranked by Number of Jurisdictions

Breastfeeding: Individual Topics	Rankings Problems	Jurisdictions Problems	Rankings Priorities	Jurisdictions Priorities
		# (%)		# (%)
<i>Total Jurisdictions</i>		29 (53)		25 (45)
Breastfeeding in General	1	22 (40)	1	20 (36)
Duration of Breastfeeding	2	16 (29)	2	6 (11)
Breastfeeding Support, Education, or Resources	3	9 (16)	3	1 (02)

Violence-related priorities (Table 13) covered a wider range of issues, such as child abuse, violence in the community, and resources for victims of family violence. In a separate calculation, five jurisdictions identified both domestic violence and child abuse as priorities in their regions. One jurisdiction mentioned three different elements of violence as priorities – violence among the family, violence among adolescents, and violence in general.

Table 13: Violence Issues as Problems and Priorities, Ranked by Number of Jurisdictions

Violence: Individual Topics	Rankings Problems	Jurisdictions Problems	Rankings Priorities	Jurisdictions Priorities
		# (%)		# (%)
<i>Total Jurisdictions</i>		39 (71)		23 (42)
Domestic, Family, or Partner Violence	1	27 (49)	1	16 (29)
Child Abuse & Neglect	2	15 (27)	2	8 (15)
Violence in the Community or in the School	3	12 (22)	4	2 (04)
Violence Among Adolescents	4	11 (20)	5	1 (02)
Violence in General	5	8 (15)	3	3 (05)
Family Violence Resources	6	5 (09)	5	1 (02)
Violence Resulting in Homicide	7	4 (07)	--	--

Table 14 in the following page shows the range of mental health issues identified as local problems. As priorities, the focus of concerns centered on three topics – mental health among women and children, the limited number of mental health services for children, and the treatment of specific psychiatric disorders, such as depression. In two out of three cases, the jurisdictions named multiple priorities related to mental health. For example, two jurisdictions each named four separate topics as being priorities: 1) mental health among the children and adolescent population, 2) suicide, depression, and other psychiatric disorders, particularly among women and children, 3) mental health among the female population, and 4) the need for psycho-social supportive services or support groups.

Table 14: Mental Health Issues as Problems and Priorities, Ranked by Number of Jurisdictions *

Mental Health: Individual Topics	Rankings Problems	Jurisdictions Problems	Rankings Priorities	Jurisdictions Priorities
		# (%)		# (%)
<i>Total Jurisdictions</i>		42 (76)		19 (35)
Children & Adolescent Mental Health Population	1	24 (44)	1	12 (22)
Suicide, Depression, or Other Psychiatric Disorders	2	23 (42)	2	8 (15)
Limited Services for Children & Adolescents	3	17 (31)	3	5 (09)
Mental Health in General	4	16 (29)	2	8 (15)
Psycho-Social Supportive Services or Support Groups	5	15 (27)	4	3 (05)
Gaps in Mental Health Services in General	5	15 (27)	6	1 (02)
Limited Inpatient or Outpatient Programs	6	12 (22)	6	1 (02)
Access to Mental Health Care	7	9 (16)	5	2 (04)
Limited Services for Women	8	8 (15)	4	3 (05)
Women Mental Health Population	9	6 (11)	3	5 (09)

* For the purposes of this analysis, substance abuse as a category was separated from the mental health category, even though it is acknowledged that substance abuse is classified as a condition under the Diagnostic and Statistical Manual of Mental Disorders (4th Edition). The goal was to distinguish between issues concerning alcohol or drug use and issues concerning depression, post-traumatic stress, and attention deficit disorder – all of which were identified in the assessments.

Each of the next five tables highlights a separate category of concern – injuries, other topics, mortality, basic needs, and education. These tables highlight the same pattern as in most other tables – local priorities concentrated in one or two topics of concerns. One noteworthy finding is that, although it was not named as a MCAH priority, 47 percent of all jurisdictions saw the lack of program funding as a problem that was serious enough to be listed in their assessments.

As will be shown later in Table 20, most of the jurisdictions that identified health promotion as a priority specifically included an interest to target children and adolescents.

Table 15: Injury Issues as Problems and Priorities, Ranked by Number of Jurisdictions

Injuries: Individual Topics	Rankings Problems	Jurisdictions Problems	Rankings Priorities	Jurisdictions Priorities
		# (%)		# (%)
<i>Total Jurisdictions</i>		26 (47)		18 (33)
Unintentional Injuries Among Teens	1	21 (38)	1	13 (24)
Motor Vehicle Accidents	2	14 (25)	3	4 (07)
Injuries in General	3	13 (24)	2	11 (20)
Injury-Related Hospitalization	4	10 (18)	4	1 (02)
Other Types of Injuries	5	3 (05)	--	--

Table 16: Other Topic Issues as Problems and Priorities, Ranked by Number of Jurisdictions

Other Topics: Individual Topics	Rankings Problems	Jurisdictions Problems	Rankings Priorities	Jurisdictions Priorities
		# (%)		# (%)
<i>Total Jurisdictions</i>		44 (80)		17 (31)
Program Funding or Personnel Staffing	1	26 (47)	--	--
Child Care	2	20 (36)	3	3 (05)
Immigration and Immigrants	3	16 (29)	--	--
Physical Exercise	4	14 (25)	1	9 (16)
Foster Care	5	12 (22)	4	2 (04)
Immunization	5	12 (22)	2	5 (09)
Air Pollution or Environmental Exposures	5	12 (22)	--	--
Early or Youth Development	5	12 (22)	4	2 (04)
Illegal or Undocumented Aliens	6	10 (18)	--	--
Need for Data and Information Systems	7	9 (16)	--	--
Unintended Pregnancies	8	6 (11)	3	3 (05)
Repeat Adolescent Pregnancies	9	4 (07)	4	2 (04)
Bio-Terrorism *	9	4 (07)	--	--
Poor Quality of Care	9	4 (07)	--	--
Social Stigma Related to Use of Program Services	10	2 (04)	--	--
Need for Clinical Treatment Guidelines	10	2 (04)	--	--
Birth Spacing	10	2 (04)	--	--
Limited Clean & Well-Lit Parks	10	2 (04)	--	--

* Bio-terrorism is an issue that was usually mentioned with respect to how public attention in this area has drawn the focus away from the needs of the MCAH population.

Table 17: Mortality Issues as Problems and Priorities, Ranked by Number of Jurisdictions

Mortality: Individual Topics	Rankings Problems	Jurisdictions Problems	Rankings Priorities	Jurisdictions Priorities
		# (%)		# (%)
<i>Total Jurisdictions</i>		30 (55)		13 (24)
Infant, Fetal, Neonatal, Post Neonatal Deaths & SIDS	1	21 (38)	1	13 (24)
Deaths Among Children & Adolescents	2	12 (22)	2	1 (02)
Deaths due to Cancer, Diabetes, etc.	3	7 (13)	--	--
Deaths due to Injuries	4	6 (11)	--	--
Deaths due to Drugs	5	4 (07)	--	--
Maternal Deaths	6	3 (05)	2	1 (02)

Table 18: Basic Need Issues as Problems and Priorities, Ranked by Number of Jurisdictions

Basic Needs: Individual Topics	Rankings Problems	Jurisdictions Problems	Rankings Priorities	Jurisdictions Priorities
		# (%)		# (%)
<i>Total Jurisdictions</i>		48 (87)		11 (20)
Poverty & Low Wages	1	32 (58)	2	2 (04)
Cost of Housing or Cost of Living	2	28 (51)	--	--
Poor Nutrition or Diet	3	20 (36)	1	9 (16)
Unemployment	4	21 (38)	--	--
Homelessness Among Pregnant Women or Children	5	9 (16)	--	--
Homelessness in General	6	8 (15)	--	--

Table 19: Education Issues as Problems and Priorities, Ranked by Number of Jurisdictions

Education: Individual Topics	Rankings Problems	Jurisdictions Problems	Rankings Priorities	Jurisdictions Priorities
		# (%)		# (%)
<i>Total Jurisdictions</i>		42 (76)		10 (18)
Low Education or Low Health Literacy	1	26 (47)	2	1 (02)
Health Education, Promotion, or Outreach	1	26 (47)	1	10 (18)
Parenting Education	2	14 (25)	2	1 (02)
After School Programs or Home Alone	3	9 (16)	--	--
Provider Education or Staff Training	4	7 (13)	--	--

Thus far, the local concerns have been examined according to issue areas, such as health condition or substance abuse. The same data could also be studied from the perspective of population groups or any other groupings. The final two tables are provided as examples of other ways by which the data could be analyzed.

Table 20 shows the priorities involving the adolescent population, while Table 21 shows the priorities involving the ethnically diverse population. The adolescent population was identified as a specific group to target in 50 individual priorities. The top three most frequently named priorities were obesity among children and adolescents, adolescent at-risk populations, and the lack of health insurance.⁴⁹ Accounting for a third of all priorities targeting adolescents, the three most frequently named subject areas were named by 69 percent of all jurisdictions.

Ethnically diverse populations were identified as a specific group to target in 19 individual priorities. The top three most commonly named priorities were adolescent at-risk populations, infant and infant deaths, and low birth weight outcomes. These three priorities were named by 18 percent of all jurisdictions. Unlike the concentration of priorities among the adolescent population, the priorities involving the ethnically diverse population were spread out over many subject categories, such as mental health, birth outcomes, and prenatal care.

**Table 20: Priorities Involving the Adolescent Population,
Ranked by Number of Jurisdictions**

Adolescent Population: Individual Topics	Rankings Priorities	Jurisdictions Priorities
		# (%)
<i>Total Jurisdictions</i>		47 (85)
Obesity in Children & Adolescents	1	24 (44)
Adolescent At-Risk Population *	2	22 (40)
Lack of Health Insurance	3	13 (24)
Substance Abuse Among Children & Adolescents	4	12 (22)
Unintentional Injuries Among Teens	5	10 (18)
Asthma	6	9 (16)
Children & Adolescents Mental Health Population	7	7 (13)
Adequacy of Prenatal Care	7	7 (13)
Health Education, Promotion, or Outreach	7	7 (13)
Motor Vehicle Accidents	7	7 (13)
STI Among Adolescents	8	6 (11)
Oral or Dental Health Care	8	6 (11)
Suicide, Depression, or Other Psychiatric Disorders	8	6 (11)
Access to Care in General	9	4 (07)
Access to Health, Medical, and Dental Care	9	4 (07)
Lack of Specific Services	10	3 (05)
Lack of Dental Insurance	10	3 (05)
Limited Dental Visits	10	3 (05)
Low Birth Weight or Premature Births	10	3 (05)
Anemia	11	2 (04)
Dental Diseases	11	2 (04)
Mental Health in General	11	2 (04)
Limited Mental Health Services for Children & Adolescents	11	2 (04)
Women Mental Health Population	11	2 (04)
Domestic, Family, or Partner Violence	11	2 (04)
Repeat Adolescent Pregnancies	11	2 (04)
Deaths Among Children & Adolescents	11	2 (04)
Injury-Related Hospitalizations	11	2 (04)

* Adolescent At-Risk Population includes at-risk behaviors, such as teenage pregnancy and sexual activity.

Table 20 Continued: Priorities Involving the Adolescent Population, Ranked by Number of Jurisdictions

Adolescent Population: Individual Topics	Rankings Priorities	Jurisdictions Priorities
		# (%)
<i>Total Jurisdictions</i>		47 (85)
Physical Exercise	11	2 (04)
Unintended Pregnancies	11	2 (04)
Early or Youth Development	11	2 (04)
Substance Abuse TX Programs or Gender/Age Specific Programs	12	1 (02)
HIV/AIDS	12	1 (02)
Psycho-Social Supportive Services or Support Groups	12	1 (02)
Limited Mental Health Inpatient or Outpatient Programs	12	1 (02)
Poor Nutrition or Diet	12	1 (02)
Poverty & Low Wage	12	1 (02)
Violence in General	12	1 (02)
Family Violence Resources	12	1 (02)
Violence Among Adolescents	12	1 (02)
Parenting Education	12	1 (02)
Infants, Fetal, Neonatal, Post Neonatal Deaths or SIDS	12	1 (02)
Breastfeeding in General	12	1 (02)
Duration of Breastfeeding	12	1 (02)
Child Care	12	1 (02)

* Adolescent At-Risk Population includes at-risk behaviors, such as teenage pregnancy and sexual activity.

**Table 21: Problems and Priorities Involving the
Ethnically Diverse Population, Ranked by Number of Jurisdictions**

Ethnically Diverse Population: Individual Topics	Rankings Priorities	Jurisdictions Priorities
		# (%)
<i>Total Jurisdictions</i>		14 (25)
Adolescent At-Risk Population	1	5 (09)
Infants, Fetal, Neonatal, Post Neonatal Deaths or SIDS	1	5 (09)
Low Birth Weight or Premature Births	2	4 (07)
Language and Cultural Communication Barriers	3	3 (05)
Lack of Cultural Sensitivity	3	3 (05)
Obesity in Children & Adolescents	3	3 (05)
Women Mental Health Population	4	2 (04)
Early Prenatal Care or First Trimester Access	4	2 (04)
Duration of Breastfeeding	4	2 (04)
Fear of Seeking Care or Lack of Trust	5	1 (02)
Anemia	5	1 (02)
STI in the General Population	5	1 (02)
Mental Health in General	5	1 (02)
Suicide, Depression, or Other Psychiatric Disorders	5	1 (02)
Psycho-Social Supportive Services or Support Groups	5	1 (02)
Gaps in Mental Health Services	5	1 (02)
Low Income or Medi-Cal Population	5	1 (02)
Single Mothers Population	5	1 (02)
Immunizations	5	1 (02)

LIMITATIONS

The analysis of needs assessments represented an exercise aimed at understanding the nature and scope of local problems at a statewide level. The analysis of the local assessment presented several limitations.

First, the reports varied in length and completeness. They also varied in the level of specificity. These limitations made it difficult to interpret the meaning behind certain commonly used

terms. For example, some jurisdictions identified access to care as a priority, but did not provide details in their narratives. On the other hand, other jurisdictions identified access to care as a priority that encompassed the lack of transportation and the difficulty of navigating through a complex bureaucracy. The latter response revealed many subtopics that more adequately described the nature of this need in the local communities. As a result, the count of priority areas may serve as an estimate rather than a precise calculation.

Second, the count of data sources and participants may be viewed as conservative. In writing their reports, some jurisdictions may have used information from sources that were not referenced in the text. In summarizing these data, some jurisdictions may have also used multiple articles from a single source, such as citing two or more reports from the Journal of the American Medical Association. The result in both situations is that the counts for data sources and participants may very likely be underestimated.

Implications for Viewing Problems and Priorities in the MCAH Population

Given these limitations, the local needs assessments were grounded mostly on evidence-based data and reflective of a holistic view in looking at the concerns with this population – the biological, psychological, sociological, and institutional factors associated with a problem. Overall, the local jurisdictions conducted a comprehensive analysis of the needs in their communities.

The comprehensiveness of the local assessments resulted in a range of issues that were specific to the MCAH field as well as generic to the entire health care arena. Many concerns, such as the lack of bilingual staff members, reflected issues that are also relevant to the larger service delivery system. For example, in addressing the issue of bilingual staff members, jurisdictions would simultaneously address other problems that might have received less recognition as a priority, such as the lack of trust to seek care. This illustration also highlighted one of the challenges in translating this type of research into practice – problems not identified as a priority may still be addressed through efforts that focus on priorities that relate to these problems. Addressing the issue of health care access, for example, may include increasing bilingual staffing of provider offices even though bilingual staffing was not explicitly mentioned as a priority.

The range of issues revealed the inter-connectedness of various individual topics. The subject of health conditions is one such issue. Although obesity among children and obesity among the general population were distinguished as two separate topics for this analysis, many obesity-related concerns between these two populations overlap with each other and, in some ways, with other issues identified in the assessments. For example, in a review of health consequences of obesity, one research group reported that pediatric obesity was likely to continue into adulthood when at least one parent was also obese.⁵⁰ Some of these consequences included the link between obesity and other health and mental health conditions, such as asthma, hypertension, diabetes, and depression⁵¹ – all of which were identified as problems by the jurisdictions. Another research group cited that the psycho-social consequences of childhood

obesity included its connection to fewer years of education, higher rates of poverty, and the likelihood of developing various behavioral problems, such as eating disorders⁵² – all of which were also identified as local concerns.

The local problems and priorities were consistent with many Healthy People 2010 goals and objectives. Throughout the list of local problems and priorities were the overriding concerns about disparities between different groups or sub-groups of people. These included differences that occur by age group, gender, ethnicity, income, and geographic location. Moreover, the range of problems that were named as local priorities was also consistent with the findings of other research findings. For example, recent findings from the 2001 California Health Interview Survey on adolescents also found that areas needing improvement included the lack of physical exercise and the need for age-appropriate health promotion and education efforts.⁵³

Some of the more frequently mentioned data-related issues concerned the need for data on childhood mental health, the need for outcomes-related information, and the need for an improved system of surveillance. These types of concerns are particularly important because knowledge generated from systematic studies can support decision-making throughout all stages of the policy process – in understanding the issues at hand and the options for addressing them, in uncovering information about the state of program or policy implementation, or in answering questions about whether programs or policies accomplished their intended purposes.⁵⁴

Implications for Future Needs Assessment Efforts

Future needs assessment efforts of this type could be improved by detailing what types of information should be documented when reporting on local concerns and having more structure to what aspects of local needs should be covered when discussing these needs. This could help address the issues of variations in completeness and specificity that was apparent in some local reports. At the same time, the process at the local level could be simplified by having jurisdictions submit the needed information in formats other than in a formal narrative report that could, at times, be more time-consuming than informative.

NEEDS ASSESSMENT PARTNERSHIP BUILDING AND COLLABORATION

The MCAH/OFP and CMS Branches conducted the Title V Five Year Needs Assessment with the help of existing and newly created collaborations/partnerships at both the local and state levels.

The MCAH/OFP Branch collaborated with FHOP to design the guidelines and indicators and to provide the technical assistance needed to enable the local MCAH jurisdictions to conduct local needs and capacity assessment reports. The local MCAH jurisdictions in turn reported that they relied upon ongoing collaborations with private healthcare providers, community-based non-profits, and other health and social service agencies.

The CMS Branch established a new relationship with FHOP in the design, data analysis, and facilitation of the needs assessment process. The Branch drew on the collaborative connections already in place through Technical Advisory Committees, hospital and provider organizations, advocacy groups, other State departments that participate on the Interagency Coordinating Council, and parents. This diverse group worked as a cohesive body to identify and prioritize issues.

Program managers representing all of the MCAH programs, along with Epidemiology & Evaluation staff, worked together to conduct the state-level capacity assessment. In meetings to discuss the Branch's capacity strengths and weaknesses, the managers discussed their challenges and successes, and in the process learned things about the other MCAH programs that they might not typically have heard as they went about the daily tasks of managing their own programs. CMS staff evaluated their many collaborative relationships as part of the internal capacity assessment. Numerous collaborative partners were identified as actively participating with the Branch in different venues and projects.

The MCAH/OFP Branch depends on the collaborative flow of data between their own and other departments statewide. The Branch received data for this report from such diverse sources as the Department of Justice and the Department of Mental Health. These data from a wide range of other state departments were vital in the process of evaluating and selecting the priority needs.

Both Branches held stakeholder meetings to help select priority needs. These meetings, with representatives from diverse entities, brought a fresh perspective to the needs assessment process. Plans are in place to maintain these relationships and draw further on the expertise of these stakeholders in other areas, such as action plans to address the priority needs.

As described in the capacity assessment sections, the two Title V Branches are involved in many intra- and interdepartmental collaborations and partnerships. However, there is still more that can be done to further enhance communication and cooperation within DHS and between DHS and other state agencies. Several of the priority needs touch upon areas that are of interest to other state agencies, and as the MCAH/OFP and CMS Branches plan for how to address these needs, care should be given to researching the possibilities for partnerships with other departments. An excellent model for this kind of cooperation is the California Obesity Initiative, which draws on the strengths of the Department of Health Services, the Department of Social Services, and the California Department of Education.

MCAH DATA REPORT

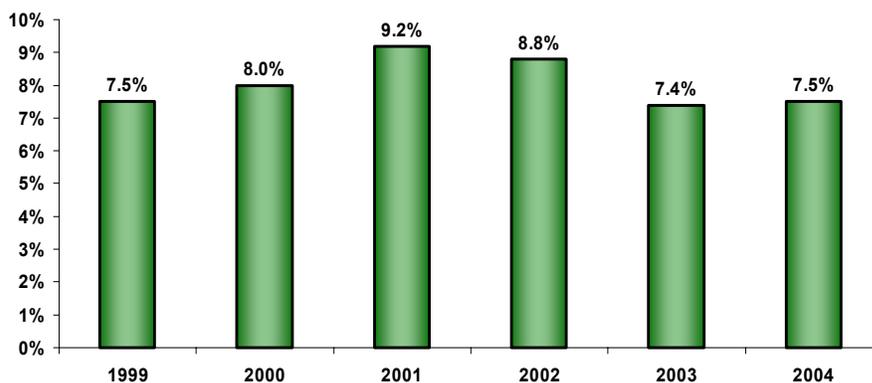
The determination of MCAH priority needs was based on the analysis of both synthesized local needs assessments and statewide data. In selecting statewide information for review, the Branch first looked for data corresponding to existing Title V indicators and HP 2010 objectives. In addition, the Branch evaluated a broad range of new statewide data with an eye to identifying emerging issues that might not have been evident from currently used indicators, objectives, or the local analyses. There were some indicators for which data were not available at the local jurisdiction level. An example of this is “maternal mortality,” an event that is too rare to determine a trend at the jurisdiction level, and therefore can only be analyzed at the state level. The data shown below represent only a subset of all the topics considered.

Pregnant Women, Mothers, and Infants

Substance Abuse. Almost 20% of mothers in California drank alcohol during the 1st or 3rd trimester of pregnancy and 7.5% continued to drink alcohol during the 3rd trimester. Rates for alcohol consumption during pregnancy were highest among Whites, women 35 years and older, and among college graduates.

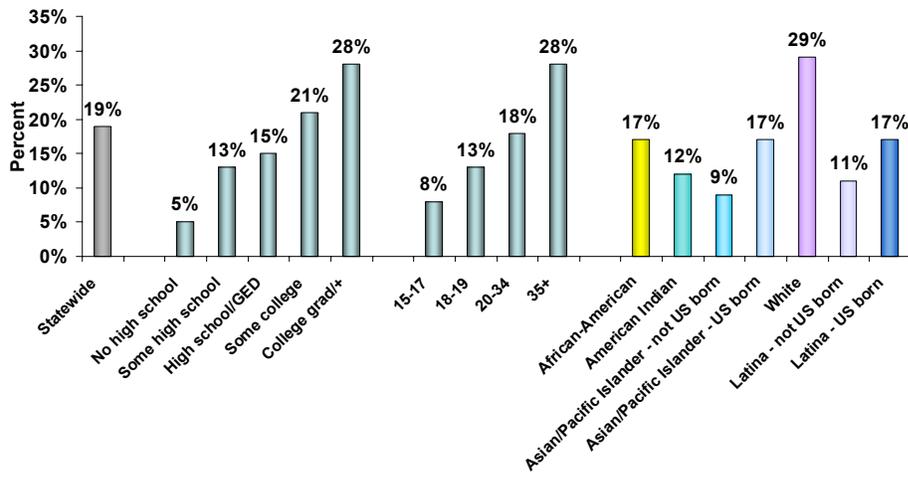
The percent of women reporting any alcohol consumption during the 3rd trimester ranged from 7.5 to 9.2 percent between 1999 and 2004⁵⁵. The percent of women 18 years and older who binge drink increased between 1997 and 2002 (7.0% compared to 7.7%)⁵⁶. However, California reports lower rates of binge drinking for women 18 years and older compared to the US (8.1%).

Percent of Pregnant Women Reporting any Alcohol Consumption During the 3rd Trimester, California 1999 - 2004



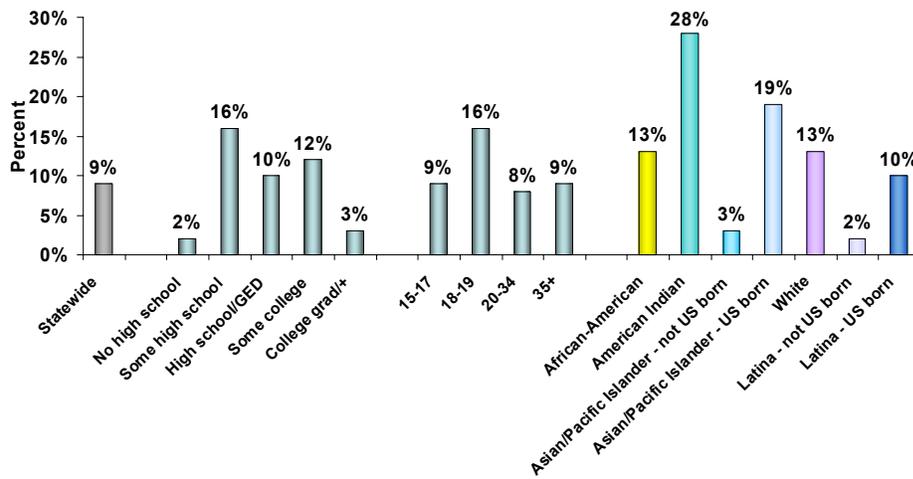
Data Source: Maternal and Infant Health Assessment (MIHA) Survey

Percent of Mothers who Drank Any Alcohol During Pregnancy: California, 2002



SOURCE: Maternal and Infant Health Survey, 2002
 During pregnancy refers to 1st and 3rd trimester

Percent of Mothers Who Smoked During Pregnancy: California, 2002

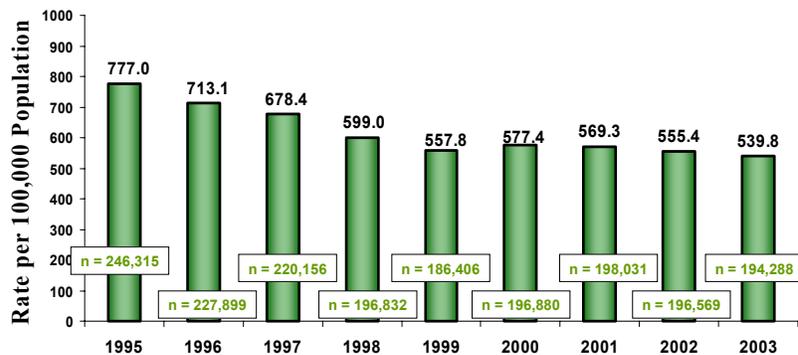


Data Source: Maternal and Infant Health Assessment (MIHA) Survey, 2002
 During pregnancy refers only to 1st and 3rd trimester

Violence. The rate of domestic violence related calls to the police department for assistance per 100,000 has decreased in California between 1995 and 2003 (777 and 539.8 per 100,000 respectively) ⁵⁷.

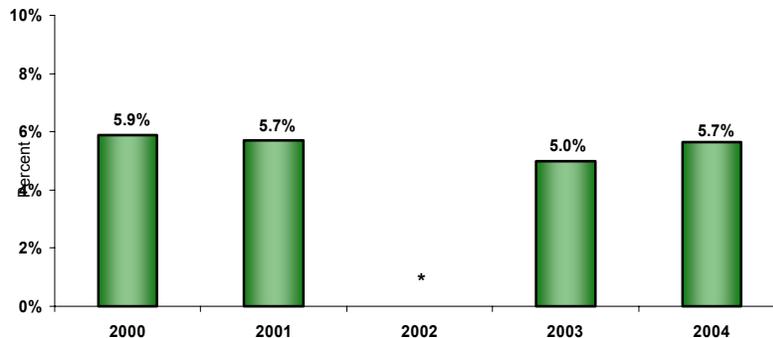
The percent of women 18+ reporting “intimate partner physical violence during the past year” has remained at or above 5% since 2000 ⁵⁸. In 2004, black women had the highest rate (13.7%), more than three times that of white women (4.4%) and almost twice that of Latinas (7.1%)⁵⁹. One hundred and fifty-one (151) women in California were killed by husbands, ex-husbands or boyfriends in 2003.⁶⁰

Rate of Domestic Violence Related Calls to Police Department for Assistance per 100,000 Population: California 1995 - 2003



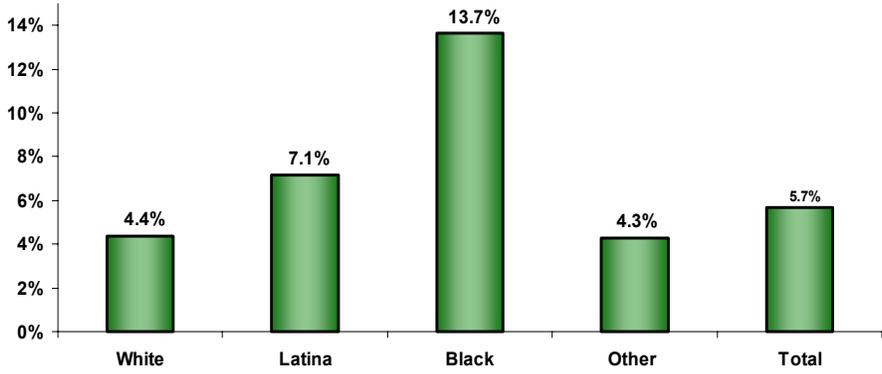
Data Source: California Department of Justice

Percent of Women 18+ Reporting Intimate Partner Physical Violence during the Past Year, California 1998-2003



Data Source: California Women's Health Survey (CWHS)
* No data available in 2002

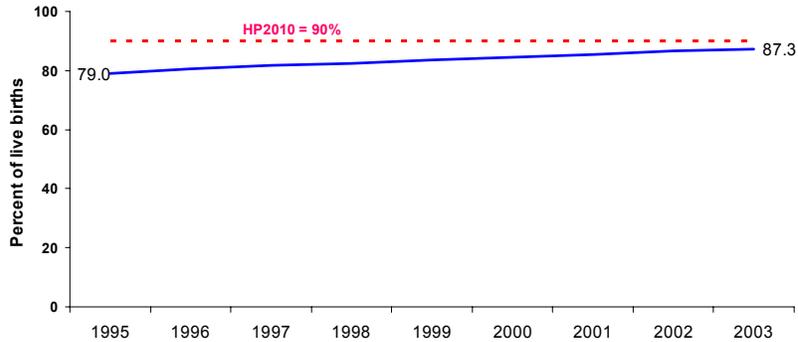
Percent of Women Reporting Intimate Partner Physical Violence during the Past Year by Race/Ethnicity, California 2004



Data Source: California Women's Health Survey

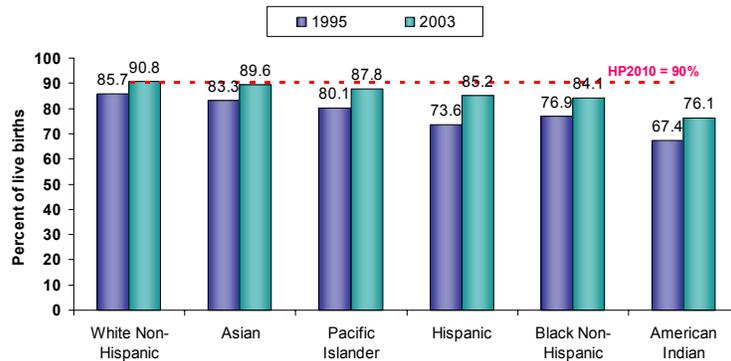
Prenatal Care (PNC). Overall in 2003, 87.3% of California moms had their first PNC visit in the 1st trimester. White non-Hispanic women had the highest proportion of women with 1st trimester care, whereas American Indian women had the lowest proportion (90.8% and 76.1% respectively) in 2003. All race/ethnic groups had an increase in the percent of 1st trimester care between 1995 and 2003⁶¹.

1st Trimester PNC Visit, California 1995-2003



SOURCE: California Birth File
Excludes mothers with unknown PNC initiation

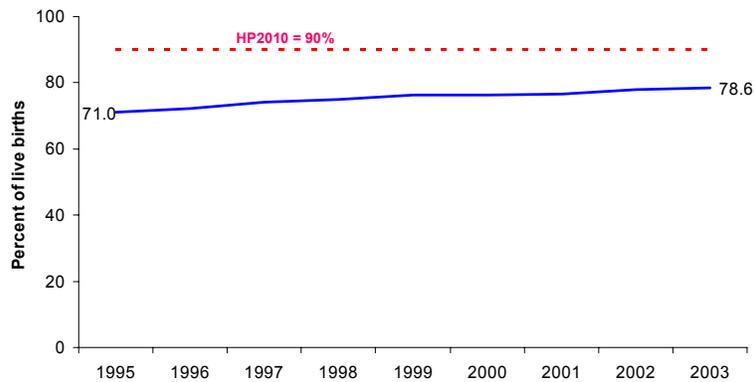
1st Trimester PNC Visit by Race/Ethnicity, 1995 & 2003



Data Source: California Birth File
Excludes mothers with unknown PNC initiation

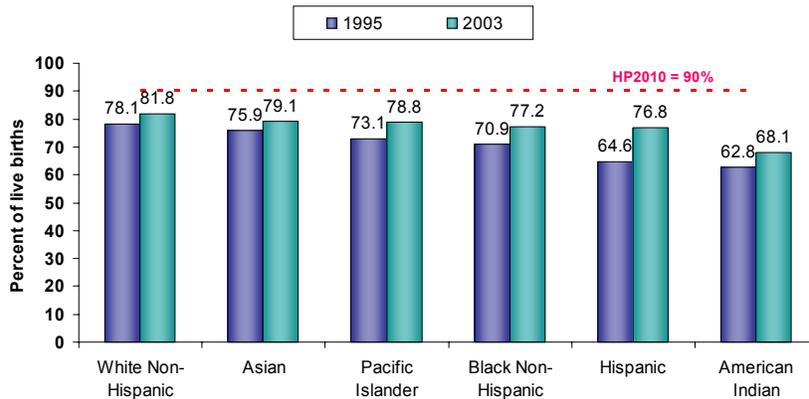
Overall in 2003, 78.6% of California moms had early and adequate PNC. White non-Hispanic women had the highest proportion of women with early and adequate PNC, whereas American Indian women had the lowest proportion (81.8% and 68.1% respectively) in 2003. All race/ethnic groups had an increase in the percent of early and adequate PNC between 1995 and 2003. Mother's using Medi-Cal as an expected source of payment for delivery had a lower proportion of women with early and adequate PNC compared to women using all other types of insurance (75.8% vs. 81.5%) in 2003⁶².

Percent Early & Adequate PNC California, 1995-2003



Data Source: California Birth File 1995-2003. Excludes mothers with unknown PNC

Percent Early & Adequate PNC by Race/Ethnicity, 1995 & 2003



Data Source: California Birth File 1995-2003. Excludes mothers with unknown PNC initiation

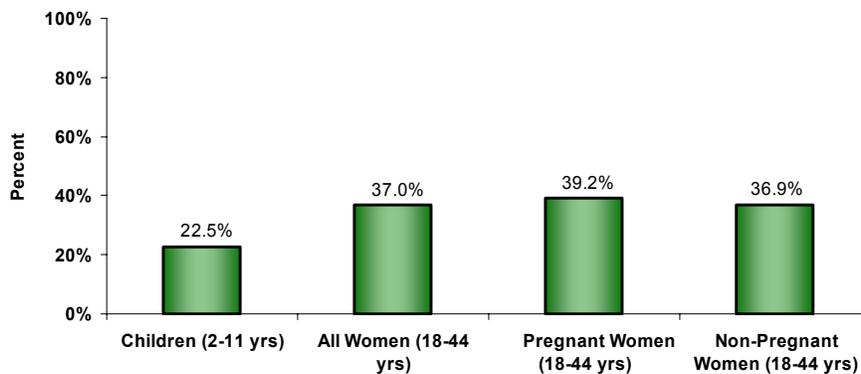
Oral Health. The percent of people without dental insurance varied by age: children 2-11 (22.5%), all women 18-44 (37%), pregnant women 18-44 (39.2%), and non-pregnant women 18-44 (36.9%)⁶³. Adult women are more likely to lack dental insurance than children age 2-11, and pregnant women between age 18-44 are less likely to have dental insurance than non-pregnant women the same age.

The 2001 California Health Interview Survey found that 62.4% of adults 18 years and older had dental insurance coverage in the past 12 months. There was no statistical difference between adult males (63.1%) and females (61.6%) in having dental insurance. There were notable differences among race/ethnic groups. Significantly more adult African-Americans (72.3%) have dental insurance compared to all other groups. Koreans and Latinos have the lowest proportions of dental coverage at 40.2% and 47.2%, respectively⁶⁴.

Healthy People 2010 sets the objective that 56% of persons aged two and older will have visited a dentist during the previous year. All adult groups meet this objective except those without medical insurance (50.8%) and those below 100% FPL (55.2%). Women are significantly more likely than men to have had a recent dental visit (71.6% vs. 68.0%). Latinos are the least likely of all race/ethnic groups to have visited a dentist in the past 12 months (59.7%), and Whites are the most likely (74.4%)⁶⁵.

The 2003 CHIS found that 22.7% of adult females could not afford dental care that was needed. This was significantly higher than the total proportion of adults in California who could not afford dental care that was needed (20.4%).

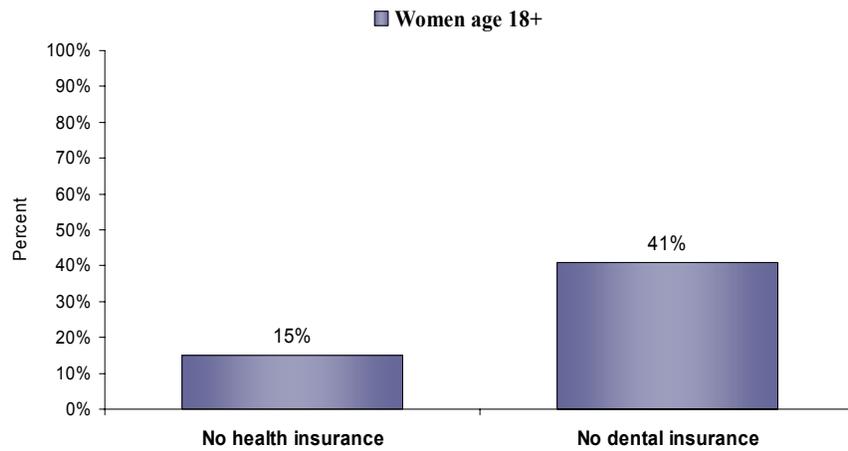
Percent of People without Dental Insurance: California, 2001



Data Source: California Health Interview Survey (CWHS)

Four in ten women age 18+ do not have dental insurance. This is almost three times the rate of women lacking health insurance.

Dental and Health Uninsurance Rates for Adult Women, 2003

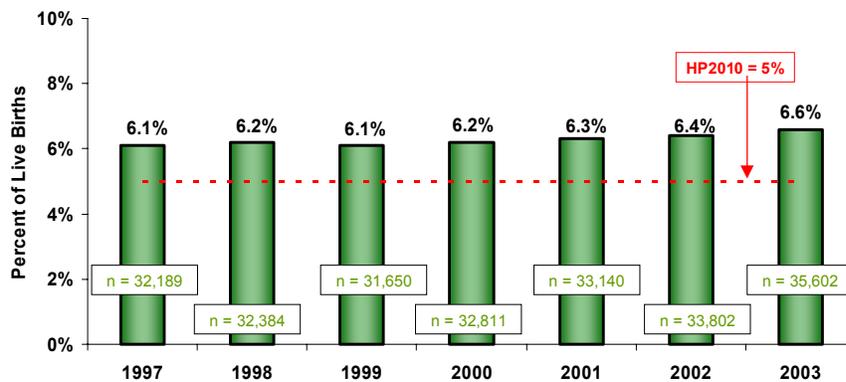


Data Source: California Health Interview Survey (CWHS)

Low Birthweight. The Healthy People 2010 objective is to reduce the proportion of low birthweight births to no more than 5.0%. California has not currently met this objective. In 2003, 6.6% (n=35,602) of all live births were low birthweight. Since 1997, the percent of low birthweight births has increased slightly. However, California reports lower rates of low birthweight births compared to the US (6.6% and 7.8% respectively)⁶⁶.

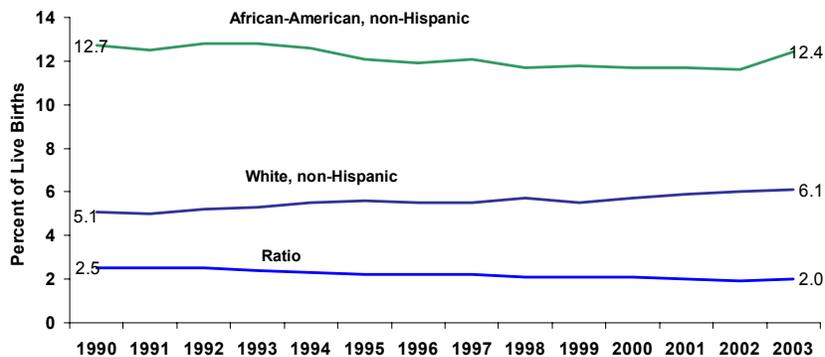
African-Americans in California have low birthweight rates which are 2.5 times greater than HP2010 and 2 times greater than that of Whites. The ratio of Black/White low birthweight births has slightly decreased between 1990 and 2003 from 2.5 to 2.0 ⁶⁷.

Percent of Low Birth Weight Births (<2,500g), California 1997-2003



Data Source: California Birth File

Percent and Ratio of Low Birth Weight Births for California African Americans and Whites: 1990-2003

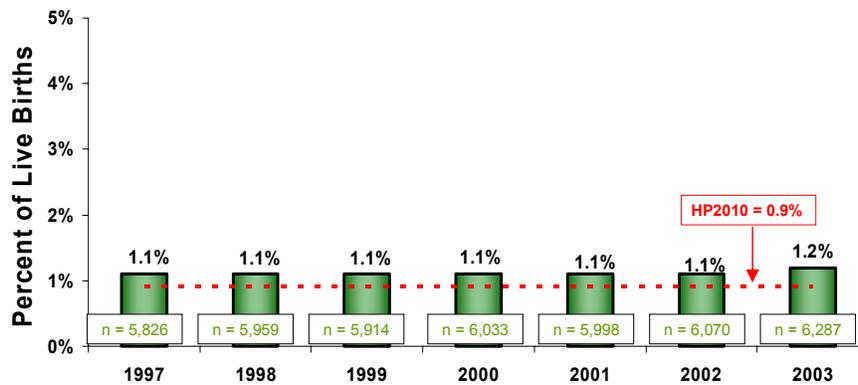


CA Data Source: California Department of Health Services, Birth File 1990-2003.
Race/Ethnicity is based on mother's 1st listed race.
Includes live births between 227 to 8,165 grams.

Very Low Birthweight. The HP 2010 objective is to reduce the proportion of very low birthweight births to no more than 0.9%. California has not currently met this objective. In 2003, 1.2% (n= 6,287) of all live births were very low birthweight. Since 1997, the percent of very low birthweight births has been stable. California reports lower rates of very low birthweight births (1.2%) compared to the US (1.5%)⁶⁸.

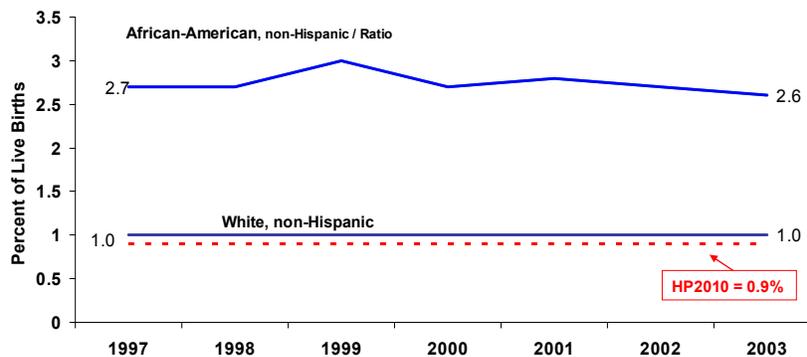
African-Americans in California have very low birthweight rates which are 2.9 times greater than HP2010 and 2.6 times greater than that of Whites. The ratio of Black/White very low birthweight births has remained stable around 2.6⁶⁹.

Percent of very low birth weight births (<1,500g), California 1997-2003



Data Source: California Birth File, 1997-2003

Percent and Ratio of Low Birth Weight Births for California African Americans and Whites: 1997-2003

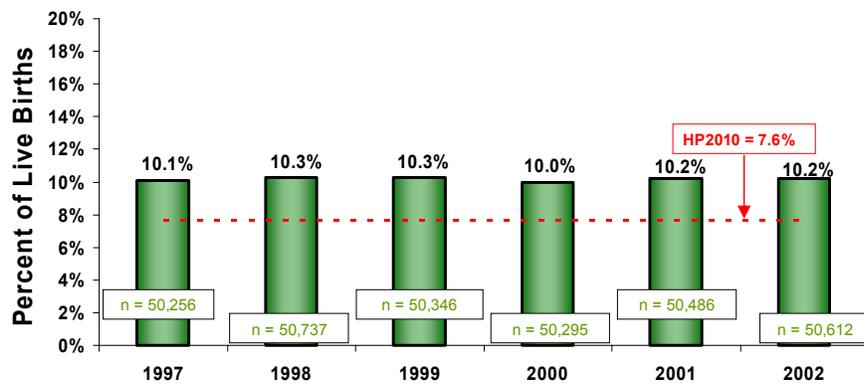


CA Data Source: California Department of Health Services, Birth File 1997-2003. Race/Ethnicity is based on mother's 1st listed race. Includes live births between 227 to 8,165 grams.

Prematurity. The Healthy People 2010 objective is to reduce the proportion of preterm births to no more than 7.6%. California has not currently met this objective. In 2002, 10.2% (n=50,612) of all live births were premature. Since 1997, the percent of preterm births has been stable. However, California reports lower rates of preterm births compared to the US (10.2% and 12.1% respectively)⁷⁰.

African-Americans in California have preterm delivery rates which are 2 times greater than the HP 2010 objective and 1.6 times greater than that of whites⁷¹.

Percent of Preterm Births (<37 weeks),
California 1997-2002



Data Source: March of Dimes, PeriStats

Neural Tube Defects. The incidence of neural tube defects (NTDs) in live births and fetal deaths is provided annually by the California Birth Defects Monitoring Program, based on their in-depth studies of eight Central Valley counties. These counties are not entirely representative of the state as a whole because of differences in their maternal population (younger, and a higher proportion of Hispanic women), relative to the overall population.

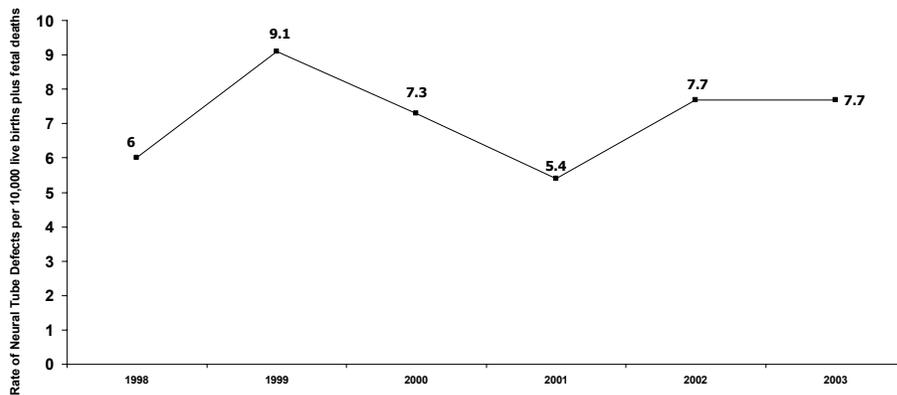
In 2001 (rolling average 1998-2001), the incidence of NTDs in the eight counties studied was 6.9 per 10,000 births and fetal deaths (including terminations). In 2002 (rolling average 1999-2002), it was 7.4, and in 2003 (rolling average 2000-2003), 7.0. Viewed yearly without rolling averages, the incidence would be 6.0, 9.1, 7.3, 5.4, 7.7 and 7.7, for 1998-2003 ⁷².

The overall rate of California women taking a supplement containing folic acid at least some of the time has shown no directional trend. This proportion remained steady at 55% from 1999 to 2001, dropped to 50% in 2002, and then moved back up to 53% in 2003.

There is some indication of improvement in the use of folic acid among women who were pregnant. In 2001, 88% of pregnant women reported taking folic acid at least some of the time, increasing slightly to 90% in 2002, and again to 93% in 2003 ⁷³. However, for women who were trying to get pregnant, the proportions decreased slightly from 61% in 2001, to 57% in 2002, to 56% in 2003.

Latinas overall have had a higher rate of NTDs ⁷⁴. They are less than half as likely as white women to take folic acid either every day or almost every day just before getting pregnant, 1999-2002 (19% for Latinas vs. 45% for whites, in 2002 ⁷⁵).

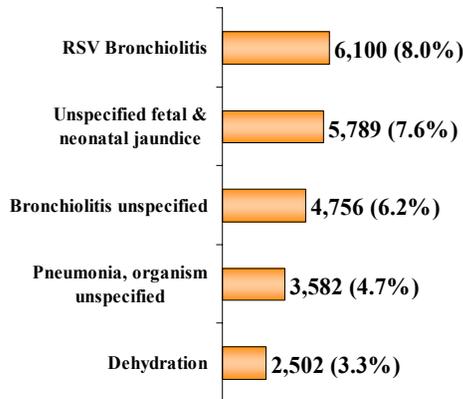
The Incidence of Neural Tube Defects (NTDs) per 10,000 Live Births Plus Fetal Deaths among Counties Participating in the California Birth Defects Monitoring System, 1998-2003



Data Source: Genetic Disease Branch

Infant Hospitalizations. The leading cause of hospitalization in 2003 for California Infants (<1 yr) was due to RSV bronchiolitis, accounting for 8% (n=6,100) of all infant hospitalizations as listed by the principle diagnosis. This was followed by unspecified fetal and neonatal jaundice (7.6%), unspecified bronchiolitis (6.2%), pneumonia, organism unspecified (4.7%), and dehydration (3.3%).

Top 5 Primary Diagnoses among hospitalized infants <1 yr of age, 2003

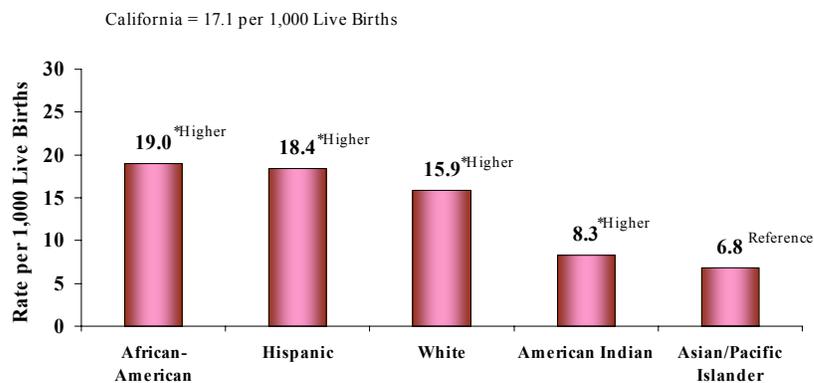


SOURCE: CA Hospital Discharge File 2003
Analyzed using the principal diagnosis variable

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Maternal, Child and Adolescent Health Branch
California Department of Health Services

African-American infants had the highest rates of RSV-hospitalizations (19.0 per 1,000 live births). All race/ethnic groups had statistically higher rates of RSV-hospitalizations compared to Asian/Pacific Islanders who had the lowest rate (6.8 per 1,000 live births).

RSV Infant Hospitalization Rate by Race/Ethnicity, 1999-2003



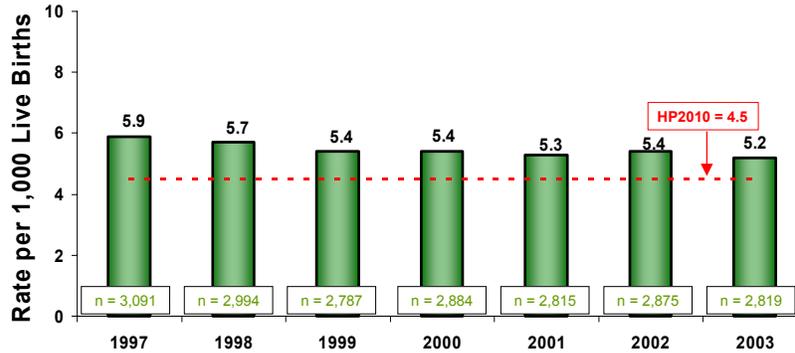
SOURCE: CA Hospital Discharge File 1999-2003
RSV hospitalizations include an RSV diagnosis in any of the 25 diagnosis fields
*Combined 1999-2003 rates statistically significantly different from Asian/ PIs (p<0.0001)

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Infant, Neonatal, and Post-Neonatal Mortality. The Healthy People 2010 objective is to reduce the number of infant deaths to 4.5 per 1,000 live births, neonatal deaths to 2.9 per 1,000 live births, and post-neonatal deaths to 1.2 per 1,000 live births. California has not currently met any of these objectives. However, since 1997 the rates of infant mortality, neonatal and post-neonatal deaths have decreased. Based on preliminary analyses of state data, California consistently reports lower rates compared to the US; infant mortality (5.2 per 1,000), neonatal mortality (3.5 per 1,000), and post-neonatal mortality (1.7 per 1,000) compared to the US (6.9 per 1,000, 4.7 per 1,000, and 2.3 per 1,000 respectively, preliminary data for 2003)⁷⁶.

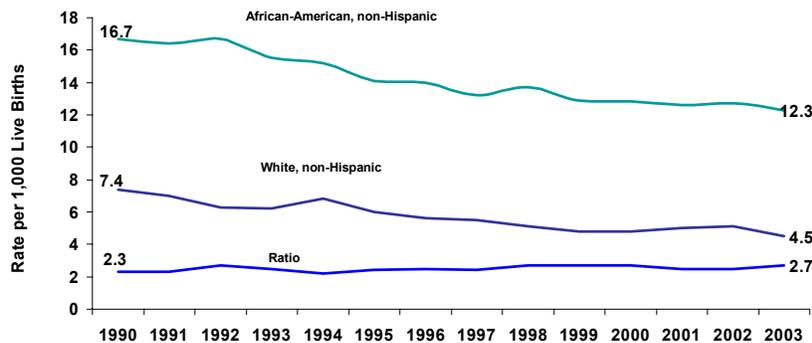
African-Americans have infant mortality rates which are nearly 3 times higher than the HP 2010 objective and that of White California infants (12.3 and 4.5 respectively). The Black/White infant mortality ratio has actually increased between 1990 and 2003 from 2.3 to 2.7⁷⁷.

Infant Mortality Rate (per 1,000 live births),
California 1997-2003



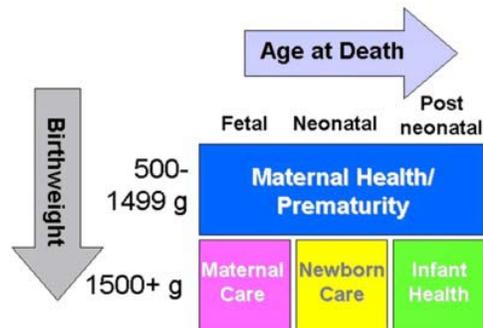
Data Source: California Birth and Death Files, 1997-2003

California African American and White Infant
Mortality Rates and Ratio: 1990-2003



Source: California Center for Health Statistics, California's Infant Mortality Rate, 2003 Table 2 Infant Mortality Rates by Race/Ethnicity, California 1994-2003; California 1990-1998. Beginning with the 2000 birth and death data, race groups changed to allow for the reporting of up to three races. Mothers in the "White" and "Black" groups are non-Hispanic and reported the single race "White" or "Black" only. This change caused a slight discontinuity with data prior to 2000 for Black and White infants.

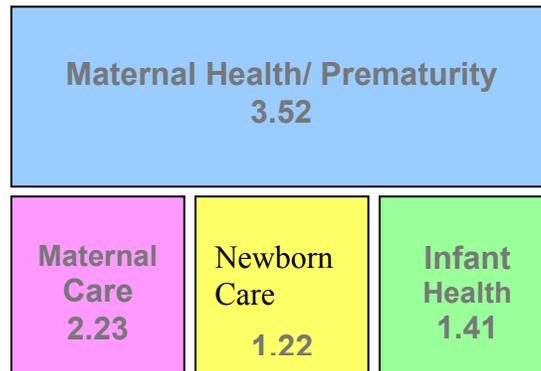
Perinatal Periods of Risk (PPOR). Infant mortality is considered a bellwether for a community’s overall health. The PPOR model maps perinatal health into four periods of risk: maternal health, maternal care, newborn care and infant health, based on the gestational age and birth weight of the fetus or infant.



This mapping allows for an evaluation of the relative importance of each period of Perinatal risk so that appropriate interventions can be targeted to specific types of risk factors.

Below is the map for the overall state using birth cohort data from 1999-2001.

**California, All Races and Ethnicities
1999-2001**



Overall, California results were similar to results seen nation-wide – that is, a large proportion of the deaths occurring under the “Maternal Health/Prematurity” cell. Overall, Non-Hispanic Whites and Asians had the best rates, whereas African American had the worst, emphasizing California’s lingering racial health disparities concerns, even in the face of improving infant mortality rates. In all populations, maternal health/prematurity was the largest rate.

Maternal Health

All infant and fetal deaths in which the birth weight is under 1500 grams are classified within the maternal health period of risk. Factors influencing the maternal health period of risk are the general state of the mother's health, preconception care, maternal nutrition, anemia, infections before and during pregnancy, stress and work, previous pregnancy outcomes, pre-pregnancy conditions (e.g. diabetes) and tobacco and alcohol use. The maternal health periods of risk accounted for 3.52 statewide deaths per 1,000 births plus fetal deaths, representing the period of risk with the greatest share of the total feto-infant mortality. The best rate was found among Asians at 2.45, whereas the worst rate was among African Americans at 7.88 deaths.

Maternal Care

Fetal deaths in which the weight is at least 1500 grams are classified within the maternal care period of risk. Factors influencing health outcomes during this period include the extent of prenatal care, nutrition during pregnancy, infections during pregnancy, recognition and management of early labor, care in a hospital providing an appropriate level of Perinatal care, monitoring during labor and obstetrical expertise. The maternal care periods of risk accounted for 2.23 statewide deaths per 1,000 births plus fetal deaths, representing the period of risk with the second greatest share of the total feto-infant mortality. The best rate was found among American Indians at 1.86, whereas the worst rate was among African Americans at 3.50 deaths.

Newborn Care

Neonatal death in which the birth weight was at least 1500 grams are attributed to newborn care. Issues related to newborn care include the quality of the hospital, the level of care available, obstetrical and pediatric expertise, NICU care, regular newborn care including feeding and prevention of infections, and the recognition of emergencies. There were 1.22 deaths related to newborn care. The best rate was found among Asians at 1.11, whereas the worst rate was among African Americans at 1.55 deaths.

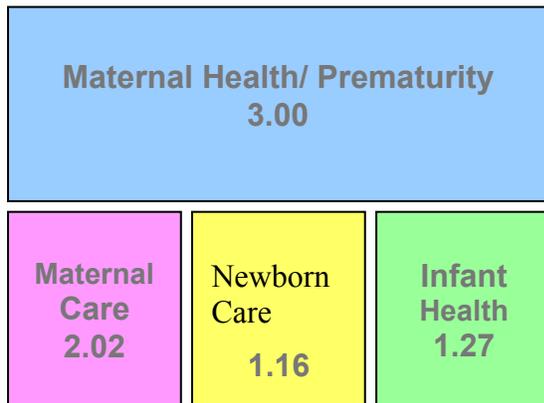
Infant Health

Post neonatal deaths with a birth weight of at least 1500 grams are classified in the infant health period of risk. Within this period significant factors include the prevention and diagnosis of infection, prevention and diagnosis of injury, recognition of birth defects and developmental abnormalities, prevention of SIDS and promotion of breastfeeding. There were 1.41 deaths related to infant health. The best rate was found among Asians at 1.25, whereas the worst rate was among American Indians at 3.58 deaths.

Summary

Based on the overall analyses of California's periods of risk, the health of women of childbearing age must be addressed generally to effect a significant reduction across racial and ethnic groups in feto-infant mortality. Efforts to reduce infant health factors such as SIDS prevention and injury prevention need to be more focused on African American and American Indian populations.

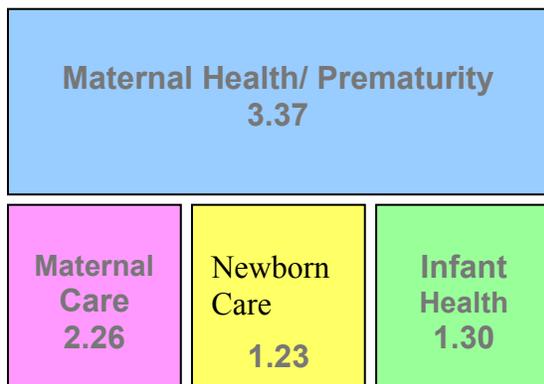
**California, Non-Hispanic White
1999-2001**



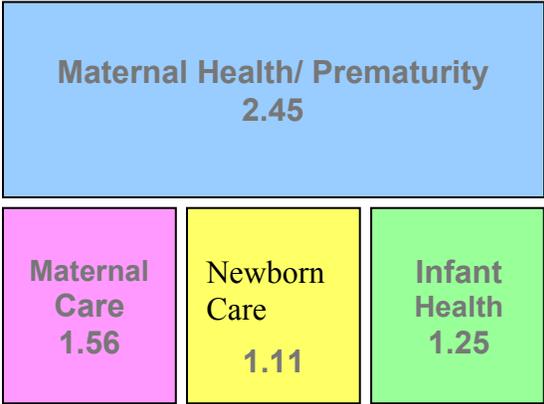
**California, African American Non-Hispanic
1999-2001**



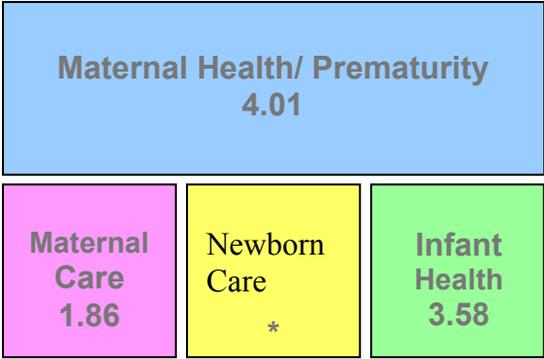
**California, Hispanic
1999-2001**



**California, Non-Hispanic Asian
1999-2001**



**California, Non-Hispanic American Indian
1999-2001**



* This cell's numerator was too small to be a reliable rate.

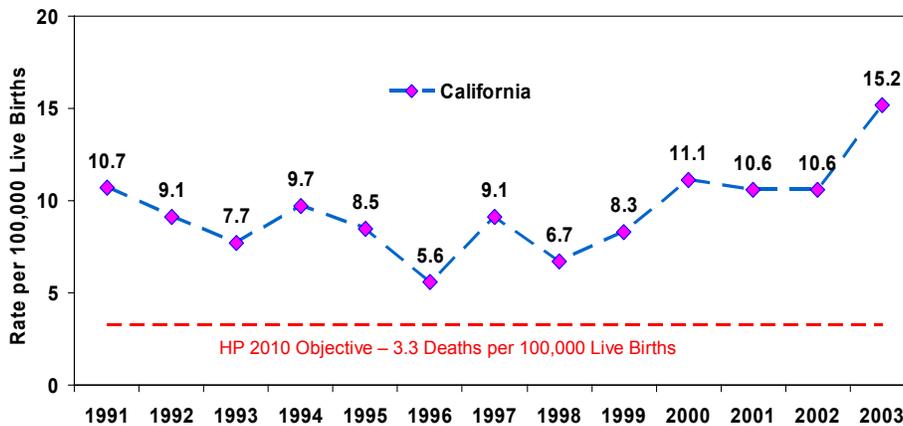
Maternal Mortality.

The HP 2010 Objective for maternal mortality is to reduce the number of maternal deaths to 3.3 per 100,000 live births. The maternal mortality rate increased in California between 1999 and 2003. Overall in 2003, California had a rate of 15.2 pregnancy related deaths per 100,000 live births and 14.6 maternal deaths per 100,000 live births, over 4 times higher than the HP 2010 objective ⁷⁸.

African-American women continue to have the highest pregnancy related death rate. In 2003, the pregnancy related death rate was 44.5, compared to White non-Hispanic women who had the lowest rate of 13.5 ⁷⁹.

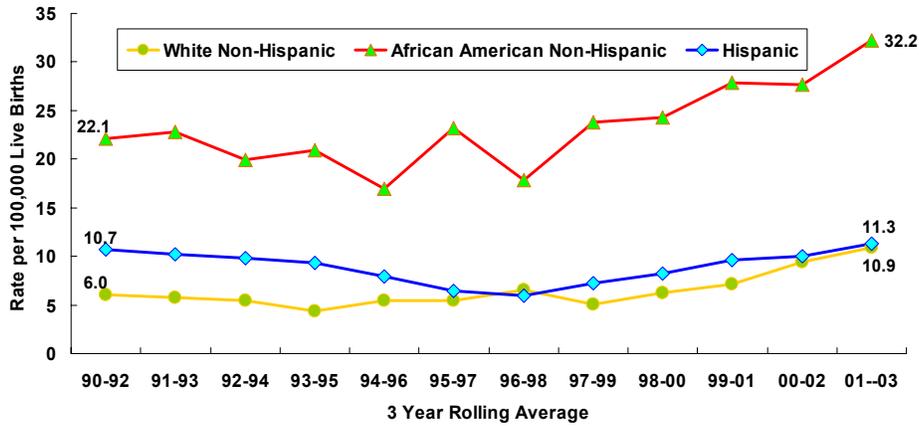
Combining data for 2000-2003, the leading pregnancy-related cause of death is from hypertension complicating pregnancy, childbirth, & the puerperium ⁸⁰.

Statewide Pregnancy Related Mortality Rate,
1991-2003



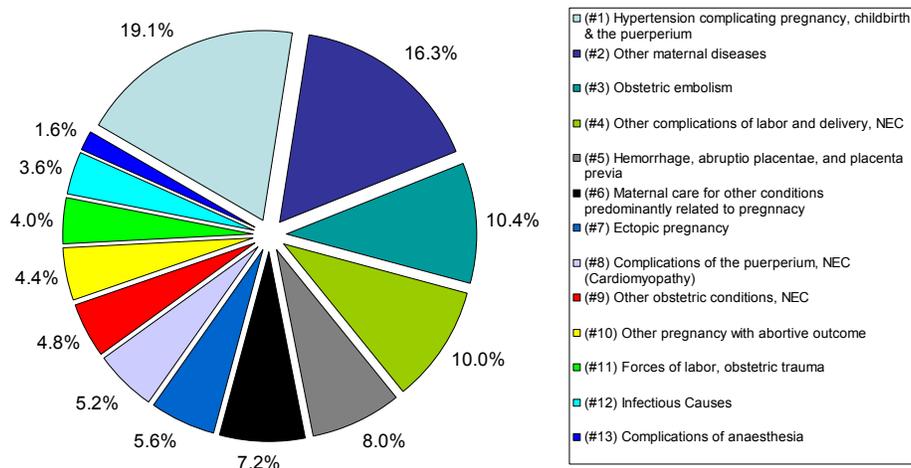
Data Source: State of California, Department of Health Services, California Birth and Death Certificate Master Files, 1991-2003
Pregnancy Related Mortality calculated beginning in 1999

Pregnancy Related Mortality Rates by Race/ Ethnicity, California Residents: 1990-2003



SOURCE: State of California, Department of Health Services, California Birth and Death Certificate Master Files, 1990-2003
Pregnancy Related Mortality calculated beginning in 1999

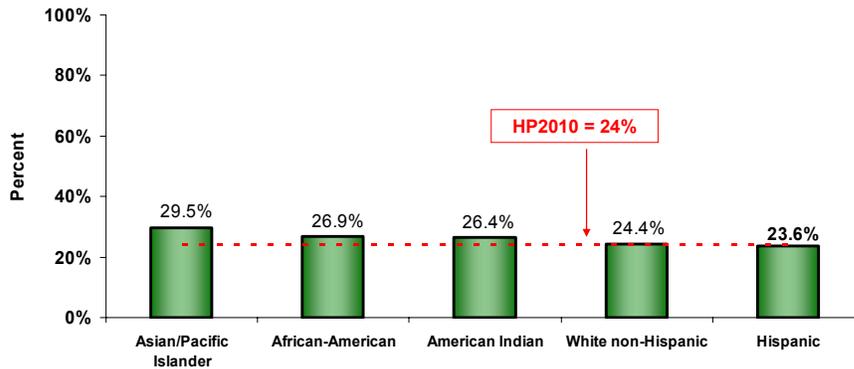
Pregnancy-Related Causes of Death, California 2000-2003 (n=251)



NEC – Not Elsewhere Classified
SOURCE: California Death File, 2000-2003
Causes of death based on ICD-10 codes

Maternal Morbidity. Reducing maternal complications during labor and delivery to 24% is the current HP 2010 objective. In 2002, 24.7% of California deliveries had a complication during labor and delivery. Asian/Pacific Islander women had the highest proportion of complications during labor and delivery (29.5%), whereas Hispanic women had the lowest proportion (23.6%) in 2002.

HP2010 maternal morbidities at the time of labor and delivery by race/ethnicity: California, 2002

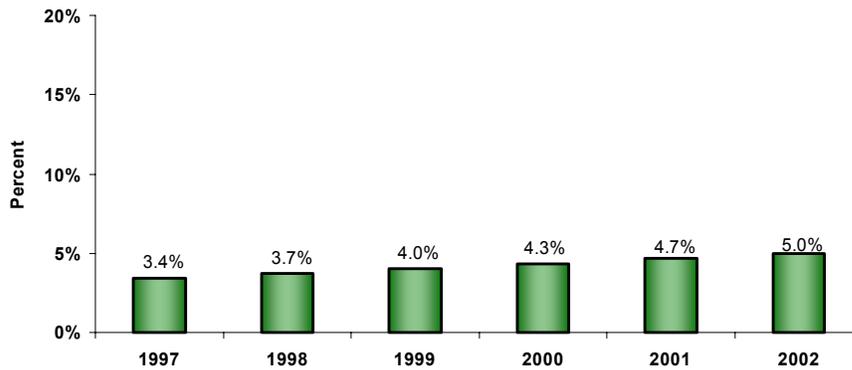


Data Source: California OSHPD, 2002

Gestational diabetes mellitus. Increases in diabetes mellitus prevalence have been reported in the United States. Previous research showed an increase in gestational diabetes mellitus (GDM) in California during the past decade ⁸¹. GDM is a disorder with both immediate and long-term complications. For example, there is an increased risk of: perinatal morbidity and mortality, obesity or impaired glucose tolerance in the offspring, and a very high-risk of the mother converting to type 2 diabetes later in life.

Analysis of the 1997-2002 California Hospital Discharge Data on GDM-complicating pregnancy during labor and delivery showed an increasing trend from 3.4% to 5%. The overall increase for the 6 year period was approximately 33%. More than 25,000 pregnant mothers were affected by GDM-complicating pregnancy during labor and delivery in the year 2002 ⁸².

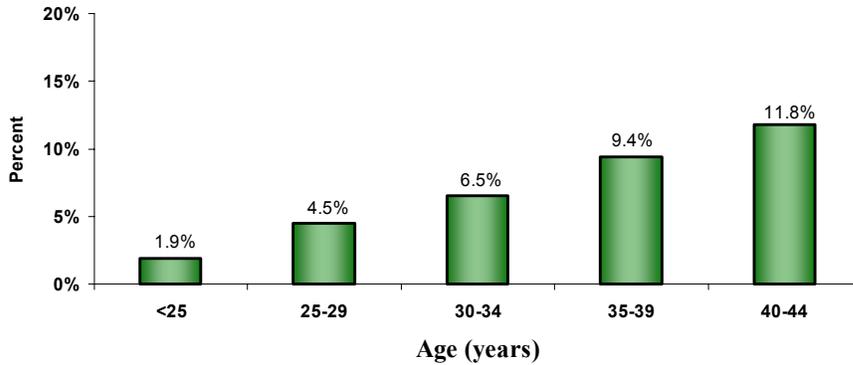
Gestational diabetes mellitus complicating pregnancy during labor and delivery in California: 1997-2002



Data Source: California OSHPD, 1997-2002

The prevalence of GDM-complicating pregnancy during labor and delivery was over six times higher in older women compared to younger women: 11.8% for 40-44 year olds vs. 1.9% for < 25 year olds, in 2002 ⁸³.

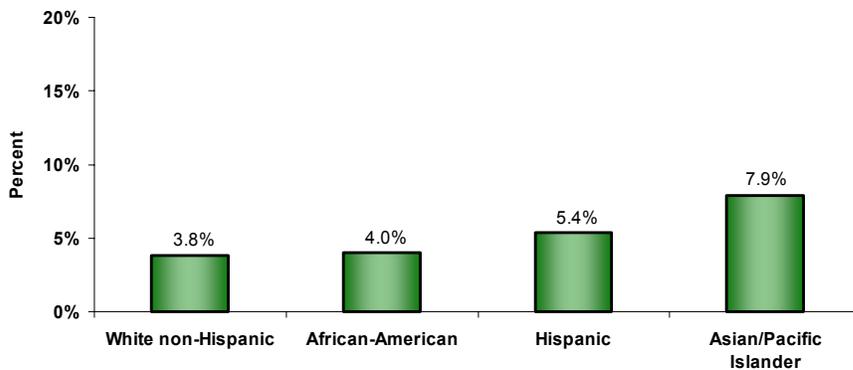
Gestational Diabetes Mellitus Complicating Pregnancy during Labor and Delivery in California by Maternal Age: 2002



Data Source: California OSHPD, 2002

White non-Hispanic women have the lowest prevalence of GDM-complicating pregnancy during labor and delivery (3.8%), whereas Asian/Pacific Islander women have the highest (7.9%) ⁸⁴.

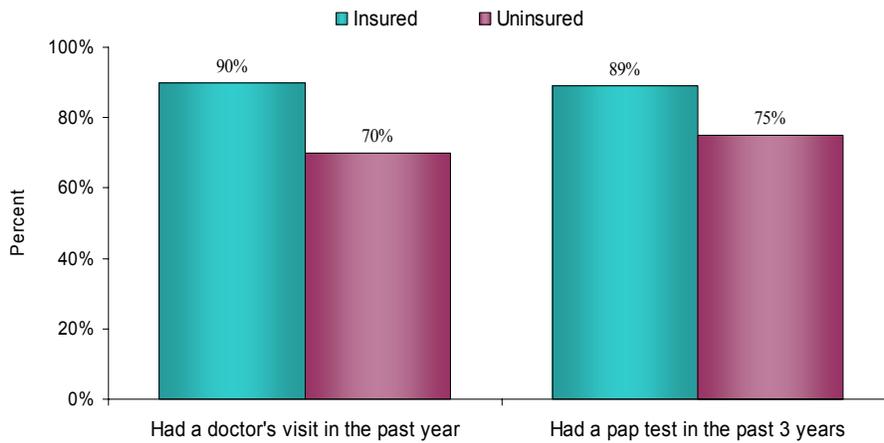
Gestational diabetes mellitus complicating pregnancy during labor and delivery in California by race/ethnicity: 2002



Data Source: California OSHPD, 2002

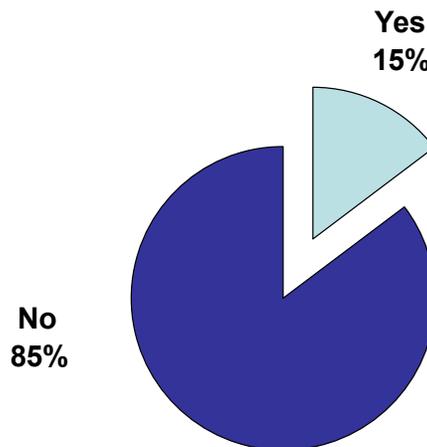
Access to care/Uninsurance. Health insurance is critical to measuring access to care. The 2001 CHIS revealed that women with health insurance were substantially more likely than those who were uninsured to have had a doctor's visit in the past year (90% vs. 70%, respectively) or to have had a pap smear in the past three years (89% vs. 75%)⁸⁵. In the same survey, 1 in 7 women (15%) responded that during the last 12 months there was a time when they wanted to see a doctor but could not because of the cost.

Access to care for Women aged 18-64 : Insured vs. Uninsured, 2001



Data Source: California Health Interview Survey

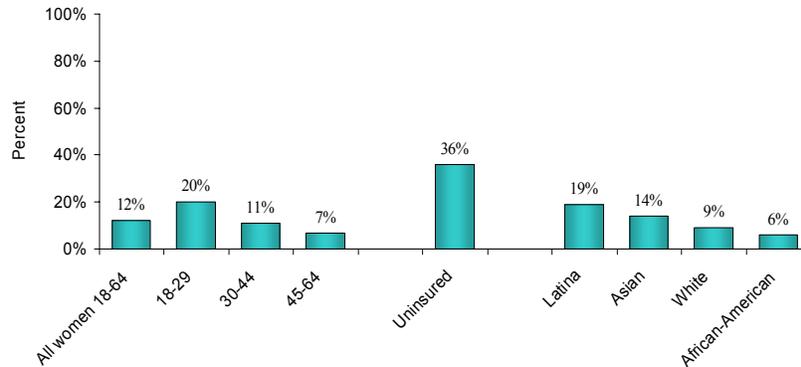
In the past year, was there ever a time when you wanted to see a doctor but could not because of the cost?



Data Source: California Health Interview Survey

Health insurance is also associated with whether or not a woman has a “usual source of care,” also known as a “medical home.” Uninsured women are the group most likely to have no usual source of care (36%). Looking at this measure by age and race/ethnicity, younger women (18-29) and Latinas were the most likely to have no usual source of care⁸⁶.

No Usual Source of Care by Age Group, Health Insurance Status, and Race/Ethnicity, Women aged 18-64, 2001

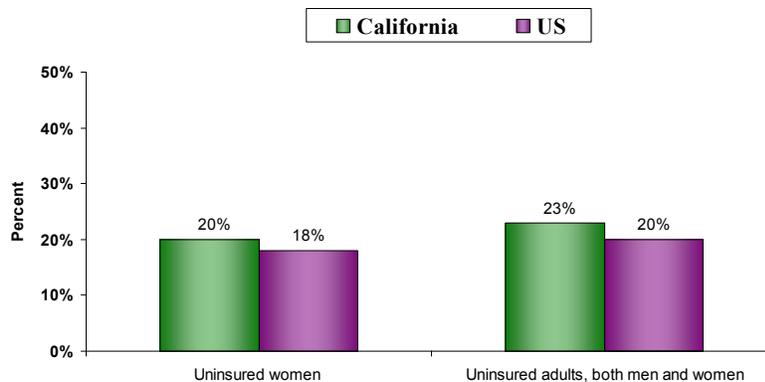


Data Source: California Health Interview Survey, 2001

In 2002, 20% of California women aged 19-64 years were uninsured, compared to 18% of women of the same age in the United States⁸⁷. The HP 2010 goal to increase the proportion of persons with health insurance to 100% has not been met.

However, women age 18-64 are less likely to be uninsured than men of the same age in both California and the U.S.⁸⁸.

Proportion of uninsured women (19-64 yrs), California & US, 2002



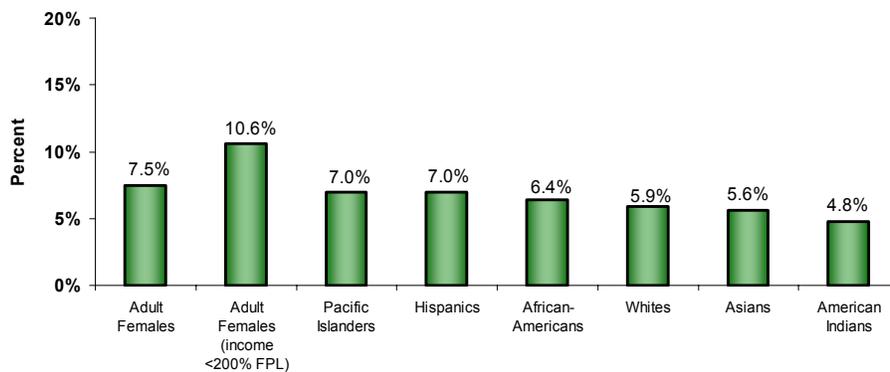
Data Source: Urban Institute and the Kaiser Commission on Medicaid and the Uninsured estimates based on the March 2003 Current Population Survey.

Mental health. One out of eight women can expect to suffer from clinical depression in her lifetime. In the United States each year, approximately 12 million women suffer from clinical depression⁸⁹. For women, depression most often occurs in the early career years, between 25 and 44 years of age⁹⁰.

Severe Mental Illness (SMI) is limited to conditions such as schizophrenia, schizoaffective disorder, manic depressive disorder, autism, and severe forms of depression, panic disorder, and obsessive compulsive disorder. SMI prevalence estimates suggest that it is associated with socioeconomic status, and is more common among women than men. In 2000, it was estimated that about 6.3% of California’s total adult population (age 18 +) have SMI, compared to 7.5 % of California’s adult female population. Among households with incomes below 200 percent of the federal poverty level, some 10.6 % of adult females may have SMI. It is estimated that 7% of Pacific Islanders and Hispanics suffer from SMI compared to 6.4% of African Americans, 5.9% of Whites, 5.6% of Asians, and 4.8% of Native Americans⁹¹.

In the 2001 CHIS survey, among those women who needed or received help for emotional/mental/ substance abuse problems in the past 12 months, 10.4% of women aged 18-44 years reported a difficulty/delay in receiving mental health care⁹². Aggregated data analyses from the California Women’s Health Survey (1998-2003) revealed that mothers of one or more children under the age of 18 were 22% more likely to report mental/emotional “distress” and were 66% more likely to express a desire for mental health services compared to those without minor children.

Percent of Severe Mental Illness*, California



*Severe Mental Illness: limited to conditions such as schizophrenia, schizoaffective disorder, manic depressive disorder, autism, and severe forms of depression, panic disorder, and obsessive compulsive disorder.
Data Source: California Department of Mental Health

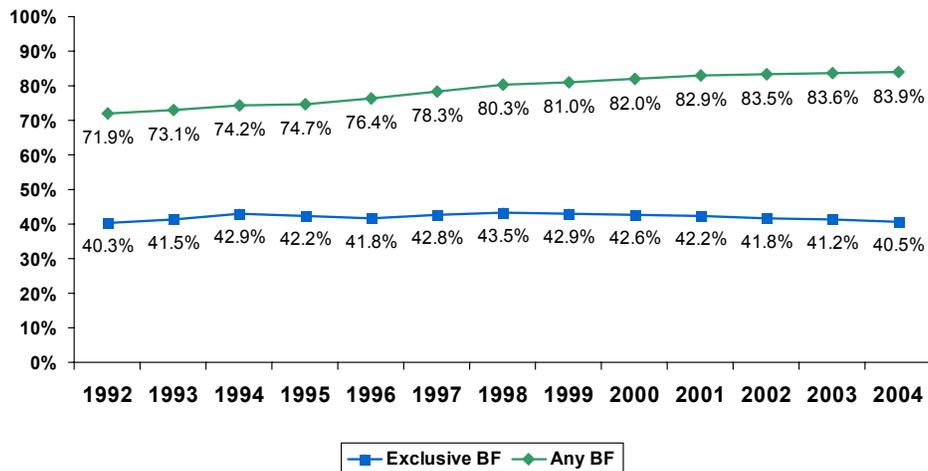
Post-partum depression. Depression is the leading cause of disease-related disability among women, and a common complication during pregnancy and the postpartum period. Some evidence suggests that pregnancy and (new) motherhood may increase the risk of depressive episodes, and may impair a woman's ability to take care of herself or her baby according to a study involving a meta-analysis of several dozens of studies focused on perinatal depression⁹³. This study estimates the incidence of major or minor depression among pregnant women at 14.5% and the incidence to also be approximately 14.5% within the first three months after giving birth. Approximately half of all these depressive episodes would be categorized "major depression".

Maternal depression, postpartum depression and other mental health disorders can have potentially serious repercussions upon the psychological, social, and physical health of mothers, their infants and children and other family members. Despite significant prevalence of depression among pregnant women, many women report an unmet need or desire for mental health services, particularly among low-income patients. Without mental health services, there is the potential for negative effects on the women's depression symptom management, health behaviors, and obstetric birth outcomes.

Breastfeeding. In-hospital breastfeeding initiation for those women who do "any" breastfeeding increased from 71.9% to 83.9% from 1992 to 2004. All race/ethnic groups had increases. However, exclusive in-hospital breastfeeding initiation has declined from a high of 43.5% in 1998 to 40.5% in 2004. Although most race/ethnic groups experienced small to modest increases, Hispanic women, who comprise approximately 50% of all California births, actually experienced a decline from 31.4% to 29.1% between 1993 and 2003. Hispanic women in 2003 had the lowest exclusive in-hospital breastfeeding initiation rates ⁹⁴.

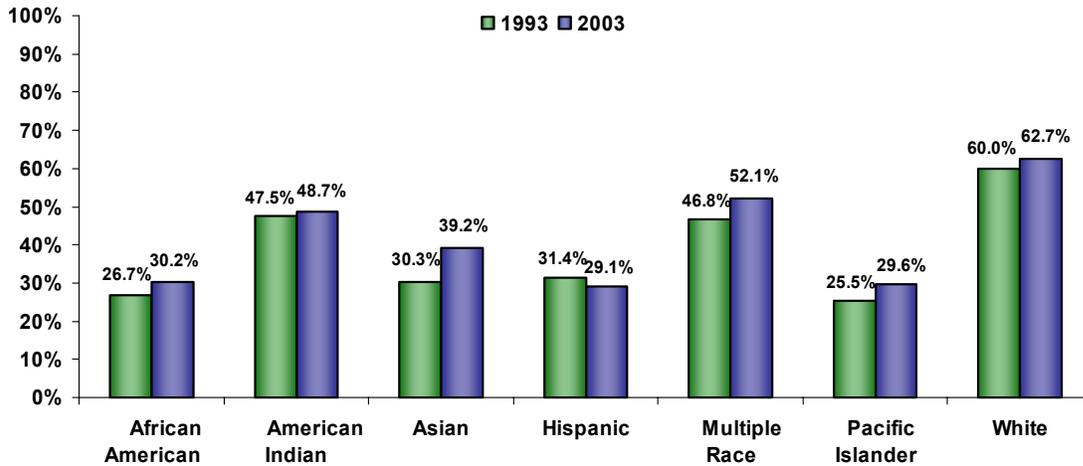
The chart below shows any breastfeeding proportions over time predicted using a lifetable model stratified by race/ethnicity using data from the MIHA survey. By 2 months postpartum, breastfeeding rates had already declined to the HP2010 6 month goal (50 percent of mothers breastfeeding) for two groups: African-American mothers and US-born Latina mothers. By approximately 4 months after the baby's birth, 40% of foreign born Latinas, 43% of Asian and 48% of white women were still breastfeeding, compared to 23% of African-American and US-born Latinas. Judging by the proportion of women exclusively breastfeeding when their babies are 4 months old, very few women meet the American Academy of Pediatrics recommendation that babies be exclusively breastfed for 6 months.

**California Any and Exclusive
In-Hospital Breastfeeding Initiation: 1992-2004**



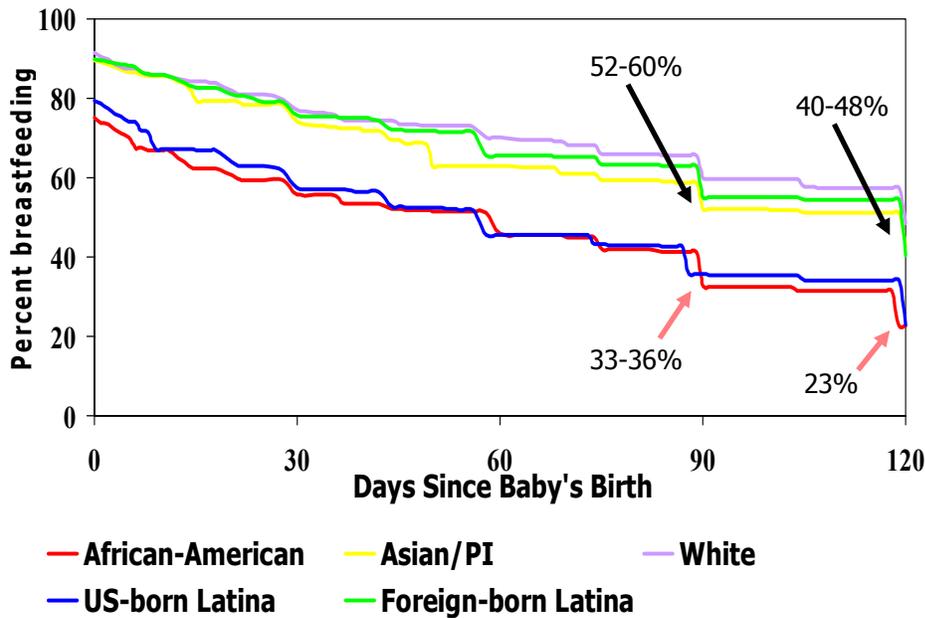
Data Source: Newborn Screening Database, Genetic Disease Branch, 1992-2004

Exclusive In-Hospital Breastfeeding Initiation in California by Race/Ethnicity: 1993 vs. 2003



Data Source: Newborn Screening Database, Genetic Disease Branch, 1993-2003

Percent of Mothers BF Since Birth, MIHA 2003



Children and Adolescents

Immunization in Children. In California, children are required to have proof of receiving the age-recommended immunizations prior to attending school or child care. Hepatitis B vaccine has been required for entry into child care centers and kindergarten since 1997 and for entry into seventh grade since 1999. Varicella vaccine and/or physician documented immunity/disease has been required for entry into child care centers and kindergarten since 2001.

The HP 2010 objective is to have 95% of all children in child care facilities and children in kindergarten through the first grade be vaccinated. In California, over 90% of children in the assessed child care facilities and 92.7% of children in kindergartens had received all required immunizations. These vaccination rates vary by type of facility. The percent of children who received all required immunizations in child care facilities were 87%, 94.5% and 96% in private, public and Head Start facilities, respectively. The percent of kindergarten students with all required immunizations was 83% in private schools compared to 94% in public schools. Overall, the percent of seventh graders that had received all required immunizations was 89.5%. The percent of seventh grade students with all required immunizations was 85% in private schools compared to 93% in public schools.

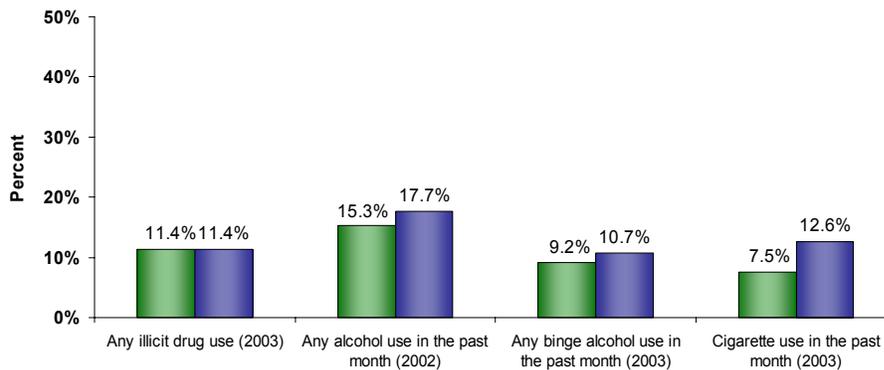
HP 2010 also has a target to achieve and maintain a 90% coverage for universally recommended vaccines. Results from the annual Kindergarten Retrospective Survey indicate that immunization coverage among these children has improved over the past 12 years. In California, the 2004 vaccine coverage is at 85% in children three months of age, 71.8% at 2 years of age and 81.3% at three years of age.

HP 2010 has a target of 80% vaccination coverage for children aged 19 to 35 months who receive the recommended vaccines (4DTaP, 3 polio, 1 MMR, 3 Hib, 3 Hep B). Using the U.S. National Immunization survey data, nationally, vaccination coverage was at 79.4 ± 0.9 percent compared to 77.4 ± 3.6 percent in California for 2003 for children aged 19 to 35 months.

Adolescent substance abuse. California and the US have the same rates – 11.4% – regarding any illicit drug use in the past month among 12-17 year olds. However, California has lower rates compared to the US for percent of adolescents 12-17 years old reporting: any alcohol use in the past month (15.3% compared to 17.7%), any binge alcohol use in the past month (9.2% compared to 10.7%), and cigarette use in the past month (7.5% compared to 12.6%)⁹⁵.

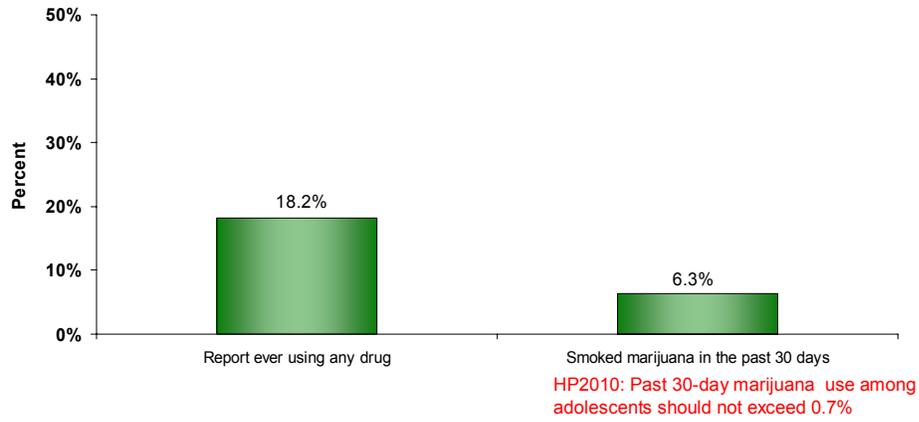
According to the 2001 CHIS, 18.2% of California adolescents (12-17 years) report ever using any drug, and 6.3% report having smoked marijuana in the past 30 days. The HP2010 objective states that past 30-day marijuana use among adolescents should not exceed 0.7%. Marijuana use is significantly higher among 15-17 year olds than it is in the 12-14 age group (10.6 vs. 2.0% respectively). Overall, gender is not a differentiating factor; males (6.8%) smoke marijuana in similar proportions as females (5.7%)⁹⁶.

Substance Abuse Among Adolescents (12-17 years): California vs. US



Data Source: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies: The National Survey on Drug Use and Health (NSDUH), 2002 and 2003

Substance Abuse Among Adolescents (12-17 years): California, 2001



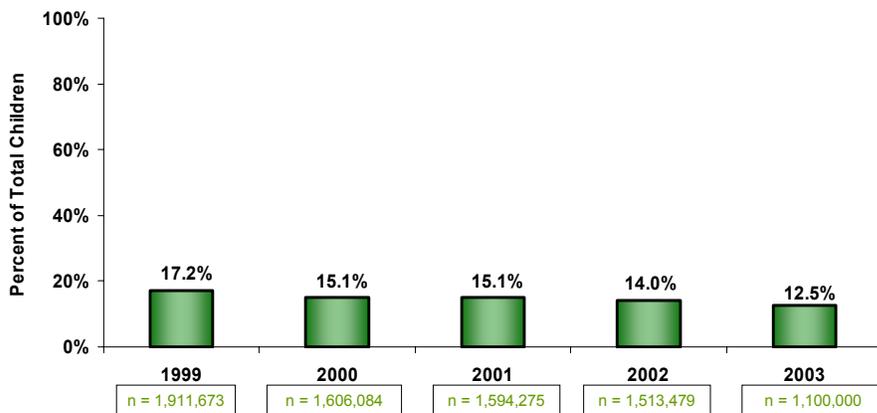
Data Source: California Health Interview Survey

Uninsurance The percent of children 18 years and under in California without health insurance has decreased: 17.2%, 1999; 15.1%, 2000; 15.1%, 2001; 14.0%, 2002; 12.5%, 2003 ⁹⁷. However, California still has higher rates of children without health insurance compared to the nation (11.4%) ⁹⁸. The HP 2010 goal to increase the proportion of persons with health insurance to 100% has not been met.

Overall 11.7% of adolescents (12-17 years) lacked current health insurance coverage in 2001. Latino adolescents have the highest uninsured rate of all groups (22.5%). This is five times the uninsured rate among White adolescents (4.4%). Approximately 8.2% of Asian youths are uninsured⁹⁹.

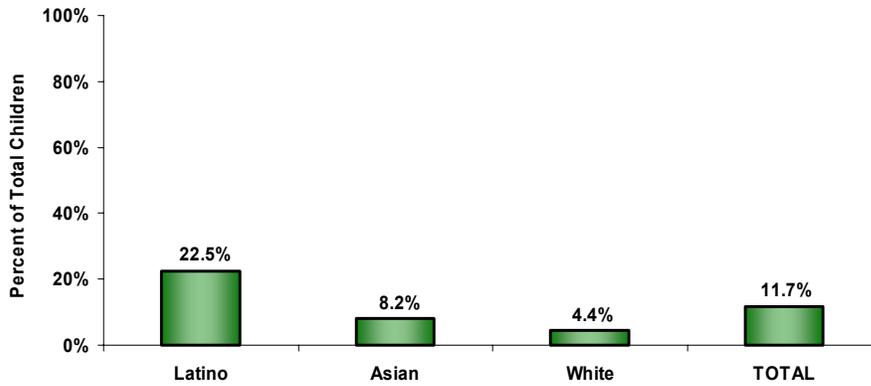
Among children (0-11 years), 8.6% were uninsured in 2001. Children 6-11 were more likely to be uninsured (10.3%) compared to children 0-5 (6.8%). Differences were also seen between race/ethnic groups with Latino children having the highest rates of uninsurance (15.5%). This was almost six times the uninsured rate of African-American children (2.6%), and is significantly higher than the uninsured proportions of White (4.3%) and Asian children (3.9%)¹⁰⁰.

Percent of Children (18 yrs and under) without Health Insurance, California 1999-2003



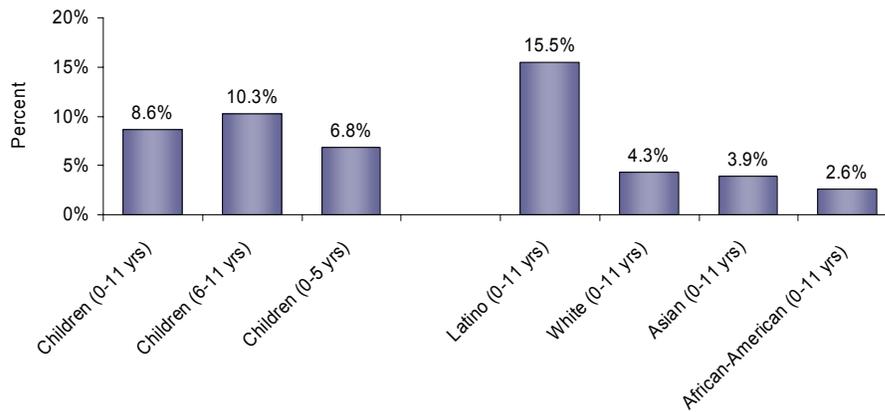
Data Source: US Census Bureau

Percent of Adolescents (12-17 yrs) without Current Health Insurance by Race/Ethnicity: California, 2001



Data Source: California Health Interview Survey
 Data not shown for African-Americans and American Indians due to a statistically unstable estimate

Percent of Children Uninsured by Age Group and Race/Ethnicity: California, 2001



SOURCE: California Health Interview Survey

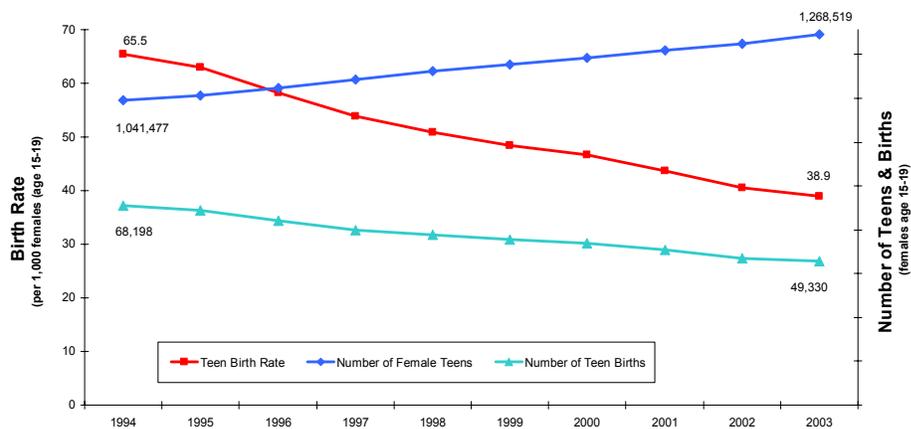
Adolescent Pregnancy and Birth. California teen birth rates have declined continuously since 1991 and are at historic lows for all age groups of teens and for all racial/ethnic groups. In 2003, there were 38.9 births per thousand California women age 15-19, a rate 45% lower than the 1991 rate of 70.9. In spite of this impressive decline in teen birth rates, it is estimated that there are still nearly 100,000 teen pregnancies in California each year. About half of these result in live births, 35% in abortions, and 15% in miscarriages or stillbirth.¹⁰¹ More than three-quarters of teen pregnancies are unintended.¹⁰²

In 2000 California's teen birth rate dropped below the national rate for the first time in more than twenty years. In 2002 (the most recent year for which comparative data are available), the rate was 40.6 for California, compared to 43.0 for the U.S. overall. While teen birth rates were on the decline in all fifty states between 1991 and 2002, the 44 percent decrease in California was the largest of any state--compared with an average decrease across the nation of 30 percent.¹⁰³

Despite notable declines in teen birth rates for all racial/ethnic groups, dramatic differences in the teen birth rate persist. For 15-19 year olds, the Hispanic teen birth rate (65.2) is more than three times higher than the rates for non-Hispanic whites (17.9) and Asian/Pacific Islanders (13.5); the African American teen birth rate (39.2) is more than twice as high than the rates for non-Hispanic whites. For 15-17 year olds, the Hispanic birth rate is more than five times higher than the rates for non-Hispanic whites and Asian/Pacific Islanders, and the African-American teen birth rate is almost three times as high.

California's female teen population aged 15 to 19 is expected to increase from 1,268,519 in 2003 to 1,448,013 in 2009; and the number of Hispanic teens is expected to increase from 525,611 in 2003 to 674,275 in 2009.

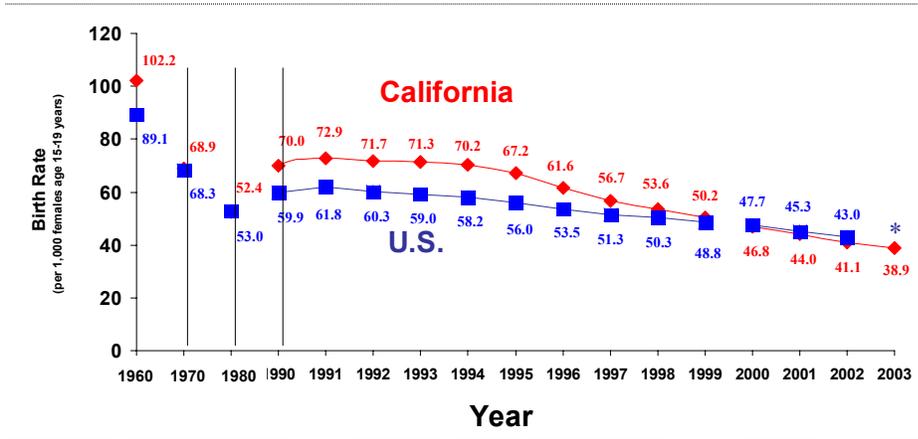
California Teen Birth Rates, Number of Teens, & Number of Teen Births (females aged 15-19 years), 1994-2003



Number of Teens: State of California, Department of Finance: *Race/Ethnic Population with Age and Sex Detail, 1990-1999 and 2000-2050. Sacramento, CA, May 2004.* Teen Birth Rate: Teen births: State of California, Department of Health Services: Birth Statistical Master File, years 1994-2003. Teen population: State of California, Department of Finance: *Race/Ethnic Population with Age and Sex Detail, 1990-1999 and 2000-2050. Sacramento, CA, May 2004.* Number of Teen Births: State of California, Department of Health Services: Birth Statistical Master File, years 1994-2003.

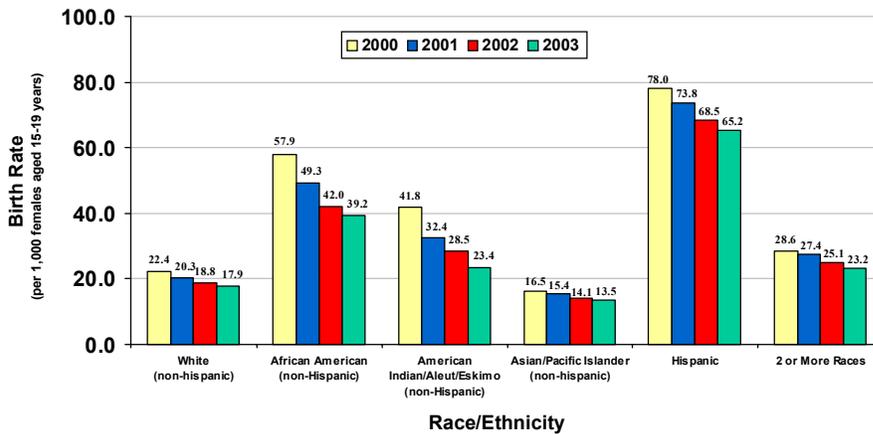
Prepared by: California Department of Health Services, Maternal, Child & Adolescent Health Branch, October 2004.

California and U.S. Teen Birth Rates (females aged 15-19 years) for Various Years, 1960-2003



Sources: Teen births: State of California, Department of Health Services: Birth Statistical Master File, years 1960-2002. Teen population: Years 1960-1999, State of California, Department of Finance: *Various years of projection or estimates*. Years 2000-2002, Special Tabulation of County Characteristics, Population Estimates for California (CADHS) Vintage 2002; Population Division, U.S. Census Bureau. Release Date: September 18, 2003 (from 2000 census). U.S. Data Source: Year 1960; National Vital Statistics Report, Vol. 49, No. 10, September 25, 2001. Years 1970-2002; National Vital Statistics Report, Vol. 52, No. 10, December 17, 2003. *US data for 2003 is currently not available.
Prepared by: California Department of Health Services, Maternal and Child Health Branch, September 2004.

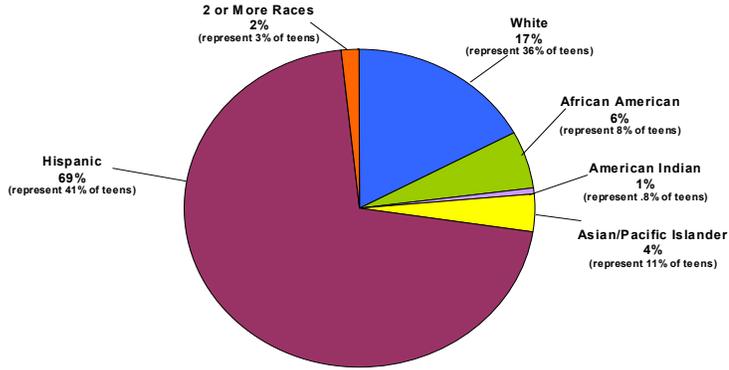
California Teen Birth Rates (females aged 15-19 years) by Race/Ethnicity & Year, 2000-2003



Data Sources: Teen births: State of California, Department of Health Services: Birth Statistical Master File, years 1994-2003. Teen population: State of California, Department of Finance: *Race/Ethnic Population with Age and Sex Detail, 1990-1999 and 2000-2050*. Sacramento, CA, May 2004.

Prepared by: California Department of Health Services, Maternal and Child Health Branch, September 2004.

**Maternal Race/Ethnicity of Teen Births (n=49,330)
& Percent of Teen Population (n=1,268,519)
for Females Aged 15-19 years, California, 2003**



Data Source: Teen births: State of California, Department of Health Services: Birth Statistical Master File, 2003. Teen population: State of California, Department of Finance: *Race/Ethnic Population with Age and Sex Detail, 2000-2050*. Sacramento, CA, May 2004.
Prepared by: California Department of Health Services, Maternal and Child Health Branch, September 2004.

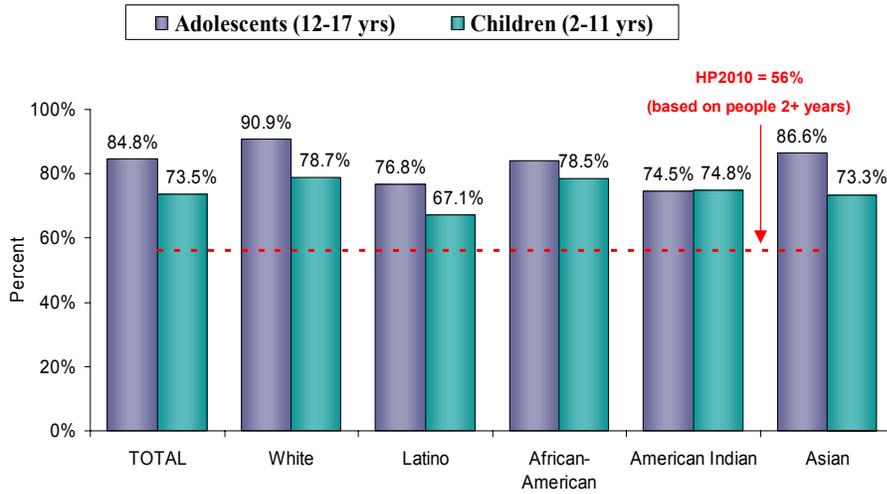
Oral Health. According to *Oral Health in America: A Report of the Surgeon General* (2000), dental decay is the single most common chronic childhood disease in the United States, five times more common than asthma.¹⁰⁴ In addition to a lack of awareness of the importance of oral health among the public, the report found a significant disparity between racial and socioeconomic groups with regard to oral health and ensuing overall health issues. The social impact of oral diseases in children is substantial. Poor children suffer nearly 12 times more restricted-activity days than children from higher-income families. Pain and suffering due to untreated oral diseases can lead to problems in eating, speaking, and attending to learning.

HP2010 sets an objective that at least 56% of persons age two and older will have visited a dentist during the previous year. While there is no age specific HP2010 objective, California's adolescents (12-17 yrs) exceed the population based HP2010 objective with 84.8% reporting that they visited a dentist in the past year. Latino adolescents (76.8%) are less likely than Whites (90.9%) or Asians (86.6%) to report they visited a dentist in the past year. Despite differences between demographic groups, all estimates meet the HP2010 objective¹⁰⁵.

For children ages 2-11, 73.5% have seen a dentist within the last 12 months. This surpasses the population based HP2010 objective for person two years and older. Older children (ages 5-11) are almost twice as likely to have gone to the dentist as children ages 2-4, 84.5% vs. 45.1%, respectively. Latinos have a statistically lower proportion of children having seen a dentist (67.1%) compared to African-American (78.5%) and White (78.7%) children. Having some dental insurance makes a difference; 78.3% of children age 2-11 with dental insurance visited a dentist in the past year, while only 58.2% of those without dental insurance did. Latino children have the lowest proportion with dental insurance, 69.3% compared to all other race/ethnic groups. At 86.5%, African-American children have a statistically higher proportion with dental insurance than either White (80.1%) or Latino (69.3%) children¹⁰⁶.

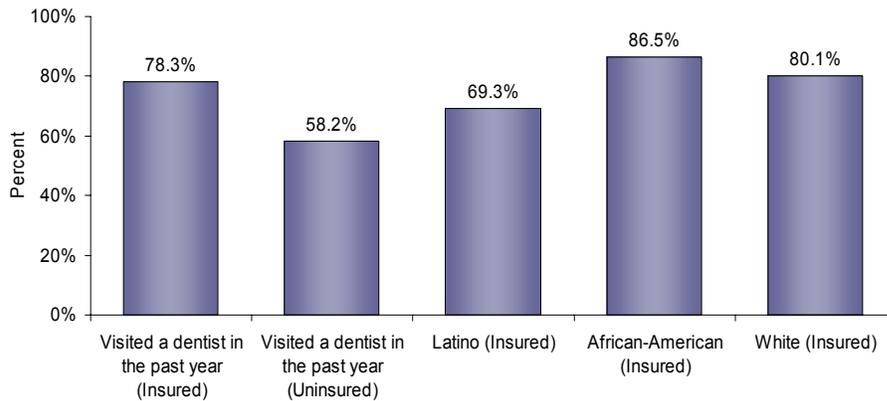
Although the overall proportion of children with dental insurance may seem relatively high at 76.7%, children and adolescents are still two to three times more likely to lack dental insurance as compared to health insurance. Moreover, results from the 2003 CHIS found that 10.2% of children (2-11yrs) and 7.7% of adolescents (12-17 yrs) could not afford dental care that was needed.

Visited a Dentist in the Past Year by Age Group and Race/Ethnicity: California, 2001



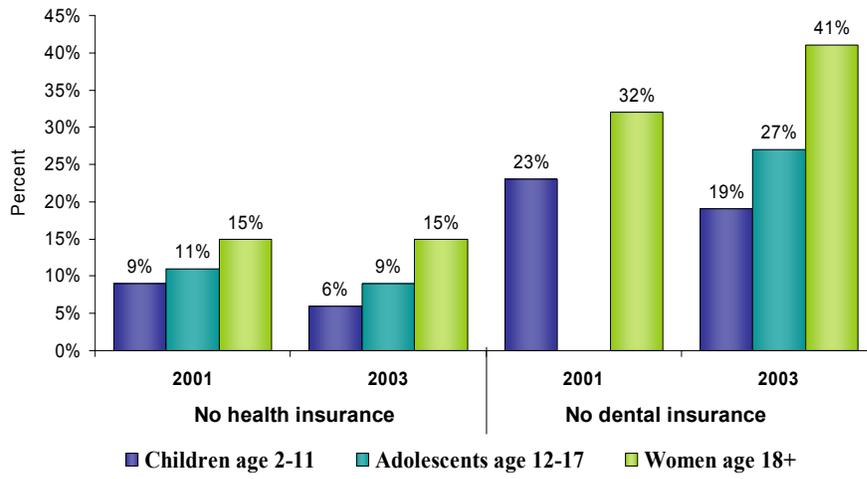
Data Source: California Health Interview Survey

Proportion of Children (2-11 yrs) with Dental Insurance by Race/Ethnicity: California, 2001



Data Source: California Health Interview Survey

Dental uninsurance rates are 2 to 3 times higher than health uninsurance rates



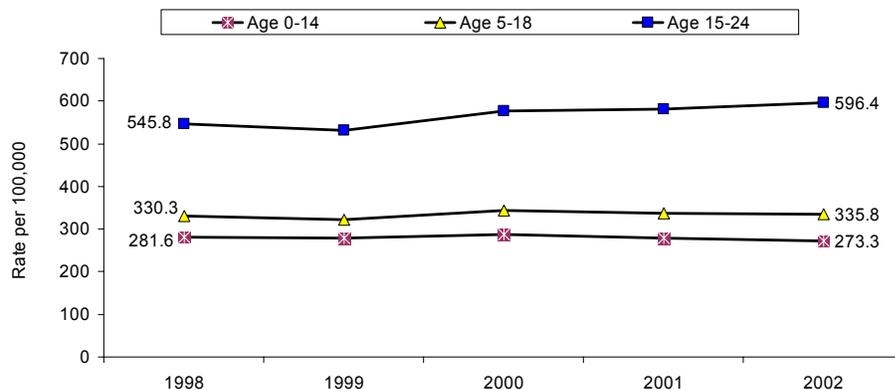
Data Source: California Health Interview Survey, 2001 & 2003

Injuries. Healthy People 2010 has an objective to reduce the number of fatal motor vehicle crashes for teenagers aged 15-19 to a rate of 9.2 per 100,000 population. California has not currently met this objective. In fact, the rates have been increasing to a high of 19.7 deaths per 100,000 in 2003¹⁰⁷.

The rates for hospitalization of both all injuries and non-fatal motor vehicle crashes (MVC) for children aged 0-14 years, and those aged 5-18 years have been stable between 1998 and 2002. In 2002, children 0-14 years had a hospitalization rate for all injuries of 273.3 per 100,000 and non-fatal MVC's of 37.4 per 100,000, while youths 5-18 years had a hospitalization rate for all injuries of 335.8 per 100,000 and a non-fatal MVC hospitalization rate of 67.2 per 100,000 ¹⁰⁸.

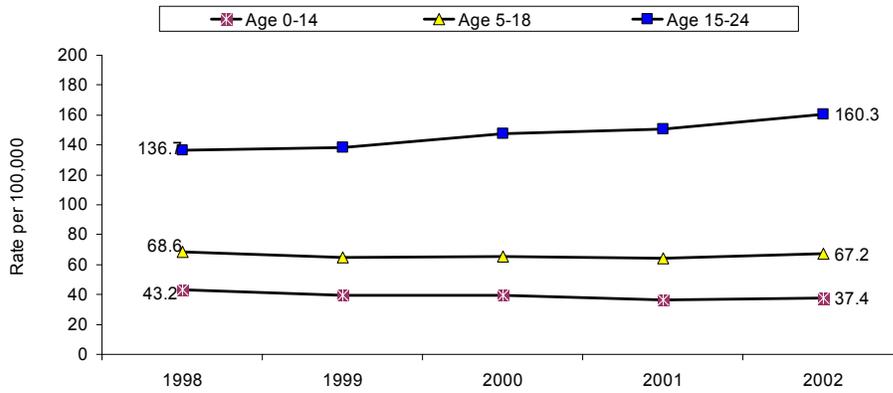
The rates of hospitalization for both all injuries and non-fatal MVC injuries for people 15-24 years have been worsening in California between 1998 and 2002. In 2002, 15-24 year olds had a hospitalization rate for all injuries of 596.4 per 100,000 and a non-fatal MVC hospitalization rate of 160.3 per 100,000¹⁰⁹.

Trends in Injury Hospitalization Rates (per 100,000) by Age Group: California 1998-2002



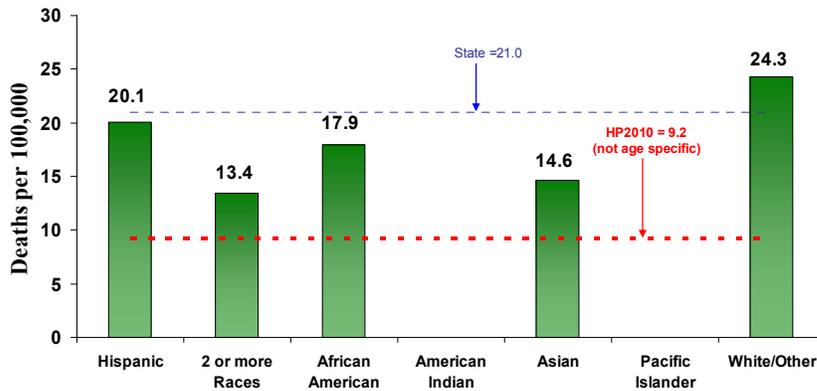
Data Source: California Epidemiology and Prevention for Injury Control (EPIC) Branch
Includes all injuries

Trends in motor vehicle injury hospitalization rates (per 100,000) by age group: California 1998-2002



Data Source: California Epidemiology and Prevention for Injury Control (EPIC) Branch

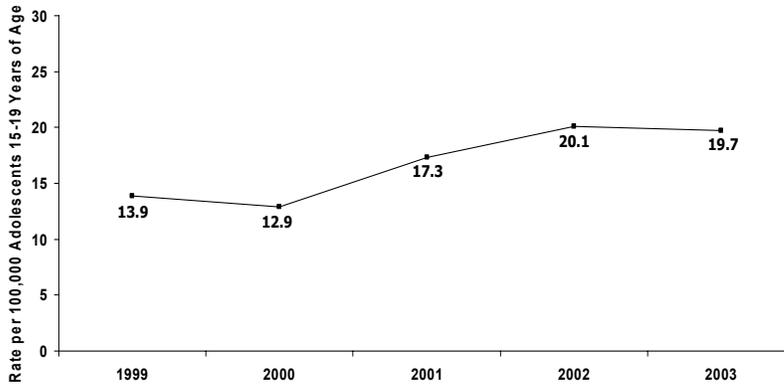
Motor Vehicle Death Among Adolescents Age 15-24: 2003



Epidemiology and Evaluation Section
 Maternal, Child and Adolescent Health/Office of Family Planning Branch
 California Department of Health Services
 Data Source: Death Statistical Master Files 2003, DOF 2000 Census Projections.

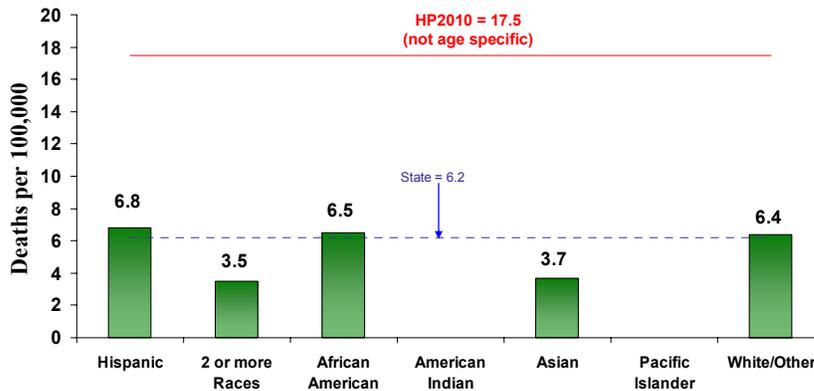
ICD10 group code 296-306.
 White/Other includes "Unknown".
 Data not shown <10 events.

Rate of Deaths per 100,000 Adolescents Aged 15-19 Years Caused by Motor Vehicle Injuries: 1999-2003



Data Source: Death Statistical Master File and California Department of Finance Population Projections

Fatal Unintentional Injuries Among Children 0-14: 2003

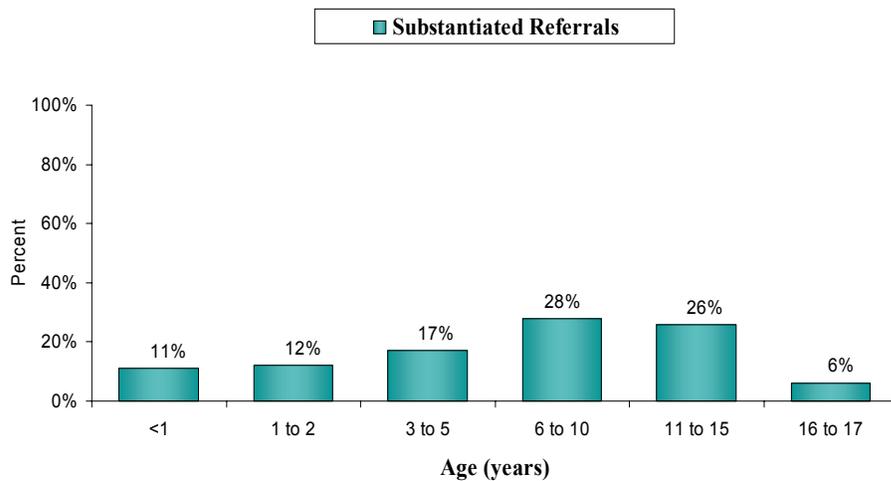


Epidemiology and Evaluation Section
 Maternal, Child and Adolescent Health/Office of Family Planning Branch
 California Department of Health Services
 Data Source: Death Statistical Master Files 2003, DOF 2000 Census Projections.

ICD10 group code 295-330.
 White/Other includes "Unknown".
 Data not shown < 10 events.

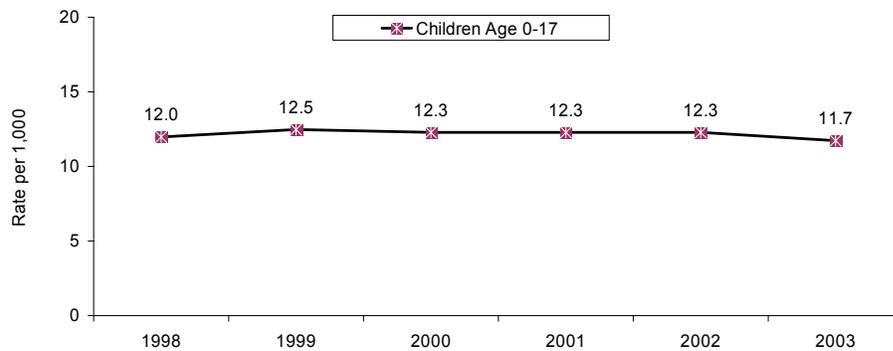
Violence. The HP 2010 goal is to reduce the maltreatment of children to 10.3 per 1,000 children under the age of 18. Of the 9,563,260 children under the age 18 in California in 2003, there were 493,091 children that had at least one child abuse referral (51.7 children per 1,000), of which 111,451 had their referral substantiated (11.7 children per 1,000). Forty percent of substantiated allegations were to children five years of age or younger, with 11% of cases occurring to children under 1 year of age). African American children had the highest rates of substantiated referrals. Statewide rates have remained relatively consistent during the 1998-2003 time period, ranging from 12.5% to 11.7% ¹¹⁰.

Proportion of substantiated child abuse referrals by age, California



SOURCE: Needell, B., Webster, D., Cuccaro-Alamin, S., Armijo, M., Lee, S., Lery, B., Shaw, T., Dawson, W., Piccus, W., Magruder, J., Kim, H., Conley, A., Henry, C., Korinek, P., Paredes, C., & Smith, J. (2005). *Child Welfare Services Reports for California*. Retrieved [month day, year], from University of California at Berkeley Center for Social Services Research website. URL: <http://cssr.berkeley.edu/CWSCMSreports/>
Time period: July 1, 2003 to June 30, 2004

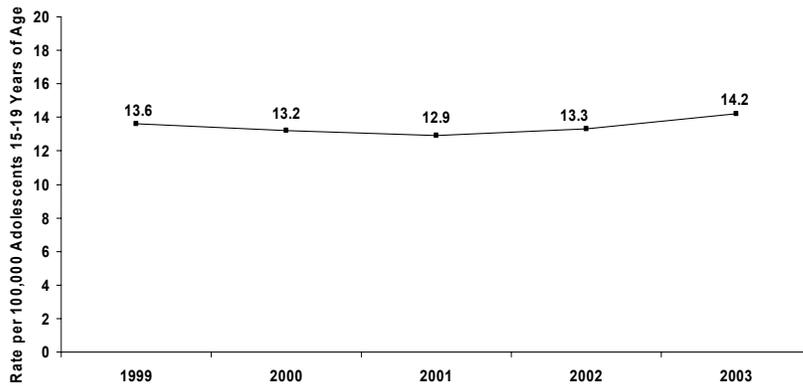
Trends in substantiated child abuse referrals (per 1,000): California 1998-2003



Data Source: Needell, B., Webster, D., Cuccaro-Alamin, S., Armijo, M., Lee, S., Lery, B., Shaw, T., Dawson, W., Piccus, W., Magruder, J., Kim, H., Conley, A., Henry, C., Korinek, P., Paredes, C., & Smith, J. (2005). *Child Welfare Services Reports for California*. Retrieved from University of California at Berkeley Center for Social Services Research website. URL: <http://cssr.berkeley.edu/CWSCMSreports/>

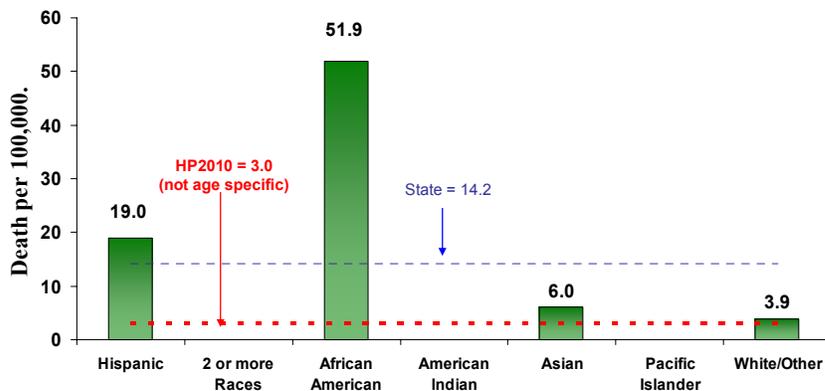
The rate of deaths by homicide among adolescents aged 15-19 overall rose from 13.3 to 14.2 per 100,000 between 2002 and 2003; it is too early to know if this is a trend or a single year fluctuation. The HP 2010 objective is no more than 3.0 deaths by homicide per 100,000, but this has not been achieved among any of the race/ethnic groups. The rate of adolescent death by homicide is especially high African Americans, at 51.9 per 100,000.

Rate of Deaths per 100,000 Adolescents Aged 15-19 Years Caused by Homicide: 1999-2003



Data Source: Death Statistical Master File and California Department of Finance Population Projections

Rate of Deaths per 100,000 Adolescents Aged 15-19 Years Caused by Homicide by Race/Ethnicity: 2003

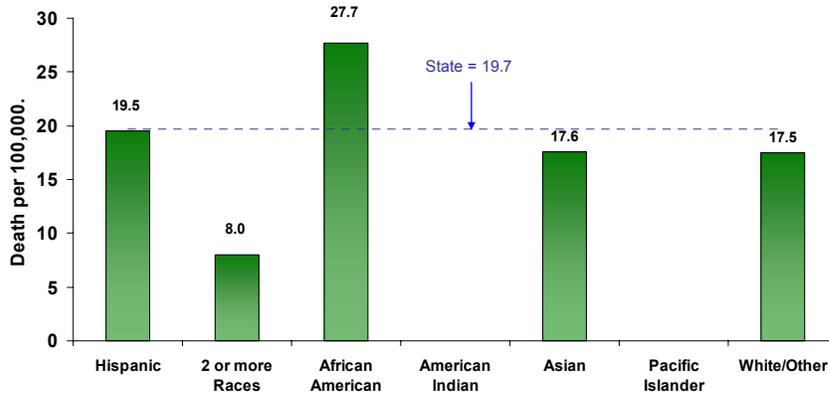


White/Other includes "Unknown".
Data not shown <10 events.
ICD-10 ucodegrp 338 and 346.

Data Source: Death Statistical Master File 2003, DOF Population Projections

Child Death Rate. In 2003, the child death rate (1-14 years) in California was 19.7 per 100,000. This rate varied by race/ethnicity with African-Americans having the highest rates (27.7), followed by Hispanics (19.5), Asians (17.6), White/Other (17.5), and Multi-Race group (8.0) ¹¹¹.

Child Death Rate (1-14 Years): 2003



Data Source: Death Statistical Master File 2003, DOF Population Projections

White/Other includes "Unknown".
Data not shown <10 events.

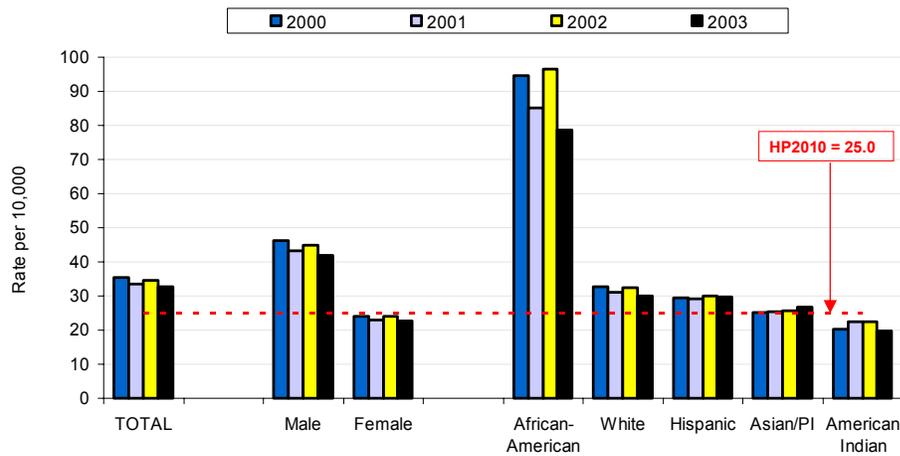
Asthma. California has not met the Healthy People 2010 objective to reduce the number of children aged <5 years old hospitalized for asthma to 25 per 10,000. However, this rate has been improving between 1990 and 2003, with the most recent rate reported at 32.6 per 10,000¹¹².

Similar to national trends, boys <5 had higher rates compared to girls <5. In fact in 2003, asthma hospitalization rates for males <5 (42.0 per 10,000) were 1.8 times higher than for females (22.9 per 10,000). Females had met the HP2010 objective, while males had rates which were 1.7 times higher¹¹³.

African-American children <5 years have the highest rates reported at 78.7 per 10,000 in 2003, whereas American Indians and Alaska Natives had the lowest rate at 19.6 per 10,000. Whites, Hispanics, and Asian/Pacific Islanders had similar rates (30.1, 29.7, and 26.7 respectively)¹¹⁴.

Rates of hospitalization for asthma have also been improving for children aged 5-9 years, 10-14 years, and 15-19 years. HP2010 does not have a corresponding objective for these age groups. The closest objective is to reduce the number of children and adults aged 5-64 years hospitalized for asthma to 7.7 per 10,000¹¹⁵.

Trends in Asthma Hospitalization Rates (per 10,000) for Children <5 Years: California 2000-2003



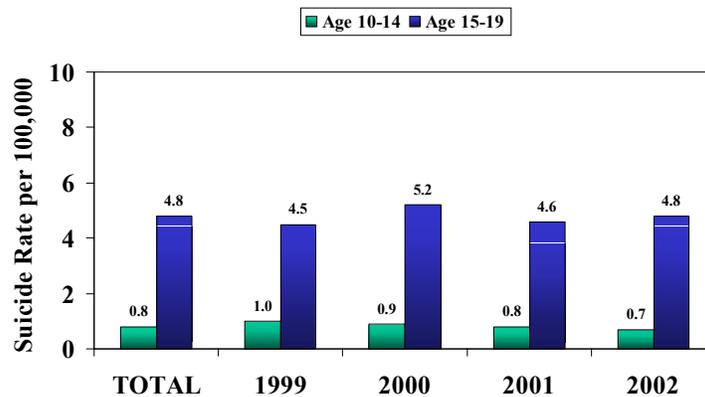
Data Source: Office of Statewide Health Planning and Development (OSHPD)

Mental health. The rate of children and adolescents hospitalized per 10,000 for a mental health issue has been stable between 1997 and 2000. In 2000, the rate of hospitalization for a mental health issue was 21.8 per 10,000 children 5-14 years, 39.2 per 10,000 10-14 years, and 80.8 per 10,000 15-19 years¹¹⁶.

According to a meta-analysis of mental health needs from one national study and two statewide studies, an estimated 2.1 million individuals in California had a serious emotional disturbance (SED) or a serious mental illness (SMI).¹¹⁷ This includes persons diagnosed with depression, attention deficit disorder, anxiety disorder, conduct disorder, eating disorders, schizophrenia, schizoaffective disorder, autism, panic disorder, obsessive compulsive disorder, and manic depressive disorder, and other severe forms of depression. About a third (32.7%) of these individuals were youths age 17 years or under. Although the percent of youths were evenly distributed by gender, the presence of SED was highest among Hispanics (8.0%), African Americans (7.9%), and American Indians (7.9%). However, in summarizing these findings it should be noted that the rates for youths included only the conditions grouped under SED, which includes depression, attention deficit disorder, anxiety disorder, conduct disorder, and eating disorders.

Suicide is the third leading cause of death among adolescents.¹¹⁸ The US average (1999-2002) for adolescents between 10 and 19 years who commit suicide is 1,859. Seven percent of these suicides occur in California.¹¹⁹

Non Homicide Related Suicide by Age Group California, 1999-2002



Data Source: NCHS vital Statistics System for numbers of deaths. Bureau of Census for population estimates.

The total 4-year rates of suicide among children age 10 to 14 and 15 to 19 were generally lower than the Healthy People 2010 objective of 5.0 deaths per 100,000 for the general population, except for year 2000 when the suicide rate peaked to 5.2 among older adolescents. The rates of suicide among the younger and pre-adolescent age group steadily decreased from 1 to .7 per 100,000, whereas the same rates for the older adolescent age group drifted between 4.8 and 5.2 per 100,000. Suicide was defined here as suicides by all injury types except for homicide.

As an aggregate total, the number of suicides committed by adolescents age 10 to 19 increased each consecutive year from 133 in 1999 to 139 in 2002, representing a 4.5 percent increase over this period. Between 80 and 86 percent of all these suicides were completed by the older adolescent age group, which is consistent with national figures that indicate the rate of suicide increases along with increases in age.¹²⁰

Adolescent suicide is often connected with a psychiatric co-morbidity. About 50 to 75 percent of all young persons who commit suicide have been diagnosed with a mood disorder.¹²¹ However, this relationship between mental disorders and suicide is complex and multifaceted in nature. Not all mental disorders carry the same risk for suicide, and the association between various suicide risk factors differs by specific mental disorders.¹²² These risk factors include age, gender, family suicide history, suicidal behavior history, alcohol use, and overall level of functioning. The risk of suicide also differs by the severity of suicidal ideation as well as by a host of other psychosocial factors, such as the presence of family violence, the lack of supportive environment at school or at home, and the lack of hopefulness about the future.^{123 124 125}

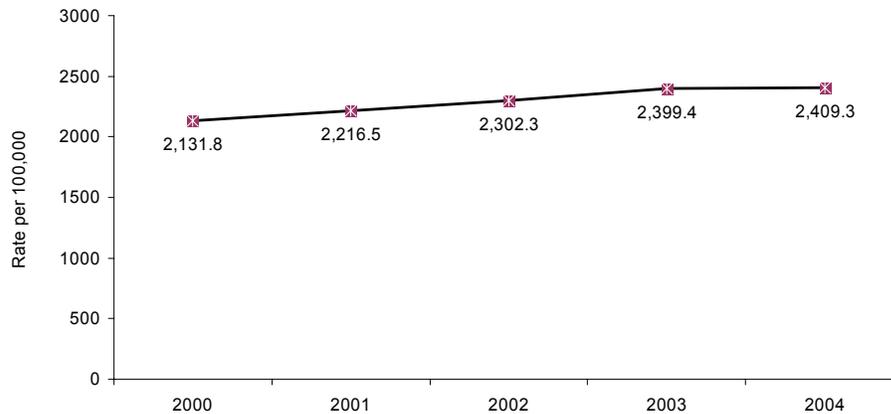
Sexually Transmitted Infections

Chlamydia. The rate of chlamydia infections per 100,000 for females 15-24 years has been worsening in California. Among 15-24 year old females attending STD clinics and family planning clinics, the HP 2010 objective is to decrease the rate of chlamydia infections to 3%. California has not met this objective, and is currently reporting higher rates than the nation ¹²⁶.

The 2003 California prevalence rate for chlamydia in family planning clinics was 6.5% among 15-19 year old females and 5.6% among 20-24 year old females, approximately two times higher than the Healthy People 2010 objective. The chlamydia prevalence was 25.3% and 14.1% for 15-19 and 20-24 year old females seen in STD clinics, respectively, which is approximately five to eight times higher than the Healthy People 2010 objective ¹²⁷.

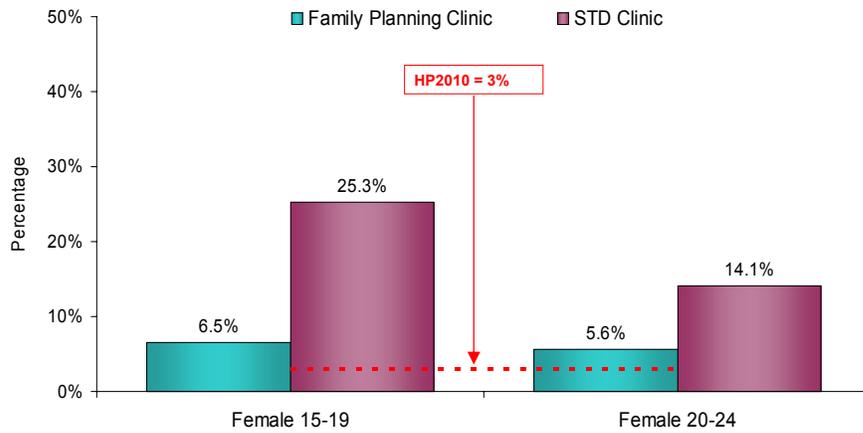
Consistent with patterns seen since 1990, the 2003 data indicated that African American chlamydia rates were higher than other race/ethnic groups regardless of gender. Among females, African American prevalence is at 902.3 per 100,000 compared to 494.2 among Latinas, 257.4 among American Indian/ Alaska Natives, 168.2 in Asian/Pacific Islanders and 141.2 among Whites ¹²⁸.

Trends in Chlamydia Infection Rates (per 100,000) for Females Ages 15-24 yrs: California 2000-2004



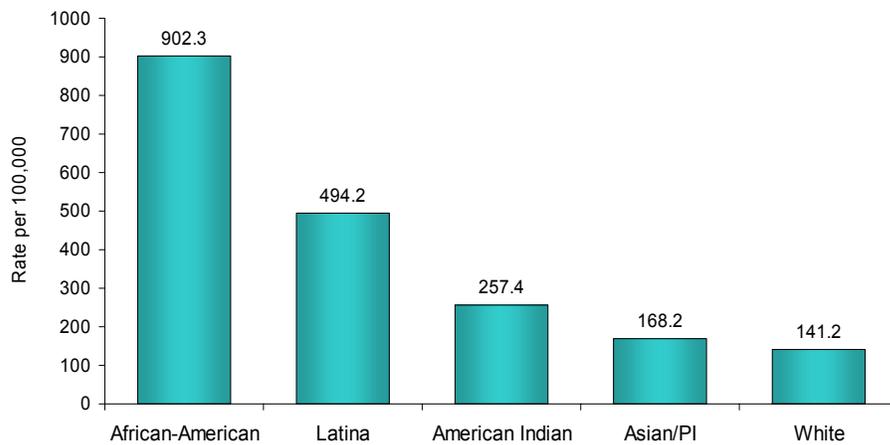
Data Source: California Department of Health Services, STD Branch

Chlamydia Prevalence Monitoring, Percent Positive for Family Planning Clinics and STD Clinics: California, 2003



Data Source: California Department of Health Services, STD Branch

Chlamydia Rates (per 100,000) for Females by Race/Ethnicity: California, 2003



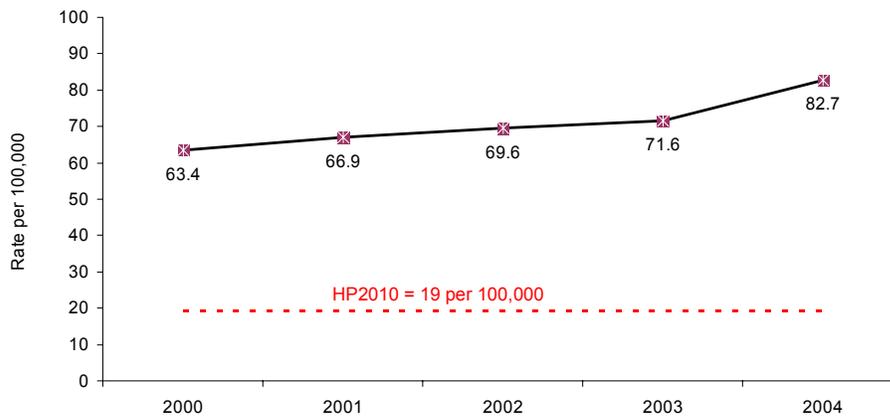
Data Source: California Department of Health Services, STD Branch

Gonorrhea. Incidence rates for gonorrhea have declined significantly between 1985 and 1999 in both California and the United States. However, California rates have been on the rise between 1999 and 2003. Nevertheless, rates in California in 2003 remain well below those reported nationally (71.6 versus 116.2 per 100,000 population, respectively). The Healthy People 2010 objective for gonorrhea incidence is fewer than 19 cases per 100,000; the incidence rate in California was 3.8 times that objective in 2003 ¹²⁹.

In 2003, the gonorrhea incidence among males was 77.3, and among females the incidence was 65.6 per 100,000. Currently, gonorrhea cases among females represent forty six percent of total cases in California. Incidence is highest among females aged 20-24 (304.8 cases per 100,000) followed by 15-19 year olds (297.1). Cases among females in the 15-19 and 20-24 year age group made up 32 and 31 percent of female cases reported, respectively ¹³⁰.

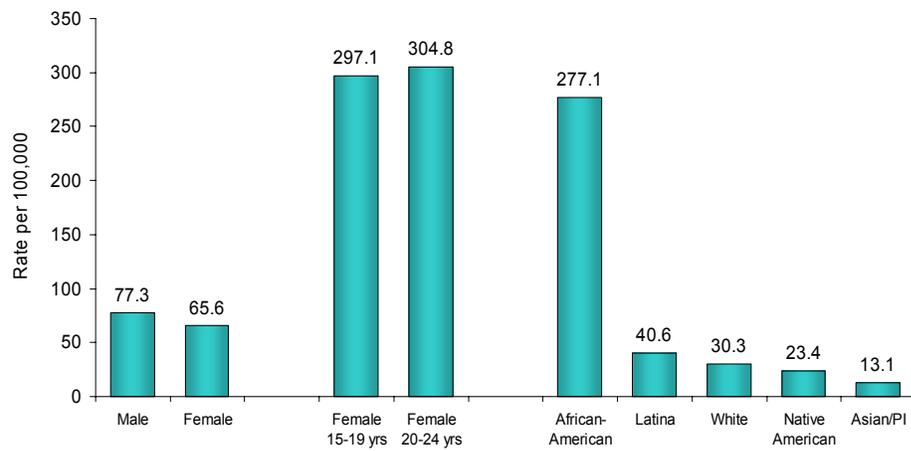
Rates of gonorrhea increased among all racial/ethnic groups but decreased among Blacks in 2003. Even with this decrease, the rate for African Americans was still more than nine times higher than that of Whites (277.1 and 30.3, respectively). Other race/ethnic incidence rates include: Latinos (40.6), Native Americans (23.4) and Asian/Pacific Islanders (13.1) ¹³¹.

Trends in Gonorrhea Incidence Rates (per 100,000): California 2000-2004



Data Source: California Department of Health Services, STD Branch

Gonorrhea Incidence Rates (per 100,000) by Sex, Age, and Race/Ethnicity: California, 2003



Data Source: California Department of Health Services, STD Branch

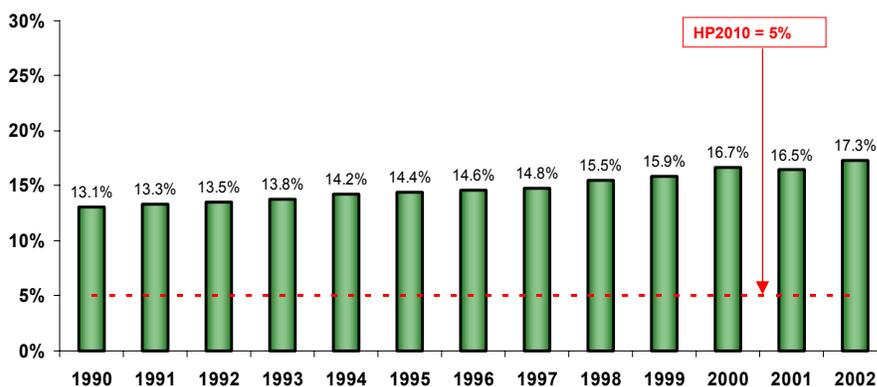
Overweight. The percent of Californians who are overweight has been increasing, as has been the percent of children aged 2-4 years and youths aged 5-19 years who are overweight. The HP 2010 objectives regarding obesity are to decrease the percent of adults who are overweight to 15%, overweight children aged 2-4 years to 5%, and overweight youths 5-19 years to 5%. In 2002, overweight children represented 17.3% of 2-4 year olds and 20.8% of youths 5-19 years old. California has a higher percent of children aged 2-4 years who are overweight compared to the nation (14.3%). Furthermore, the percent of children aged 2-4 years and youths aged 5-19 years who are at risk of being overweight has also been increasing ¹³².

In 2003, 21.7% of youths aged 5-19 were overweight. These rates varied by race/ethnicity, with all groups surpassing the HP 2010 objective. American Indians had the highest proportion at 27% (5.4 times higher than HP 2010), while Asian/Pacific Islanders had the lowest proportion at 15.2% (3 times higher than HP2010). Other race/ethnic rates include: Hispanic (23.2%), Black (19.3%), and White (18.2%). Similar rates were reported by race/ethnicity for those youths 5-19 who are at risk of being overweight ¹³³.

Between 1994 and 2003, all race/ethnic groups evidenced dramatic increases in the percent of youths aged 5-19 years who are overweight. American Indians have consistently had higher rates than all other race/ethnic groups – from 16.2% in 1994 to 27% in 2003. Similarly, Asians have consistently had the lowest rates compared to all other race/ethnic groups from 7.3% in 1994 to 15.2% in 2003 ¹³⁴.

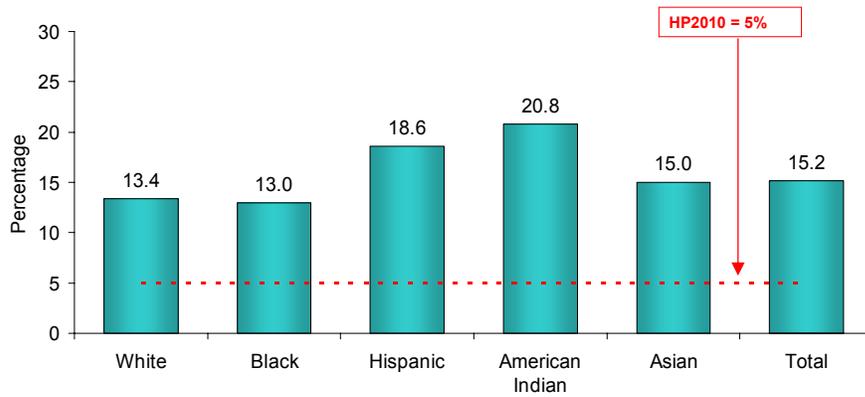
Based on the Surgeon General’s (2001) assessment of the annual national cost of obesity, (including direct medical costs and costs attributed to illness, disability, and premature death), and based on population figures, the estimated cost of obesity in California is \$14.2 billion ¹³⁵.

Percent of Overweight Children 2-4 years,
California 1990 - 2002



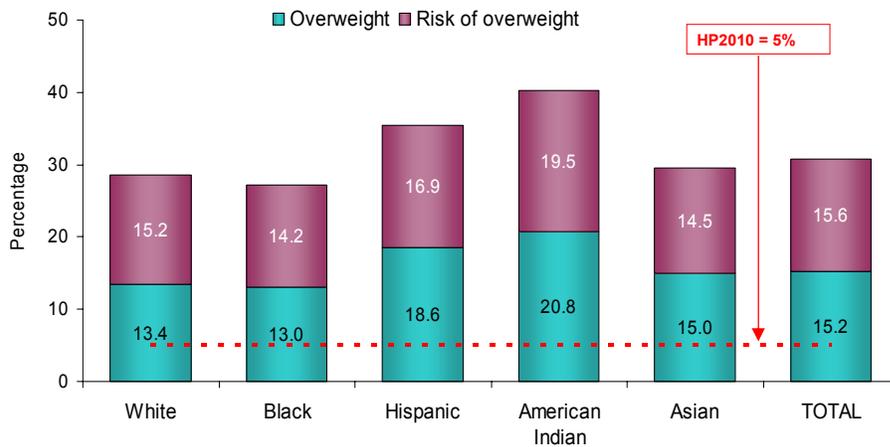
Data Source: PedNESS California 2002, Table 12C
^a≥ 95% BMI-for-age, CDC Growth Charts, 2000

Prevalence of overweight* among children aged 2 to <5 years, by race and ethnicity



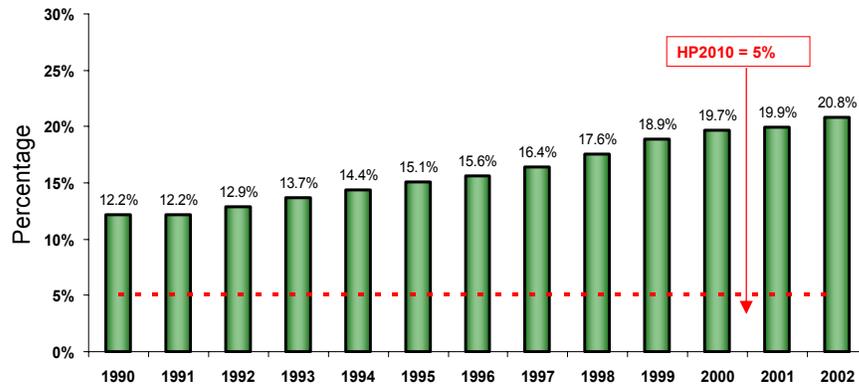
Data Source: PedNESS California 2002, Table 8C
 *≥ 95% BMI-for-age, CDC Growth Charts, 2000

Prevalence of overweight and risk of overweight* among children aged 2 to <5 years, by race and ethnicity



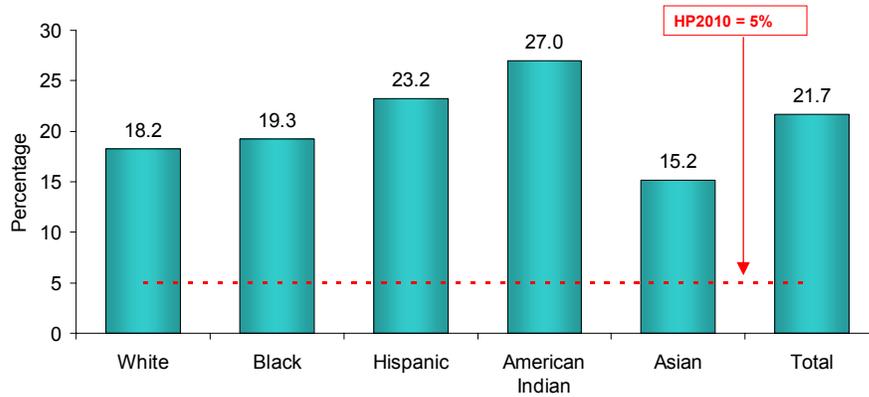
Data Source: PedNESS California 2002, Table 8C
 •Overweight: ≥ 95th percentile BMI-for-age; at risk of overweight: ≥ 85th-~95th percentile BMI-for-age, CDC Growth Charts, 2000.
 •15% of children are expected to fall above the 85th percentile (5% above the 95th percentile and 10% between the 85th and 95th percentiles).

Percent of Overweight* Children 5-19 years, California 1990 - 2002



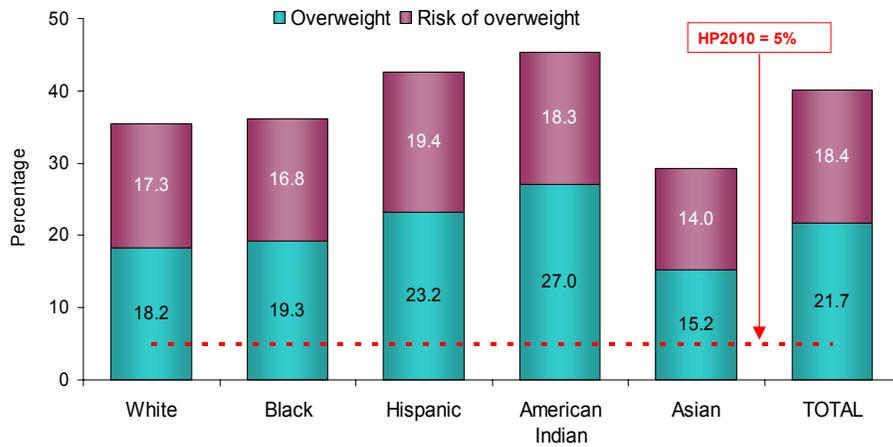
Data Source: PedNESS California 2002, Table 12C
 *≥ 95% BMI-for-age, CDC Growth Charts, 2000

Percent of Overweight* Children 5 to <20 years, by race and ethnicity



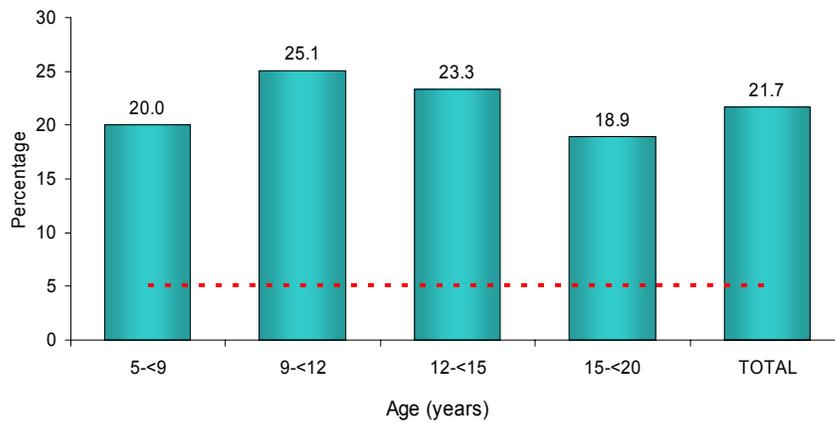
Data Source: PedNESS California 2002, Table 8C
 *≥ 95% BMI-for-age, CDC Growth Charts, 2000

Prevalence of Overweight and Risk of Overweight* among Children aged 5 to <20 Years, by Race and Ethnicity



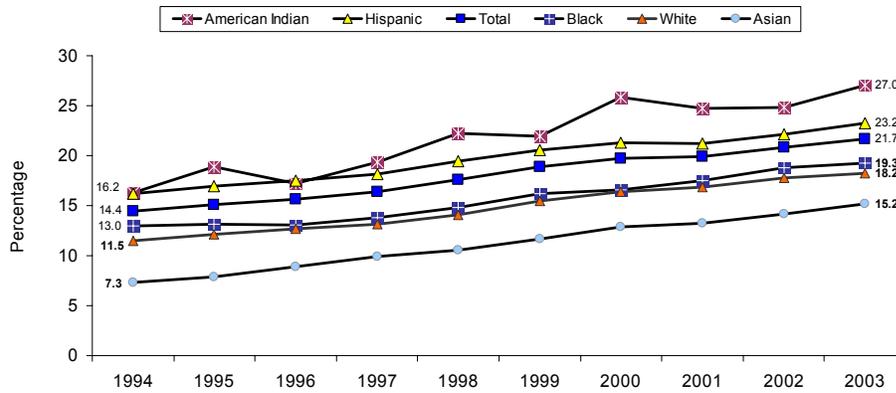
Data Source: PedNESS California 2002, Table 8C
 *Overweight: \geq 95th percentile BMI-for-age; at risk of overweight: \geq 85th- $<$ 95th percentile BMI-for-age, CDC Growth Charts, 2000.
 •15% of children are expected to fall above the 85th percentile (5% above the 95th percentile and 10% between the 85th and 95th percentiles).

Prevalence of Overweight* among Children aged 5 to <20 Years, by Age



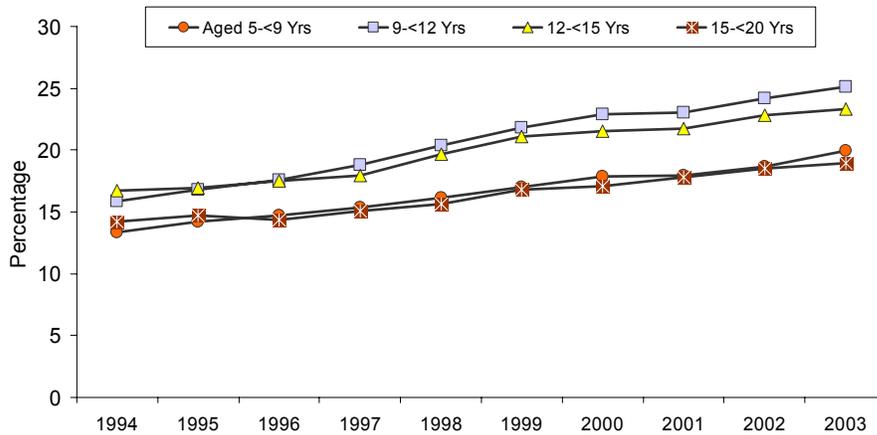
Data Source: PedNESS California 2002, Table 8C
 * \geq 95% BMI-for-age, CDC Growth Charts, 2000

Trends in Prevalence of Overweight* among Children Aged 5 to <20 Years, by Race and Ethnicity



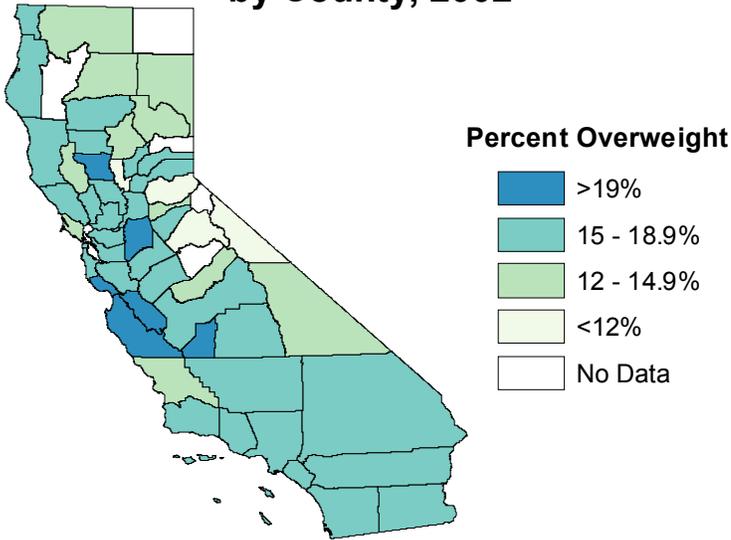
Data Source: PedNESS California 2002, Table 8C
 *≥ 95% BMI-for-age, CDC Growth Charts, 2000

Trends in Prevalence of Overweight* among Children Aged 5 to <20 Years, by Age

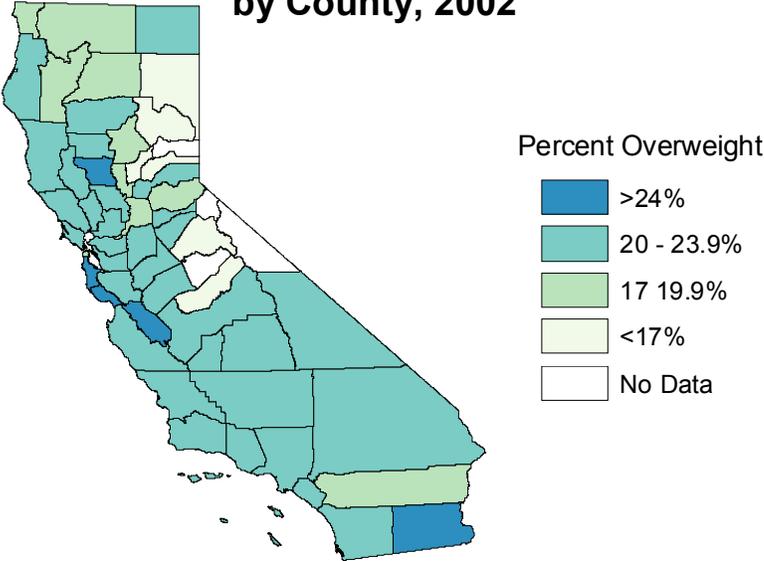


Data Source: PedNESS California 2002, Table 8C
 *≥ 95% BMI-for-age, CDC Growth Charts, 2000

**Percent of Overweight Children (2-4 Years)
by County, 2002**



**Percent of Overweight Children (5-19 Years)
by County, 2002**



MCAH CAPACITY ASSESSMENT

The MCAH/OFP Branch used the “Ten Essential Public Health Services to Promote Maternal and Child Health in America” tool to evaluate MCAH capacity at the state level. “Ten Essential Services” is a part of the CAST-5 (Capacity Assessment for State Title V) capacity assessment tool. This module was designed as a means by which MCAH professionals, both within and across states, can have a common understanding of those services that are essential to an effective MCAH program.¹³⁶ (See Appendix 2 for the detailed list of essential services.)

More than fifteen staff from the Epidemiology and Evaluation section and the Programs and Policy section participated in the evaluation, which was conducted both individually and in group discussions. Branch staff considered both individual programs and the Branch functioning as a whole in their assessments.

The results of this input were synthesized into a single document, detailing the Branch’s “strengths” and “weaknesses/areas for improvement” by each of the ten essential services.

Ten Essential Public Health Services to Promote Maternal and Child Health in America

1. *Assess and monitor maternal and child health status to identify and address problems.*
2. *Diagnose and investigate health problems and health hazards affecting women, children, and youth.*
3. *Inform and educate the public and families about maternal and child health issues.*
4. *Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.*
5. *Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth and their families.*
6. *Promote and enforce legal requirements that protect the health and safety of women, children and youth, and ensure public accountability for their well-being.*
7. *Link women, children and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.*
8. *Assure the capacity and competency of the public health and personal health workforce to effectively and efficiently address maternal and child health needs.*
9. *Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal and child health services.*
10. *Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related problems.*

Essential Service #1: Assess and monitor maternal and child health status to identify and address problems.

All of Essential Service #1 corresponds to level 4. Infrastructure Building Services on the MCH Pyramid.

Strengths

1. The MCAH/OFP Branch's Epidemiology & Evaluation section has access to high quality public health data sets to assess and monitor the health status of the MCAH population's problems and needs. These available data include:
 - live birth file
 - death file
 - fetal death file
 - linked live birth/infant death file
 - California hospital discharge data
 - census data
 - Healthy Kids Survey
 - Behavioral Risk Factor Survey (BRFS)
 - California School Survey
 - California Health Interview Survey (CHIS)
 - Maternal and Infant Health Assessment (MIHA)
 - the California version of PRAMS
 - produced through the MCAH/OFP Branch in collaboration with UCSF
 - California Women's Health Survey (CWHS)
 - California Birth Defects Surveillance System (CBDMP)
 - Genetics Disease Branch (GDB) newborn screening files
 - breastfeeding data
 - Pediatric Nutrition Surveillance System (PedNSS)
 - WIC data sets linked to birth data
2. These data allow Epidemiology & Evaluation section staff to conduct program monitoring and evaluation, goal compliance, responding to funding opportunities, and dissemination of findings to state and national audiences via professional presentations and/or publication.
 - Information from the Maternal and Infant Health Assessment survey (MIHA) has been used to discuss the relative success of public health campaigns related to infant sleep positions, breastfeeding, domestic violence, and smoking during pregnancy
 - Data from federally funded entities are often used to compare California health indicators with national norms or emerging regional and national trends
 - Recent internet-based analyses helped to document the relatively low rates of smoking among California women when compared to national norms
 - Other analyses have found domestic violence is reported at a higher rate in California than nationally
3. The data also allow comparisons of health status measures across other populations in the state
 - by race/ethnic group

- by the 61 California health jurisdictions, such as that published in the California MCAH Data Book
 - by different age group populations, such as teen mothers and mothers over 35
 - by payment source of services populations, such as Medi-Cal population compared to non-Medi-Cal population
4. The Epidemiology & Evaluation section of the MCAH/OFP Branch conducts analyses of public health data sets that go beyond descriptive statistics.
 - Epidemiology & Evaluation section staff are intimately involved in the analyses of public health data sets for
 - goal compliance
 - program monitoring
 - responding to funding opportunities, and
 - dissemination of findings to state and national audiences via professional presentations and/or publication
 - The analysis of data provided by local health jurisdictions is useful in determining the allocation of health resources – both in expertise and financial resources – that are to accrue to communities.
 - In addition, these data provide feedback in measuring progress in meeting local, state and national performance objectives.
 5. The MCAH/OFP Branch interpret and report on primary and secondary data analysis for use in policy and program development.
 - Data from MIHA and CWHS have been included in reports for use by DV, the Folic Acid Use Promotion project, Breastfeeding Promotion projects, and various perinatal programs promoting pregnant/postpartum depression screening.
 - The Office of Women’s Health, which coordinates the California Women’s Health Survey (CWHS), releases periodic publications called “Data Points” using data from the CWHS. “Data Points” are briefs on selected, timely MCAH/OFP issues and are distributed via the MCAH/OFP website. MCAH/OFP Branch staff produced some of the MCAH-related articles and researchers from other DHS departments authored other MCAH-related articles.
 - The Epidemiology & Evaluation section regularly provides DV, Breastfeeding Promotion, and Tobacco Control Section (TCS) information from MIHA. MIHA “Fact Sheets” will soon be posted on MCAH/OFP website on an ongoing basis. Epidemiology & Evaluation section staff assist with the production of Perinatal Profiles, a report based on information collected about individual hospitals’ birth outcomes data. Once collected, this data is then shared confidentially with the maternity hospital for its quality improvement.
 - The Branch has several contracts and agreements with university and private agencies to disseminate the results of current research studies that may have an impact in planning and policy development at the local level. For example, MCAH contracts with SafeNetwork Talk to disseminate current research studies and policy-related newspaper articles related to intimate partner violence and assault.
 - SafeNetwork Talk is an email list serve for shelter-based agencies, domestic violence prevention programs, and others committed to ending domestic violence
 6. The MCAH/OFP Branch has established population-based standards/indicators about core data expectations for local health agencies and other MCAH providers and programs.

- Much of this work was done in collaboration with the MCAH/OFP-funded FHOP at UCSF.
 - FHOP provides many data resources for local health jurisdictions as part of its contract, and helped produce the most recent California MCAH Data Book, containing many MCAH status indicators by county.
 - Many of the FHOP materials are posted on the FHOP website (<http://www.ucsf.edu/fhop/index.htm>) which is accessible from the MCAH/OFP website and thus is available to both Title V-funded local health jurisdictions and other local programs and providers.
 - Two of the indicators reported on in the local jurisdictions' needs assessment reports are perinatal data products developed in collaboration with two MCAH-funded contractors.
 - One contract with University of California Berkeley (UCB) produces the Perinatal Profiles website, which provides reports containing selected MCAH/OFP status indicators for perinatal regions and maternity hospitals for quality improvement purposes.
 - Another contract, with Health Information Solutions, produces the web-based Improved Perinatal Data Outcome Reports (IPODR) containing many MCAH health status indicators by state, county and zip code level.
 - The California Perinatal Quality Care Collaborative (CPQCC), funded in part by the MCAH/OFP Branch, participated in the selection and/or development of MCAH health status indicators related to infant morbidity and mortality for its data collection system with many California hospitals.
 - CPQCC provides data reports on these indicators on a regular basis to the hospital participants.
 - The Branch funded researchers at the University of California Los Angeles (UCLA) to develop or select Maternal Quality Indicators in order to compare different health care systems as a foundation for these systems to develop quality improvement projects.
 - Recently, the Maternal Quality Indicator group has been collaborating with CPQCC to increase the maternal health part of perinatal health.
 - In general, the many indicators developed by the MCAH/OFP Branch or with Branch collaboration are based on data collected by other entities. However, the Branch established or participated in the development of two annual population-based surveys that include a multitude of MCAH health status indicators.
 - The Branch collaborates with researchers at the Department of Family and Community Medicine at UCSF on MIHA, a survey (based on CDC's PRAMS) of California women who recently gave birth.
 - The Branch also participates, with Office of Women's Health and other entities, in the California Women's Health Survey (CWHS).
 - In addition, the Branch works with local providers, sometimes collaborating with FHOP at UCSF, to construct mutually useful data collection templates or frameworks for program information that can serve as indicators of health status. However, since these data are not population-based, their application for the entire population is limited.
7. The MCAH/OFP Branch provides training and expertise about the collection and use of MCAH data to local health agencies for MCAH populations, primarily through a contract with FHOP.

- FHOP provides technical assistance to localities on data use, and maintains a web site and a phone help line.
 - Technical assistance is available to the maternity hospitals reporting their vital statistics through the Automated Vital Statistics System (AVSS), which in turn assists the local health departments with their jurisdictions' vital statistics. FHOP provides trainings to local health jurisdictions on using their AVSS data, which includes information on how to contact an AVSS technical person for assistance.
 - DV has allotments in local jurisdiction budgets for data-related work. In addition, all Epidemiology & Evaluation section research staff respond to data requests.
 - Birth certificates are a source of many of the MCAH indicators. The DHS Office of State Registrar, in conjunction with the MCAH-funded RPPCs, has recently done some extensive local training of maternity hospital staff on completing the birth and fetal death certificates, including the importance of accurate and complete reporting.
 - DHS Medi-Cal staff do trainings for CPSP providers on billing and data reporting, which can later be analyzed as MCAH-related data.
8. The MCAH/OFP Branch assists local health agencies in data system development and coordination across geographic areas so that MCAH data outputs can be compared.
- Funded by both the MCAH/OFP Branch and the David and Lucille Packard Foundation, the California Perinatal Quality Care Collaborative (CPQCC) is a data development and coordination effort that collects information from public and private obstetric and neonatal providers.
 - The goal is to create a mechanism to improve patient care by allowing comparisons among hospital programs that provide care to newborns requiring critical care.
 - Currently, 80 hospitals across the state participate in the CPQCC.
 - The Genetic Disease Branch is involved with a project that aims to collect data on laboratories, follow ups, diagnoses, treatments, and outcomes for children with potential metabolic disorders. These data are being collected as part of a three-year evaluation process supported by HRSA.
 - The AFLP Program, BIH Program, and SIDS Program all have data collection components to them. The SIDS Program has been working with locals in the field to update and create a new data collection tool for scene investigations in the sudden, unexplained death of an infant.

Weaknesses/Areas for improvement

1. MCAH/OFP Branch capacity could be enhanced by the development of an interactive module that allow staff to query existing databases without having to learn programming language for simple descriptive statistics.
 - This interactive module could be created using Epi-Info, Microsoft Access or SAS GUI.
2. The Branch could also improve capacity by emphasizing greater proactivity in identifying other datasets, particularly of surveys or studies being conducted by other departments within California DHS on health issues that affect mothers and children.
3. There is a need for on-line reporting capacity, with integrated, statewide databases both within and across MCAH programs
 - The Branch is working on developing this capacity.
 - Some local MCAH jurisdictions have been able to address issues such as HIPAA regulations and now allow data sharing across county departments, but this is not yet possible at the State level.

Essential Service #2: Diagnose and investigate health problems and health hazards affecting women, children, and youth.

All of Essential Service #2 corresponds to level 4. Infrastructure Building Services on the MCAH Pyramid.

Strengths

1. The MCAH/OFP Branch uses epidemiologic methods to respond to MCAH issues and sentinel events as they arise.
 - Mental health issues – including adolescent mental health, and Fetal Alcohol Spectrum Disorder (FASD) have been recognized as emerging issues (and have been included among the priority needs), and MCAH has responded in a number of ways.
 - MCAH programs play an important role in identifying needs, intervening before mental health problems become debilitating, and facilitating access to integrated, comprehensive treatment. In addition to direct services to clients, MCAH programs provide guidelines and training for healthcare providers.
 - The Branch also participates in statewide efforts to bring together various state agencies and other stakeholders to plan and implement coordinated needs assessments, programs, and services.
 - Dr. Ira Chasnoff, a nationally known expert on FASD, has worked with several California MCAH jurisdictions to combat FASD, including Fresno, Ventura, Madera, and Alameda Counties.
 - The Branch has recently begun conducting surveillance on mental disorders and substance abuse among pregnant women and teens using Hospital Discharge data.
 - The state legislature began looking at expanding domestic violence service funding to underserved populations. Title V staff developed an epidemiologic profile of violence to describe the incidence and distribution of domestic violence among hard-to-reach populations, as requested by consultants of the Budget Committee to the State Legislature.
 - In response to media coverage as well as public interest, teen birth rates are analyzed on a regular basis.
2. The MCAH/OFP Branch has developed ongoing surveillance systems/population risk surveys and disseminates the results at the state and local levels.
 - The Title V program participates in and/or develops its own statewide surveillance survey systems to address gaps in knowledge, including CWHS, CHIS, and MIHA.
 - Annually, questions on these surveys may change based on Title V program needs.
 - The BIH, AFLP, DV, and CDAPP programs systematically collect data from providers.
 - The Title V program has recently been investigating the quality of data in the California Birth Statistical Master File which is produced from the Center for Health Statistics (CHS). The CHS performs limited checks for inaccuracies in the data, but implausible data points are not retrieved and edited.
 - While the Birth File is a public health file compiled by the Office of Vital Statistics ,

- MCAH/OFP, through its Perinatal Profiles project, produces an annual report to all reporting maternity hospitals on perinatal performance indicators. This program also evaluates completeness of data and provides feedback to the reporting hospitals on the quality of perinatal data they collect.
3. The Branch serves as the state's expert resource for interpretation of data related to MCAH issues.
 - The Branch has been consulted on relevant issues by key stakeholders and relies on the current science base and results of current research studies to address the information needs.
 - The Branch has been primary analyst for numerous legislative bills that have been proposed and may have an impact on service delivery to mothers and children.
 - In looking at a legislation that would modify current mandates on HIV testing for pregnant women, MCAH/OFP sought HIV/AIDS perinatal surveillance data and compiled research and evaluation findings by CDC from states using the "opt-in" and "opt-out" approach.
 - The "state of the art" scientific evidence gathered was used in evaluating the strengths and weaknesses of proposed bill language and recommendations that would strengthen policies that will advance prevention of perinatal HIV transmission in California.
 - A Research Scientist of MCAH/OFP also serves as community advisor for the county of Sacramento in planning and implementing its perinatal HIV prevention efforts.
 - MCAH/OFP staff have also been asked to participate in an expert panel convened by the State Office of AIDS to discuss perinatal HIV prevention policy needs for the state.
 4. The MCAH/OFP Branch provides leadership for reviews of fetal, infant, child, and maternal deaths and provide direction and technical assistance for state and local systems improvements based on their findings.
 - The MCAH/OFP Branch houses a FIMR coordinator and supports 17 county FIMR programs.
 - In addition, an expanded Black Infant Health FIMR (BIH/FIMR) project was launched in November, 2004, to provide additional funds, training, and support for eight BIH/FIMR sites.
 - These sites were based on the county African-American fetal death and infant death rate and African-American live birth rate.
 - The BIH/FIMR project is meant to be a pilot project that will result in standardization of all community FIMR programs. Specifically, local FIMR programs will use the same forms, a centralized database, case selection, and use similar methods of data collection.
 - The Branch houses a SIDS program. In addition to the prevention focus, the SIDS program supports SIDS death scene investigations, and includes an extensive database of completed investigations.
 - The Branch also works in cooperation with DHS's Child Death Review Team, and provides technical support to localities for conducting FIMRs as well as SIDS death scene investigations.

- The Branch is currently preparing a statewide maternal mortality review, in collaboration with UCLA, UCSF, and the Public Health Institute (PHI) in Santa Cruz, California.
 - It will be based on a sample of maternal deaths, with an over-sampling of African-Americans.
 - The study will include a retrospective chart review that will separate maternal deaths into pregnancy-associated and pregnancy-related. These cases will be matched to hospital discharge data (through OSHPD) to gain further information.
 - The current funding is allocated for a single review; however, the Branch is investigating the possibility of funding reviews on an annual basis.
5. The MCAH/OFP Branch uses epidemiologic methods to forecast emerging MCAH threats that must be addressed in strategic planning.
- The two surveys that the Branch participates in on a regular basis (MIHA and CWHS) are a means to survey a representative sample of the MCAH population to identify emerging trends.
 - For example, Epidemiology & Evaluation section researchers recently examined MIHA data on women who reported having been told they had diabetes during pregnancy, and the percentages for foreign-born Hispanic and foreign-born Asian women were much higher than their U.S. born counterparts. This is a red flag that should be examined further.
 - Examples of other recent forecasts and identified emerging threats include:
 - Teen birth rates are declining, but trends in demographics such as age and race suggest possible future increase in teen birth rates.
 - The percent of foreign-born mothers is increasing in California. The Branch recently added the variable “foreign-born mothers” to the Perinatal Profiles data sheets. This data might help community planners develop specific interventions for these populations if there are found to be health disparities among this population.
 - Epidemiology & Evaluation section researchers recently found that the percent of 3rd graders reported as receiving dental sealants was lower for those children in the Medi-Cal program (Denti-Cal) than in private insurance (Delta Dental).
 - The Branch is now in the process of establishing a statewide oral health surveillance system that will regularly provide information about the oral health status of California children in kindergarten and third grade.
 - Descriptive variables collected in this survey include race/ethnicity, whether the child is eligible for free or reduced lunch program, whether the child was U.S. born or foreign born and what kind of insurance pays for the child’s dental care. Such information will help to determine if there are discrepancies in access to and receipt of dental services for different MCAH/OFP populations, followed by strategic planning to develop appropriate interventions.
 - The Environmental Health Investigations Branch is partnering with the MCAH/OFP and WIC Branches to conduct a survey of fish consumption among pregnant women in San Joaquin County. This county borders the California Delta where there is concern about mercury contamination in the fish supply.

Weaknesses/Areas for Improvement

1. Capacity could be improved in this area by encouraging local MCAH directors to consult with state staff on a regular basis and make MCAH staff available for testimonies regarding MCAH/OFP issues before their local Board of Supervisors, Parent Teacher Association, and other community stakeholders groups.

Essential Service #3: Inform and educate the public and families about maternal and child health issues.

The following section of Essential Service #3 corresponds to level 2. Enabling Services, and level 3. Population-based Services, on the MCAH Pyramid.

Strengths

1. Health education has long been a key function for MCAH programs. (*corresponds to level 2. Enabling Services, and level 3. Population-based Services, on the MCH Pyramid.*)
 - Comprehensive Perinatal Services Program (CPSP) and California Diabetes and Pregnancy Program (CDAPP) are directly funded for health education.
 - The Domestic Violence (DV) program has an especially strong public education program: the program holds an annual shelter executive directors meeting during which they update directors on the latest health education methods.
2. The MCAH/OFP Branch produces and disseminates evaluative reports on the effectiveness of public awareness campaigns and other population-based health information services. (*corresponds to level 4. Infrastructure Building Services on the MCH Pyramid.*)
 - State surveys (MIHA, CWHS, CHIS) are used to help identify baseline measures and/or change following particular public awareness campaigns, such as folic acid, breastfeeding, DV and tobacco control.
3. The Branch has a very successful public health education model in the national SIDS Risk Reduction Campaign (known as the Back To Sleep Campaign in California), facilitated in California by the SIDS Program. (*corresponds to level 3. Population-based Services on the MCAH Pyramid.*)
 - The rate of death due to SIDS in California fell dramatically during the campaign, from 94.5 per 100,000 live births in 1992, to 31.7 per 100,000 live births in 2002.

Weaknesses/Areas for Improvement

1. In recent years, budget cuts have led to a retrenchment or even elimination of some health education programs.
 - For example, the Adolescent Family Life Program's (AFLP) budget for health education has been decreased at the local level.
 - The Branch used to hold an Annual MCAH Conference for the purpose of improving health education, but this practice was discontinued after the 2001 conference. The annual conference used to serve as a routine mechanism for identifying existing and emerging health education needs and appropriate target audiences; in its absence, there is no formalized method of doing so.

2. MCAH/OFP receives information from funded agencies on populations reached by information campaigns but has not yet had the opportunity to conduct systematic analysis of this data. Capacity in this area could be enhanced by collecting such process measures in a systematic way to allow summation and analysis of such data.
3. Provision of information may increase knowledge but does not necessarily translate into behavioral change. Short-term changes in knowledge can be measured through pre and post-test surveys. However, behavioral change is a more complex subject. Were the funding for such evaluation available, the Branch could better measure the effects of its public health education efforts.
 - Perhaps the Branch could develop logic models or map out theory-based models of behavioral change when planning its programs.
 - Besides looking at individual changes, MCAH/OFP could also consider collecting information on changes at other levels of an individual's environment which include interpersonal, community, institutional and systems changes.

Essential Service #4: Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.

All of Essential Service #4 corresponds to level 4. Infrastructure Building Services on the MCAH Pyramid.

Strengths

1. At the local level, MCAH jurisdictions reported strong "collaboratives, coalitions and partnerships" with community groups, faith-based organizations, schools, medical community and policy makers.
 - Results from the self assessment ratings of 25 MCAH programs show that coordination and collaboration received the highest ratings of all the capacities. 100% of jurisdictions rated themselves as either "strong" or "adequate" in this capacity.
 - This is true among both populous and more rural jurisdictions. For example:
 - Contra Costa County, with a population just over one million, convenes six coalitions and participates in fifteen coalitions. Contra Costa has included members from local programs serving adolescents, law enforcement, CBOs, dieticians, dentists, state staff, community residents, parent organizations, health educators and a variety of service providers in their coalitions.
 - Likewise, although more limited in capacity by a small staff, working through collaboratives is a key attribute of smaller programs. For example, Amador County, with a population of roughly 36,000, convenes two collaboratives and participates in eight coalitions. Amador has included members from day care providers, community members, law enforcement, hospital staff, nutritionists, and child protective services staff in their coalitions.
2. The MCAH/OFP Branch has a record of disseminating data products and health findings through its web site, via partnerships with key health policy advocates, and through participation in local, regional and state academic and professional meetings.
 - The Branch produces fact sheets and brochures about several health issues that affect women and children. These are available at the MCAH/OFP website, <http://www.mch.dhs.ca.gov/programs/factsheets.htm> .

- CWSHS fact sheets are posted through the MCAH/OFP website at <http://www.dhs.ca.gov/director/owh/survey.htm> , and MIHA fact sheets will be posted there soon.
- The website contains some trend information on state and local MCAH status and needs such as the MCAH Data Book. Such publications have also been distributed at many MCAH/OFP sponsored conferences and activities.
- The MCAH/OFP Branch leads a statewide informational campaign to promote the importance of folic acid intake in reducing birth defects during the prenatal period.
 - To promote the benefits of folic acid, the MCAH/OFP Branch has created partnerships with other DHS Branches, state agencies, and national groups that focus on healthy babies.
 - These include collaborative work with the Genetic Disease Branch, WIC, and the March of Dimes.
 - A staff member of the Branch is a Steering Committee member of the National Council on Folic Acid.
- Ad hoc reports are produced as requested through existing DHS administrative channels. In addition, technical assistance in obtaining or interpreting other data (such as from Vital Statistics or FHOP) is frequently provided either by state staff or by contract staff.
- Epidemiology & Evaluation section staff regularly attend and present papers and posters at the meetings of the Association of Maternal and Child Health Programs (AMCHP) and MCH-Epi.

Weaknesses/Areas for Improvement

1. The MCAH/OFP Branch could do more to disseminate data findings/summaries directly to the diverse ethnic and racial communities that it serves. The Branch could consider systematically sponsoring or participating in community health and wellness forums or events that are aimed at reaching diverse ethnic and racial communities.
2. Since MCAH/OFP relies heavily on the web to make information available, MCAH/OFP should maximize having cross-linkages with other websites (e.g. its partners, funded agencies, or agencies with which it has MOUs or interagency agreements) to ensure maximal advertising of the MCAH/OFP website.
3. The MCAH/OFP Branch website should be redesigned to make it easy for the general public to find the information in the website.

Essential Service #5: Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth and their families.

All of Essential Service #5 corresponds to level 4. Infrastructure Building Services on the MCAH Pyramid.

Strengths

1. Several individual MCAH programs either have or are forming advisory groups.
 - Domestic Violence and SIDS have advisory groups.
 - The Black Infant Health (BIH) Program is now in the process of forming an advisory group.

- Regional Perinatal Programs of California (RPPC) holds regular regional stakeholder meetings
 - The California Perinatal Transport System (CPeTS) solicits input from hospital and ambulance staff that work with the program.
2. Advisory groups exist or are being formed to study emerging issues that affect the MCAH population.
 - Fetal Alcohol Spectrum Disorder (FASD) is not currently a program, but Branch staff are working with a statewide advisory task force, consisting of representatives from the public and private sectors, to decide how best the state might address this very serious problem.
 - Local MCAH jurisdictions reported that perinatal substance abuse is an emerging issue.
 - The Office of Alcohol and Drugs has a section called Perinatal Substance Abuse.
 - MCAH staff are now working to establish a collaborative relationship with that section, so as to leverage their greater experience for the benefit of the MCAH population.
 - Another emerging issue is child and adolescent obesity.
 - In this case, however, there is already a large, diverse, and very active interdepartmental obesity stakeholder group in which the MCAH/OFP Branch is an active partner.
 3. The MCAH/OFP Branch participates in and provides consultation as a member of other stakeholder groups and advisory committees.
 - The Branch is an active participant in the California Conference of Local Health Officials (CCLHO).
 - The Branch works with the governor-appointed Domestic Violence Advisory Council made up directors of local shelters and advocacy groups
 - The Branch participates in the Perinatal Data Workgroup comprised of a health economist, a neonatologist, an RPPC representative, a UC public health statistician, and MCAH/OFP staff.
 - MIHA has an Advisory Committee of MCAH/OFP researchers, policy experts, and leading health providers.
 4. The MCAH/OFP Branch actively promotes the use of the scientific knowledge base in the development, evaluation, and allocation of resources for MCAH/OFP policies, services, and programs.
 - Title V program funds for SIDS prevention were allocated to counties based on the number of live births and the number of SIDS deaths.
 - Funds for teen pregnancy prevention were allocated to AFLP based on the teen birth rate and the teen population in a given area.
 - A newly established BIH/FIMR program was created to focus on the infant and fetal morality disparity in African-Americans.
 - Funds were allocated based on the number and rates of African-American births, infant deaths, and fetal deaths.
 - PPOR methodology was used for sampling BIH/FIMR cases.
 - The DV program uses research literature and state surveys (MIHA and CWHS) to guide policy and program.
 - An example is the recent promotion of partnerships between local DV programs and local health jurisdictions to provide prenatal care to pregnant DV victims.

- This was based on both research literature and our survey results that demonstrated a strong relationship between pregnancy complications and DV experience.
 - CPSP and CDAPP are strengthening their mental health components based in part on research literature and state survey results that demonstrate the strong connection between mental health and healthy mothers and babies.
5. The MCAH/OFP Branch supports the production and dissemination of annual (or more frequent) state reports on MCAH status, objectives, and programs, beyond the annual Block Grant submission.
- In a joint effort, the MCAH/OFP Branch and FHOP produce the annual MCAH Data Book, which reports MCAH indicators by health jurisdiction, race/ethnicity, and trends over time.
 - Data are routinely produced on a subject-by-subject basis, including the SIDS press release, the Teen Birth Rate press release, and breastfeeding data which is used annually by the CHS for their county health status report.
 - Breastfeeding data from both MIHA and the Genetic Disease Branch (GDB) are presented annually at the State Breastfeeding Promotion Advisory Committee.
 - MIHA fact sheets on various topics will be posted to the MCAH/OFP website on an ongoing basis.
 - The Improved Perinatal Outcome Data Reports (IPODR) website includes an annual county profile report based on California Birth/Death Vital Statistics and Hospital Discharge Data aggregated to the ZIP code level.
 - IPODR is the result of a collaboration of the MCAH/OFP Branch and the School of Public Health at the University of California, Berkeley.
 - IPODR is intended to provide information on which to base health planning and allocation decisions, and evaluation of these decisions. The IPODR
 - For many of the statistics, maps are available to see variations and are downloadable.
 - The IPODR website is at: <http://datamch.berkeley.edu/>
 - The Perinatal Outcomes Project (POP) at the School of Public Health at the University of California, Berkeley is funded by MCAH.
 - POP is a collaboration with MCAH/OFP and the Regional Perinatal Programs of California (RPPC), another project funded by MCAH.
 - The annual report, entitled “Perinatal Profiles,” is posted on a website to provide data to all the maternity hospitals in California for the purpose of continuous quality improvement, at <https://perinatalprofiles.berkeley.edu/>
 - The public website includes state and regional reports, information on how to use data for quality improvement as well as samples of what is available on the confidential, hospital specific site.
6. The MCAH/OFP Branch uses diverse data and perspectives for data-driven planning and priority setting. In addition to the use of population estimates, birth certificate, death certificate and OSHPD data, the Branch and the local MCAH programs regularly use data from other agencies to inform their health objectives and planning. Following are some of the agency sources for these data and examples of how the data are used.
- State of California DHS sources of data:
 - Center for Health Statistics, Office of Vital Records
 - Used to draw sample for MIHA
 - FIMR
 - Maternal Mortality Review

- Adolescent Family Life Program uses teen birth rate and teen population numbers
 - SIDS Program use data for determining target population and appropriate messages
 - CPSP and BIH use data on newborns with low birth-weight and very low birth-weight, as well as data on late/no prenatal care
 - CIPP and various Adolescent programs use information on deaths due to various types of injuries
 - Many programs (e.g., BIH) use birth information by age and race/ethnicity to address health disparities, target populations and produce appropriate programs and messages
 - Medi-Cal
 - Protective sealant use data for Oral Health Program
 - CPSP services billing data
 - Genetic Disease Branch
 - Birth hospital breastfeeding information for breastfeeding promotion planning and targeting
 - Birth Defects Monitoring Program
 - Folic acid promotion program to determine target population and appropriate messages
 - State of California non-DHS sources of data:
 - Office of Statewide Health Planning & Development (OSHPD)
 - Maternal Quality Improvement Project as basis for hospital comparisons leading to quality improvement projects
 - Entities Outside of the State Government sources of data:
 - Hospitals
 - CPQCC as basis for hospital comparisons leading to quality improvement projects
 - RPPC to determine population of pregnant women and infants to approach for risk-appropriate quality health services
 - Delta Dental
 - Protective sealant use data for Oral Health Program
 - UCLA Center for Health Policy Research
 - Information on uninsured children
7. The MCAH/OFP Branch has developed, regularly reviews, and routinely updates formal interagency agreements for collaborative roles in established public programs. *(Note: While WIC, family planning, Medicaid, etc. are separate agencies at the federal level, in California, these are all housed under the Health and Human Services Agency. So, rather than formal interagency agreements, the MCAH/OFP Branch works with these different divisions and departments with a formalized MOU or informal agreement.)*
- MIHA has interagency agreements with WIC and GDB to provide contact information on non-respondents for telephone follow-up.
 - The Branch has a formal interagency agreement with WIC, GDB, CMS and the PCFH Division for “nutrition coordination,” which covers breastfeeding promotion and education.
 - The Memorandum of Understanding (MOU) has been updated at least as recently as 2003.
 - The Branch cooperates with Medi-Cal on a regular basis.

- A prenatal program developed by MCAH/OFP has been funded through Medi-Cal (CPSP) for several years.
 - MCAH/OFP staff have access to Medi-Cal services data through Medi-Cal's Medical Care Statistics Section and other Medi-Cal offices and also through Medi-Cal's MIS/DSS provided through a contract with a company called MEDSTAT.
 - The Branch coordinates and collaborates with DOE, DSS, DMH, and DDS and other entities for the 2-year (2003-2005) SECCS project to provide state level leadership for early childhood health programs.
8. The MCAH/OFP Branch advocates for programs and policies necessary to promote the health of MCAH populations based on the scientific knowledge base/data and community input.
- Recent funding to counties has created the opportunity to explore racial disparities related to infant deaths.
 - Funding has been allocated to local health jurisdictions to devote focused attention by FIMR committees to the causes of death of African American infants.
 - Prior to the recent funding allocation, lack of money negatively affected the ability of these local jurisdictions to enhance FIMR projects other than the publication and distribution of information materials (e.g., the FIMR Newsletter; the FIMR Report Card).
 - Research on SIDS from Vital Records is disseminated to locals and the general public. Data from the mandated death scene and autopsy protocols are being made available to disseminate to locals to assist in improvements in local systems.
 - Research and data on teen births is routinely produced and disseminated to the general public and providers.

Weaknesses/Areas for Improvement

1. During the process of assessing capacity in this area, MCAH/OFP Branch staff became aware that these advisory committees tend to act a silos; they are effective within a given program or MCAH/OFP subject area, but there is room for more cross-pollination both between MCAH programs and between MCAH/OFP Branch and other DHS programs.
2. In considering this element of capacity, MCAH/OFP staff have suggested that it will be helpful if MCAH/OFP were to compile and update a listing of its formal and informal advisory committees for tracking purposes. MCAH/OFP could also have a common branch calendar to schedule meetings and formal agenda included. Minutes or summary of meeting notes should be compiled. This would help in tracking information on when these meetings occurred, what had been discussed, resolved and recommended.
3. Funding from HRSA/MCAHB is insufficient to fully support and address the five critical components of the State Early Childhood Comprehensive Systems (SECCS) grant.

Essential Service #6: Promote and enforce legal requirements that protect the health and safety of women, children and youth, and ensure public accountability for their well-being.

All of Essential Service #6 corresponds to level 4, Infrastructure Building Services on the MCAH Pyramid.

Strengths

1. The MCAH/OFP Branch programs tend to be policy-driven rather than regulation driven, but in the past two to three years there has been an increased awareness throughout the Branch of the need for periodic review of both regulations and policies.
 - The Comprehensive Perinatal Services Program (CPSP) is currently reviewing existing state MCAH-related legislation to assess adequacy and any inconsistencies in legislative/regulatory mandates.
 - The California Diabetes and Pregnancy Program (CDAPP) and the Office of Family Planning are writing new regulation packages.
 - A stakeholders group has been assembled to measure and assess current levels of maternal care with the goal of enacting standardized state regulations for quality of maternal care.

Essential Service #7: Link women, children and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.

Essential Service #7 is most closely related to level 2, Enabling Services, but aspects of this Essential Service correspond to all four levels on the MCAH Pyramid.

Strengths

1. Toll-free lines are either in place or under development for MCAH services.
 - Most local MCAH jurisdictions have well-publicized toll-free lines for public access to information about health services availability. Local area referral networks are strong and active.
 - The 211 telephone service initiative is underway in California.
 - The concept of 211 is to be a telephone-based, single point of access referral “hotline” for health and social service needs throughout the state, much as 911 is for emergency services.
 - The 211 telephone service will offer assistance on a range of issues from homelessness, placing relatives in hospice care and locating the nearest food bank or county shelter to finding runaway teens and getting help with spousal abuse.
 - Currently, California access to the system is occurring on a county-by-county basis.
2. Resources and technical assistance for outreach, improved enrollment procedures, and service delivery methods for hard-to-reach populations are common throughout MCAH programs.
 - CPSP and OFP both have vital outreach efforts.
 - BIH employs outreach workers who are active in the community.
 - The Domestic Violence section has a program for the underserved.
 - Several MCAH jurisdictions operate mobile vans for oral health care.

3. The MCAH/OFP Branch makes cultural sensitivity a cornerstone of every program activity.
- AFLP and ASPPP have included training in cultural competence for their local leadership.
 - The April 2005 statewide AFLP and ASPPP Directors Meeting included a presentation and workshop entitled “It’s in Their Culture: Culture, Relativism and Competency.”
 - The presentation and workshop were led by Sujata Warriar, PhD, Director, Health Care Bureau, New York State Office for the Prevention of Domestic Violence.
 - The BWSP has added cultural competence as a core service standard required of funded agencies.
 - MCAH program consultants will provide consultation and supervision to ensure that standards are met.
 - Regional training, consultation and technical assistance have been developed and are being implemented to provide support to grantees. The regional trainings are again conducted by Sujata Warriar, PhD.
 - A statewide diverse advisory committee also provides support, leadership, advice and guidance to shelter agencies on the development and implementation of cultural competence policies.
 - California's BIH programs identify and enroll a high-risk population, pregnant and parenting African-American women, for focused interventions. Comprehensive services offered to this population include the development of client-centered, culturally sensitive education, case management, and prenatal and pediatric care.
 - CDAPP incorporates cultural competence awareness in all CDAPP trainings and materials.
 - At-risk women, including Hispanic, African American, and Asian/Pacific Islander women, are targeted.
 - Direct services are provided by a well-trained, ethnically diverse work force of diabetes and pregnancy specialists.
 - Food plans are developed to include foods that are compatible with the dietary customs of each client.
 - CPSP includes cultural competence in its Model of Care.
 - Perinatal Service Coordinators and CPSP provider staff are representative of the communities and are often Hispanic, bicultural, and bilingual.
 - State CPSP staff and Perinatal Service Coordinators are developing cultural competence with regard to new immigrant groups, including Russian, Oaxacan, Mixtecan, and Somali immigrants.
 - State MCAH/OFP staff have received the following training in cultural competence this year:
 - Cultural Competency and Domestic Violence: Its relevance to MCAH, by Sujata Warriar, PhD, Director, Health Care Bureau, New York State Office for the Prevention of Domestic Violence (February 8, 2005); and
 - Cultural Competency in Healthcare settings, by Dr. Melanie Tervalon, Director of Education Core NIH Center for Nutritional Genomics (March 8, 2005).
 - Local communities also work to achieve cultural competence and reduce health disparities.

- San Diego's Mid City Community Action Network conducts focused meetings to address the needs of the immigrant Somali refugee population in central San Diego.
- The Multicultural Health Promotion Program, a northern California organization, provides pregnant and parenting women culturally competent health care information.
- The Orange County MCAH "Promotores" program used matching funds through the First Five program to work with pregnant Hispanic women and their families to ensure they have access to all appropriate services and are enrolled in prenatal care.
- In Contra Costa County, the Perinatal Service Coordinator has conducted an Ethnic Diversity Training Day to engage medical and health care providers to provide culturally sensitive care.
 - The Contra Costa County Health Department distributed the Steps to Take (STT) Guideline Client Handouts and SIDS materials in several languages.
 - The SIDS materials are available via the SIDS website, www.californiasids.com.

Weaknesses/Areas for Improvement

1. Greater publicity is needed for the statewide MCAH toll-free line.

Essential Service #8: Assure the capacity and competency of the public health and personal health workforce to effectively and efficiently address maternal and child health needs.

Essential Service #8 corresponds to level 4. Infrastructure Building Services on the MCAH Pyramid.

Strengths

1. The MCAH/OFP Branch maintains formal and informal relationships with schools of public health and other professional schools to enhance state and local public agency analytic capacity.
 - The Branch's Pediatric Consultant serves on the advisory board for the University of California at Berkeley's School of Public Health.
 - MCAH/OFP contracts with nine universities for the Advanced Practice Nurse Program (APNP).
 - The majority of the RPPC, CDAPP, and CPeTS programs are housed at universities.
 - A Public Health Nutrition Consultant has a part-time student assistant who is majoring in Nutrition.
2. The MCAH/OFP Branch makes available and/or supports continuing education at the Branch and local jurisdiction levels.
 - Through an interagency agreement with UCSF, MCAH/OFP works with FHOP to provide training in data analysis to MCAH/OFP staff in the local jurisdictions.
 - Internal MCAH/OFP Branch Epidemiology & Evaluation section staff convene on a bi-monthly basis to share statistical techniques in data analysis or share information about trainings attended by in-house staff through the RIC/RAC meetings.
 - Epidemiology & Evaluation section staff are also encouraged to attend trainings offered by external agencies. These include attending various conferences focused on diverse health areas, attending seminars by the SAS Users' Group of Sacramento Valley, getting formal trainings in SAS offered by the Health and Human Services

- Development Center and attending a five day MCAH Epidemiology training sponsored by HRSA and CDC.
- The MCAH/OFP Branch holds monthly MCAH/OFP Branch meetings that often help educate our own staff on program and data related facts and emerging issues. Other professionals are often invited to these meetings.
 - MCAH/OFP-funded RPPC contractors are able to provide continuing education credit for some of their trainings to targeted professional audiences on emerging MCAH/OFP related issues.
3. The MCAH/OFP Branch has developed and maintains formal and informal relationships with schools of public health and other professional schools to enhance state and local public agency analytic capacity.
- MCAH/OFP works closely with UCSF's FHOP to assist in local needs assessment and planning.
 - MCAH/OFP has sought opportunities to host student assistants and fellows. The California Epidemiologic Investigation Services program, (CAL-EIS) of the California Department of Health Services (DHS) trains epidemiologists for leadership positions in public health.
 - For the current year, an MPH graduate from George Washington University was sponsored by MCAH/OFP as a CAL-EIS fellow to work on statewide surveillance of breastfeeding, adolescent motor vehicle collisions, as well as utilizing GIS and census derived data as a means of determining the extent to which socioeconomic inequities affect racial/ethnic disparities in maternal, child and adolescent health.
 - The Branch is working closely with CDC to place an EIS officer in our branch to augment our epidemiologic and evaluation capacity.
 - The Branch has offered opportunities for undergraduates to work as student assistants in the different sections of MCAH/OFP recruited from the California State University in Sacramento. This provides students an opportunity to experience working in a public health environment that focuses on maternal and child health issues. At any given time, MCAH/OFP has one to four student assistants who work part-time within the branch.
 - MCAH/OFP staff have also been asked to participate in an expert panel convened by the State Office of AIDS to discuss perinatal HIV prevention policy needs for the state.
 - A Branch research scientist was part of the advisory committee for the U.C. Davis Center for Nutrition and Advanced Social Marketing whose mission was to advance social marketing practice, research and evaluation regarding diet and physical activity for the primary prevention of cancer and other chronic diseases.
 - A Branch research scientist has been invited twice to serve as an epidemiologist of a grant review panel that has reviewed HIV prevention applications to CDC and part of a special emphasis panel to review a diverse set of research applications from a grant by the Association of Teachers of Preventive Medicine, Association of Schools of Public Health and the Association of American Medical Colleges.
 - Research application priority areas include 1) Physical Activity and Fitness; 2) Nutrition; 3) Tobacco; 4) Violent and Abusive Behavior; 5) Unintentional Injuries; 6) Occupational Safety and Health; 7) Environmental Health; 8) Oral Health; 9) Heart Disease and Stroke; 10) Cancer; 11) Diabetes and Chronic Disabling Conditions; 12) HIV Infection; 13) Sexually Transmitted Diseases; and 14) Immunization and Infectious Diseases.

- A research scientist with MCAH/OFP was tapped by the CDC Foundation to select fellows for the Price Fellowships for HIV Prevention Leadership and select fellows for the Cal-EIS programs of the California Department of Health Services.
- The UCLA Center for Health Policy Research conducts the California Health Interview Survey (CHIS) to provide public health information for California's diverse health community. A Branch research scientist is part of the Violent Victimization work group that recommends intimate partner violence questions for inclusion in the survey.
- MIHA collaborates with UCSF in the survey development, analysis and reporting. Sometimes postdoctoral fellows at UCSF work with our UCSF collaborators to analyze MIHA data and report it; one recent example of this was a study of oral health.
- MCAH/OFP Branch has a data contract with UCB School of Public Health to produce Perinatal Profiles and also to collaborate with MCAH/OFP on in-depth research analyses about perinatal risk factors and publish as appropriate.

Weaknesses/Areas for Improvement

1. The University of California, Davis, which offers graduate degrees in Epidemiology and Public Health, is only 15 miles from Sacramento. MCAH/OFP Branch capacity in this area could be further enhanced by taking advantage of the proximity and possibly establishing training and employment programs for graduate students.
2. The MCAH/OFP Branch does not typically play a leadership role in monitoring of the MCAH/OFP labor force statewide. Primarily, their monitoring activities have been limited to meeting local (MCAH) staffing needs.
3. Program Managers report insufficient funding for several programs. The lack of funding inhibits the ability to hire staff needed to meet goals. For example:
 - California Diabetes and Pregnancy Program (CDAPP) is addressing a growing rate of type II and gestational diabetes across the State. CDAPP would like to hire a full-time Nurse Consultant III in order to do the communication and coordination with high-level agency directors in order to meet the demand presented by the increase in pregnant women affected by diabetes, but are not able to do so due to budget constraints.
 - The California Sudden Infant Death Syndrome (SIDS) and Adolescent Family Life Program (AFLP) have both had to shift funds from the State programs to local jurisdictions, or from other areas to these programs at the local level.

Essential Service #9: Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal and child health services.

All of Essential Service #9 corresponds to level 4. Infrastructure Building Services on the MCAH Pyramid.

Strengths

1. Most MCAH/OFP Branch programs have ongoing monitoring or evaluations.
 - CDAPP and CPeTS require monitoring and evaluation from their local programs.
 - BIH and AFLP conduct process reports.
 - DV has a legal mandate to conduct evaluations, and 5% of the local grants are set aside for evaluation purposes.
 - Some, but not all, of the local Fetal and Infant Mortality Review (FIMR) programs have conducted evaluations.
 - The Black Infant Health Fetal and Infant Mortality Review (BIH/FIMR) is still under development, and evaluations are being built into the process.
 - SIDS data is being analyzed and will also be disseminated to the public.
 - SIDS data has not been compared to national data because no other states have published reports using data from the protocols.
 - The SIDS program conducts evaluations of the level of satisfaction that parents feel with the services offered after a SIDS incident.
 - At the end of 2003, RPPC conducted a statewide survey of hospitals' effectiveness and satisfaction with regional cooperation agreements, transports, access issues and quality of care; the report of this study is pending.
 - The Automated Vital Statistics System (AVSS) birth data from the hospitals in each county is accessible to local health departments. This system provides reports for hospitals and local health jurisdictions that can assist them in conducting local evaluations.
 - The Maternal Quality Improvement Project and CPQCC compare hospital outcomes and inform hospitals of these distinctions without hospital identifiers.
2. The MCAH/OFP Branch provides technical assistance to local health agencies in conducting evaluations through its contract with FHOP.
 - The Branch-funded contract with FHOP provides extensive technical assistance to local health departments in conducting evaluations.
 - FHOP provides access to state data for local agency use, training, technical assistance, and resources to local MCAH/OFP agencies to enable them to use state data at the local level.
3. The MCAH/OFP Branch performs comparative analyses of programs and services.
 - The Branch routinely analyses health outcomes by comparing population sub-groups (race, gender, geographic region, educational status, age, etc.) with each other and with the state average to get a sense of disparities. Outcome indicators are also compared with data from other states, national averages, and the Healthy People 2010 objectives.
4. The MCAH/OFP Branch disseminates information about the effectiveness, accessibility, and quality of personal health and population-based MCAH/OFP services.
 - The Domestic Violence program has a Best Practices section in its website (<http://www.safenetwork.net/bestpractices.cfm>) to share and disseminate information among funded shelters and nationally.

- MCAH-funded Perinatal Profiles is distributed to maternity hospitals and perinatal regions and risk-adjusted mortality data for a hospital or region for five years is compared to data for similar hospitals, regions and the state to help monitor and improve quality of care at the hospital and in the perinatal community.

Weaknesses/Areas for Improvement

1. A Branch-wide centralized data system would improve the Branch's ability to conduct both process and outcome evaluations of programs.

Essential Service #10: Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related problems.

All of Essential Service #10 corresponds to level 4. Infrastructure Building Services on the MCAH Pyramid.

Strengths

1. Infrastructure is in place to improve prenatal care and birth outcomes for relatively diverse groups of women at risk of alcohol use/abuse, including referrals for prevention and treatment services.
 - Community-based prevention programs, including CPSP, BIH, AFLP, ASPPP, DV, and CDAPP provide pregnant women with information about FASD, identify women at high risk, and refer them for mental health and social support services.
2. The MCAH/OFP Branch monitors the progress of state and national research activities, and disseminated these findings to providers, public health practitioners, and policy makers.
 - Through its sponsorship of, or participation in, the development of several statewide surveys, the Branch provides data on relevant issues such as health disparities, family planning, physical and psychosocial risk factors, health behaviors, incidence and prevalence of chronic disease, domestic violence, and oral health.
 - Summaries of hospital discharge data provided by the Branch are distributed to all delivery hospitals, and are used by the member hospitals themselves, other DHS Branches, and by other state agencies for public health surveillance and monitoring.
 - The Branch's Regional Perinatal Programs of California (RPPC) consults with hospitals and health care providers. Its work helps to meet several goals:
 - Facilitating regional planning, coordination and recommendations including levels of care;
 - Collecting and analyzing hospital and provider data, aimed at quality improvement;
 - Facilitating communication among agencies and providers; and
 - Providing resource directories and referral services for hospitals, providers, and individuals.
 - The MCAH/OFP webpage (<http://www.MCAH.dhs.ca.gov>) is a means of disseminating information.
 - In the past year, the MCAH/OFP Branch has participated in several local meetings aimed at educating public health caregivers, advocates, and constituency groups about FASD.

Weaknesses/Areas for Improvement

1. The MCAH/OFP Branch's capacity in preparing grant applications might be improved if there were a point person who would systematically and regularly gather information, screen, and apply for grants with potential for the MCAH/OFP Branch alone or in partnership with other stakeholders.
 - In 2004, the Branch prepared a grant application to CDC for a Fetal Alcohol Syndrome Program, but it was not funded.
 - The Branch developed a grant that was approved, but not funded, for mental health.
 - The Branch developed a grant that was approved, but not funded, for folic acid.
 - The Branch also applied for a System Capacity for Adolescent Health Technical Assistance Grant from AMCHP last year but did not receive one.

MCAH STAKEHOLDER INVOLVEMENT IN PRIORITIZATION OF NEEDS

External stakeholders representing a variety of public and private organizations were invited to a meeting on April 6, 2005. The purpose of the meeting was to elicit input from the MCAH stakeholders regarding the setting of MCAH priorities based upon the priorities identified by local jurisdictions in their needs assessments.

Representatives from over 50 organizations were invited and representatives from 37 organizations attended. Attendees represented other state agencies (Department of Alcohol and Drug, Department of Mental Health, STD Control Branch, etc.); local health jurisdictions (California Conference of Local Health Officers, etc.); provider groups (American College of Obstetricians and Gynecologists, California Public Health Association, etc.); consumer groups (March of Dimes, Planned Parenthood, Minority Health Advisory Group, etc.); academic institutions (UCSF Dept. of Family and Community Medicine); and MCAH programs (Black Infant Health program, Adolescent Family Life Program, etc.). *(The complete list of invited organizations is in Appendix 3, and the meeting agenda is in Appendix 4.)*

Prior to the meeting, stakeholders were provided with a summary of the results of the local needs assessments, guidelines used by the jurisdictions to complete their needs assessments, and statewide indicator data trended and compared to a benchmark (HP 2010 or the nation). Stakeholders were asked to review this information prior to the meeting and to suggest any additional potential priority areas or data sources.

Staff from FHOP facilitated the meeting. The Deputy Director of PCFH opened the meeting and was followed by MCAH staff who gave an overview of the Title V Five Year Needs Assessment process and a description of MCAH jurisdiction involvement in that process.

The stakeholder meeting centered on a four-step process:

1. Choose criteria. FHOP provided a list of possible criteria upon which to rank the potential priority areas and stakeholders had a lively discussion that produced several more potential criteria. A stakeholder vote narrowed this list down to five criteria.
2. Weight the selected criteria. The next step was to weight the five selected criteria. By another vote, the stakeholders decided whether each of the five criteria should have a weight of 3 – highest priority, 2 – medium priority, or 1 – lower priority. The five selected criteria and their weights included:
 - a. Problem has serious health consequences – *weight: 3*
 - b. A large number of individuals are affected by the problem – *weight: 2*
 - c. Disproportionate effects among subgroups of the population – *weight: 2*
 - d. Problem results in significant economic/ social cost – *weight: 1*
 - e. Problem is cross-cutting to multiple issues/ life span effect – *weight: 3*
3. Present data. Stakeholders were presented with data relating to the potential priority areas. These data showed trends and comparisons to Healthy People 2010 and/or national data, as well as how many local jurisdictions had chosen the given need as one of their priorities.

4. Rank needs. In the final step, individual stakeholders used a worksheet grid to apply a ranking from 1-5 for each of the five weighted criteria to each of the potential priority areas. The 1-5 numerical ranking scale was defined as:
 - a. 1 = Problem is not life threatening to individuals
 - b. 2 = Problem is rarely life threatening, but is sometimes disabling
 - c. 3 = Problem is moderately life threatening and/or disabling
 - d. 4 = Problem is moderately life threatening and there is a strong likelihood of disability
 - e. 5 = Problem has a high likelihood of death or disability

(The list of MCAH Criteria is in Appendix 5, and the Priority Rating Tool is in Appendix 6.)

Throughout the meeting there was extensive discussion among stakeholders regarding a number of fundamental issues about how to organize and rank potential MCAH priorities. One issue discussed was that many of the identified priorities were cross-cutting. For example, it was noted that concerns about mental health, substance abuse, and sexually transmitted infections might all be interrelated. Stakeholders suggested that MCAH strengthen partnerships with other California DHS departments like the STD Control Branch and the Office of AIDS.

Given that race/ethnic disparities are present to varying degrees in every potential priority area, the stakeholders also debated whether ameliorating race/ethnic disparities should be considered as a possible stand-alone priority need. The other possibility was that disparities could be recognized as a cross-cutting issue that should be considered when establishing action plans for priority needs. While there was considerable discussion over this issue, the group decided to treat disparities as an issue that is part of each priority area and not as a separate potential priority area. The presence of disparities within a given priority area was later added as one of the criteria for weighting the potential priority areas.

Stakeholders also noted that, while the indicators for some of the potential priority needs under consideration have improved, efforts must be made to maintain programs or else these gains could quickly be lost. An additional point made was related to the issue of delivering culturally competent services. It was noted that while translation services are an essential part of cultural competence, translation alone is not enough to overcome the access barriers that exist for some in the MCAH population.

A total of 32 stakeholders completed the ranking worksheet. At the end of the meeting, FHOP staff collected the Priority Rating Tools from the stakeholders and tabulated the results. The final ranked list of the 13 potential priority needs that were considered are shown in Table 22.

Table 22: Ranking of MCAH Priorities by Participants in the MCAH Needs Assessment Stakeholder Meeting

Specific Topics	Priority Rankings	Stakeholder Score	Percent of Total Possible Score*
			(%)
Overweight	1	1451	91
Access to Care	2	1375	86
Birth Outcomes/Mortality	3	1348	84
Mental Health	4	1333	83
Substance Abuse	5	1331	83
Unintentional Injuries	6	1219	76
Asthma	7	1196	75
Domestic Violence	8	1172	73
Teen Births	9	1169	73
Prenatal Care	10	1156	72
Chlamydia Infections	11	1097	68
Oral Health	12	1009	63
Breastfeeding	13	931	58

*Maximum possible score = 1,600.

CSHCN NEEDS ASSESSMENT PROCESS

The approach for developing the five year needs assessment for CSHCN included an evaluation of internal capacity, assistance from the Family Health Outcomes Project in the collection and analysis of data as well as the facilitation of the stakeholder process, and input from stakeholders in the identification of issues and the prioritization of needs. This was the first time that the Branch utilized such an extensive process in developing the needs assessment.

As part of the broader planning process and the identification of the 3 priority CSHCN action areas, CMS has conducted an assessment of the needs and systems issues related to delivering services to children and families eligible for the California Children's Services (CCS) program, California's Title V CSHCN program. While CMS and stakeholders recognize that Federal Title V guidance promotes assessment and planning for the broader CSHCN population, CMS is limited in its capacity to plan across programs by limited funds as well as California's fragmented Health and Human Services structure that separates health, mental health, developmental, and social services and makes coordination among these services difficult.

The Champions for Progress project, a recently funded HRSA initiative, will utilize the CCS Needs Assessment Stakeholders Group to develop an action plan to address the priority areas identified in this needs assessment process. The Stakeholders will develop a long-term strategic plan for serving CSHCN, identify resources in California to carry out the activities in the strategic plan, and develop a monitoring and evaluation strategy to assure continued improvement and progress toward achievement in the priority areas.

CMS recognizes that a critical aspect of the assessment process is to encourage and facilitate participation by stakeholders throughout the state in identifying health and health systems problems or needs, prioritizing among the identified issues, developing strategies to intervene in prioritized issue areas, and evaluating the effectiveness of intervention strategies. Accordingly, CMS established a CCS Needs Assessment Stakeholders Group and contracted with the Family Health Outcomes Project (FHOP) to facilitate a stakeholder process to determine Action Priorities to be addressed during FY2005-2010 and to assist in identifying the most important and potentially effective areas in which CCS can improve services for CCS-eligible children.

FHOP proposed a framework and process for conducting the CCS Title V Assessment. FHOP recommended an inclusive and systematic process of selecting indicators and issues to be assessed, analyzing and presenting data, identifying issues and needs, and setting priorities among them. CMS approved the framework and it was shared with CCS program stakeholders prior to the first stakeholder meeting. *(The framework is included in Appendix 7.)*

CSHCN DATA REPORT

The CMS Branch does not have a data system from which comprehensive data about CSHCN can be extracted. The CMS Net data set is the case management system that is used for CCS. All counties utilize this system except Los Angeles, Orange, and Sacramento. Approximately 55% of the children enrolled in CCS are included in CMS Net.

California's CCS program has not adopted the federal definition of CSHCN to identify the population eligible for the program. The federal definition includes children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. Children eligible for CCS are a subset of this nationally defined population, and they must meet program-specific financial, residential, and medical criteria.

California-specific data that have been used for this needs assessment have come from several sources, including the National Survey of CSHCN, CMS Net, two publications from the University of California Los Angeles, and an unpublished survey report from Family Voices. Whenever possible, data for the broader definition of CSHCN have been used.

The National Survey of Children with Special Health Care Needs

The National Survey of Children with Special Health Care Needs, sponsored by the Maternal and Child Health Bureau, provides national and state-level information about the numbers of children and youth, 0 - 17 yrs old, in the population with special health care needs. In addition, the survey asked 750 families of CYSHCN (Children and Youth with Special Health Care Needs) in each state about:

- Access to health care and unmet needs
- CYSHCN health and functioning
- Health care quality and satisfaction
- Impact of child's health on family activities, finances, and employment
- Adequacy of health insurance to cover needed services

In each state, telephone interviewers screened at least 3,000 households with children to identify CYSHCN. In-depth interviews were conducted with the parents of approximately 750 CYSHCN per state. Although 759 interviews were completed in California, for some questions on the survey, the sample size was much smaller and severely limited the statistical power needed for detecting significant differences when making comparisons between subgroups.

The screening questions used in the survey to identify children with special health care needs addressed five major components. Parents/caregivers were asked about health consequences in the following areas: the use of or need for prescription medication; the use of or need for more medical care, mental health services, or education services than other children of the same age; the use of or need for treatment or counseling for an emotional, developmental or behavioral problem; a limitation in the child's ability to do the things most children of the same age do; or the use of or need for special therapy, such as physical, occupational, or speech therapy. In order to qualify as having a special health care need, the child must have a condition that has lasted or is expected to last at least one year.¹³⁷

Experiences with health care for California's children with special health care needs, UCLA Center for Healthier Children

This chartbook provides California data on access to care for CSHCN, comparing care of children in Medi-Cal to care received by other children in California and to other State Medicaid programs. It presents data from the National Survey of Children with Special Health Care Needs (NS-CSHCN) and the California Health Interview Survey (CHIS). Both surveys are based on parent report in telephone interviews, as reported in 2001. Figures, tables, and text present California and national averages; statistical comparisons are between California and all other states excluding California. Due to larger sample size nationally (more than 36,000 children) than in California (750 children), subgroup comparisons often detect statistical differences nationally but not in California.¹³⁸

What Do Families Say About Health Care for Children with Special Health Care Needs in California? Your Voice Counts!! Family Survey Report to California Participants

This survey was conducted in 1998 by Family Voices and Abt Associates Inc., to assess the health care experiences of children with special health care needs and their parents. This survey was distributed to a random sample of 7,100 families from CCS mailing lists and 6 California family resource organizations. 954 Families returned the survey, 153 of which were in Spanish. In order to get a sample that was more geographically representative of California, the surveys were mailed to families in Los Angeles, San Diego, Fresno, Sacramento, and two rural areas in the state. Family Voices states that the findings from the survey should be interpreted with caution for two reasons - the low response rate (13%) means that the survey may not be representative of all children from the CCS and family organizations in the sample, and the children from participating organizations may not represent all children with special health care needs in California.¹³⁹

Assessment of factors influencing the adequacy of health care services to children in foster care, UCLA Center for Healthier Children, Families and Communities

This study examines the "readiness" of state and local child welfare, child health, mental health, and Medicaid agencies to systematically meet the needs of children in foster care. Gaps between best practices developed by AAP and the Child Welfare League of America (CWLA) and current agency performance are examined, and agency policies and administrative procedures are evaluated for their ability to achieve Adoption and Safe Families Act of 1997 (ASFA) objectives and improve children's well-being. The study evaluates performance on basic standards, and collaboration and performance monitoring activities, and provides a foundation on which new policies can be developed to address problems with performance and other challenges faced by agencies.¹⁴⁰

CCS Program Data

CMS Net is a full-scope case management system for CCS program. The State's CMS Net resides at the Health and Human Services Data Center (HHSDC). Data from CMS Net are active cases through 3/15/05. Los Angeles, Orange, and Sacramento counties, home to approximately 45% of the State's CCS children, do not yet have data in the CMS Net system, but plans are underway to include these counties in the coming fiscal year.

Prevalence

Based on the National Survey of CSHCN 2001, California has significantly fewer children identified as having special health care needs than the United States as a whole (10% vs. 13%).

This survey identifies CSHCN based on their use of prescription medication; elevated need/use of medical, mental health, or educational services; functional limitation; need/use of specialized therapies; and emotional, developmental, or behavioral conditions. Significantly fewer California children qualify as CSHCN based on the use of prescription medication (7% in CA vs. 10% nationally) and on the elevated need/use of medical, mental health or educational services (5% in CA vs. 6% nationally). California rates were similar to the rest of the country in the other screening criteria categories.¹⁴¹

Based on the Family Voices survey, most children were affected by more than one condition. Thirty-seven percent (37%) had two or three conditions, 53% had four or more conditions. Fourteen percent (14%) of the children were technology dependent or assisted, needing devices such as a feeding tube, shunt, or ventilator. Ninety-seven percent (97%) of the CSHCN in California needed prescription medications; 85% needed therapy services, 43% needed durable medical equipment; 21% needed home health services, and 11% needed mental health services.¹⁴²

The impact of the disabilities that are experienced by the CSHCN and their families can be quite profound. Twenty-four percent (24%) of CSHCN in California have their daily activities consistently affected by their health condition, 40% have their daily activities moderately affected, and 36% never have them limited or affected. Nationally, rates are very similar. Absences from school affect not only the child but also the parent who is caring for that child. Sixteen percent (16%) of CSHCN in CA missed 11 or more days of school due to illness, 15% missed 7 to 10 days, and 19% missed 4 to 6 days.¹⁴³

Approximately 7.4% of the children enrolled in Medi-Cal and 3.5% of the children enrolled in Healthy Families in 2001 were children with special health care needs, as noted in the UCLA study. About 15% of California's CSHCN receive case management and specialty care through the CCS program (150,000 annually at the time of the study).¹⁴⁴

The poorest children in California (199% of the Federal Poverty Level (FPL) or less) are significantly less likely than the poorest children in the nation to be identified as CSHCN (8% vs. 14% for <100% FPL; 10% vs. 14% for 100-199% FPL). Within California, children in households earning 99% or less of the FPL are significantly less likely to be identified as a CSHCN than children in households earning 400% or greater than the FPL (8% vs. 13%).¹⁴⁵

Based on data from the CMS Net data base, the most prevalent primary diagnoses of children who are enrolled in the CCS program are Congenital Anomalies (23%), Diseases of the Nervous System (14%), and Diseases of the Ear or Mastoid, including hearing loss (9%).¹⁴⁶

Health Insurance Coverage

Research shows that for children generally, retention of insurance coverage is important for health care continuity, quality of care, parent adherence to medical advice, and parent self-management of children's conditions. CSHCN in California are significantly more likely than CSHCN nationally to have private or employer based insurance only (72% vs. 65%) and significantly less likely to have solely public insurance (17% vs. 22%).¹⁴⁷

Insurance coverage for CSHCN in California is not optimal, as evidenced by the approximately 10% of CSHCN who are without health insurance at some point during a one year period, and the 37% who report that their current insurance was not adequate.¹⁴⁸

The Family Voices survey shows that more than half (53%) of California CSHCN children are enrolled in Medi-Cal managed care, 26% are enrolled in private managed care plans, 20% in Medi-Cal fee for service, and 1% in private fee for service plans. Although nearly half (46%) of the families did not know whether their child was in a managed care plan, most of the children (72%) had insurance coverage with at least one feature of managed care, such as having a network of doctors or requiring a primary care physician.¹⁴⁹

Insurance coverage varies by race/ethnicity. Nationally, Hispanics are more likely than all other groups to have inadequate insurance for their CSHCN. California data reflect a similar pattern, although small sample sizes result in Hispanics (46%) differing significantly from Blacks (22%), but not from Whites (33%).¹⁵⁰

Inadequate insurance coverage was evaluated in the Family Voices survey. Of children who need home health care, 39% report problems accessing services. Of those, 51% have trouble getting payment for enough home health care hours. Of children needing therapy, 35% report problems. The most common problem is that they did not receive the needed therapy. Lack of coverage for occupational therapy and speech therapy is the second most common problem, followed by difficulty getting a referral and an adequate number of visits to meet their child's needs.¹⁵¹

Nationally, CSHCN managed by prescription drugs are significantly more likely to have adequate insurance (74%) than CSHCN who have functional limitations (57%), have above routine needs/use of services (60%) or have both (67%). California data reflect similar patterns, but only CSHCN who are managed by prescriptions drugs are significantly more likely to have adequate insurance than CSHCN who have above routine need/use of services (76% vs. 47%). With a larger sample size, other differences would likely be significant.¹⁵²

Most health services needed by CSHCN in Medi-Cal are covered benefits of the federal Medicaid program. Unlike adult services, children's benefits in Medi-Cal are enhanced by the expansive federal Early and Periodic Screening Diagnosis and Treatment (EPSDT) requirements. The medical necessity definition of EPSDT requires the state Medicaid program to provide children with any medically necessary service that is needed to correct or ameliorate a condition, even if the same service is not available to the adult population. The CCS program also covers specialty care for those children in Healthy Families with severe or disabling conditions. CCS pays for some specialty services for commercially insured children whose health plans limit benefits. Despite this, fewer parents of CSHCN in Medi-Cal (61%) compared to those with private insurance (86%) reported in the UCLA study that their child's needs are met by insurance benefits. Parents of 18% of CSHCN in Medi-Cal said that the benefits "never" meet their child's health care needs.¹⁵³

The financial impact of filling in the gaps created by inadequate insurance coverage for CSHCN can be significant. Over half of the parents in the Family Voices survey reported spending some time each week providing health care at home. One-fifth spent 20 or more hours per week providing this care. One-third of the parents reported that their child's health conditions caused financial problems - 28% said they stopped working and 37% cut down the hours they worked. Almost half the parents reported spending between \$500 and \$3000 out of pocket for the special health care needs of their child in the past year. Ten percent (10%) said they spent \$3000 or more.¹⁵⁴

Medical Home

The National Survey of CSHCN utilizes the American Academy of Pediatrics definition of a medical home – medical care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective and that is delivered or directed by a well-trained primary care or specialty physician who helps to manage and facilitate essentially all aspects of care for the child. The medical home variable is derived from responses to questions about having a usual source of care, having a personal doctor or nurse, having no problems receiving referrals when needed, and family-centered care.

Fifty-five percent (55%) of CSHCN in California are lacking a medical home, significantly more than the national rate of 47% of CSHCN without a medical home. Only about half of children surveyed have a case manager, most of whom are employed by the Regional Centers (35%) or CCS (28%). Only 3% of the case managers are employed by a health insurance plan.¹⁵⁵

The UCLA study found that fewer California CSHCN in Medi-Cal than in other state Medicaid programs have a usual source of health care, with a much greater use of community and hospital clinics than doctor's offices. Fewer CSHCN in California than other states have a personal doctor or nurse.¹⁵⁶

The CMS Net data base identifies a child's primary care provider. The CCS program uses this as a proxy measure for medical home. California counties vary widely in the percentage of CCS children who are identified with a medical home. In 35% of the counties, 80% or more of the children have a medical home. Fewer than 20% of the CCS children are noted to have a medical home in 15% of the counties (*see Appendices 8 – 11*).¹⁵⁷

Access to a medical home varies by race/ethnicity. In California, Hispanics are significantly less likely than Whites to have a medical home (35% vs. 52%), as are children in the "Other" race/ethnicity category (22% vs. 52%). The sample size for African Americans is too small to test for significant differences. Asians were included in the "Other" category. Rates for California CSHCN are not significantly different than national rates for racial/ethnic groups.¹⁵⁸

Significantly fewer insured CSHCN in California are linked with a medical home compared to national rates for insured CSHCN (46% vs. 54%). Uninsured CSHCN in California have even less access to a medical home (27%). This rate does not differ significantly from the national rate of 37%.¹⁵⁹

Children whose special needs are managed by prescription drugs are more likely to have a medical home (58%) than children with functional limitations (35%) or those who have above routine needs and use of services (31%).¹⁶⁰

The UCLA study showed that fewer CSHCN in Medi-Cal (83%) than with private insurance (94%) were reported to have a usual source of health care. Further, fewer CSHCN in Medi-Cal (72%) than with private insurance (91%) had a personal doctor or nurse. California's Medi-Cal program lags behind other state Medicaid programs on this important indicator.¹⁶¹

One of the performance measures reported by the local county programs is designed to demonstrate that CCS, CHDP, and the Health Care Program for Children in Foster Care provide effective case management. The measure combines responses to 7 questions regarding

CCS children having a documented medical home/primary care provider, children in out-of-home placement having a preventive health and dental exam within the past year documented in the health education passport, children referred to CCS having their program eligibility determined within prescribed guidelines per the 2001 Procedure Manual, children enrolled in CCS whose conditions require CCS special care center services being seen at least annually at appropriate Special Care Centers, fee-for-service Medi-Cal eligible children whose CHDP screening exams reveal a condition requiring follow-up care receiving it, and non-Medi-Cal eligible children whose CHDP screening exams reveal a condition requiring follow up care receiving it. Based on annual reports from 56 counties, 32% of the reporting counties scored 80% or higher on this measure, while 23% of the counties scored less than 60%.¹⁶²

Unmet Medical Needs

Unmet need is a direct measure of access to health care services. Unmet service needs may affect severity of the disease, lead to more urgent care contacts and greater emergency department utilization, and ultimately reduce children's physical and mental well-being. The National Survey revealed that CSHCN in California are significantly more likely to have unmet needs for health care services (23%) than are CSHCN nationwide (18%).¹⁶³

Nationwide, Black, Hispanic, and Multi-racial CSHCN are significantly more likely to report unmet needs for health care than are Whites (15% for Whites vs. 23% for Blacks, 24% for Hispanics, and 26% for Multi-racial). California data reflects this same pattern, although the small sample size prevents these differences from achieving statistical significance.¹⁶⁴

CSHCN nationwide without medical homes are significantly more likely to have unmet needs for health care services (25% for those without medical homes vs. 11% for those with). California data again reflects the same pattern, but differences fail to achieve statistical significance (27% for those without medical homes vs. 16% for those with).¹⁶⁵

In both California and nationwide, CSHCN without insurance are significantly more likely to report unmet medical needs than those with insurance. In California, 22% of those currently insured report unmet needs compared to 57% without insurance. Nationwide, 16% of those currently insured report unmet needs compared to 46% of those not insured. The differences between California and the nation are not statistically significant.¹⁶⁶

Nearly half of the children in Medi-Cal (43%) report having at least one unmet need in the UCLA study. Rates of unmet need among those children in Medi-Cal requiring a particular service are high for mental health (42%) and specialty care (10%).¹⁶⁷

The UCLA study found that among CSHCN in California regardless of insurance status, the highest reported rates of unmet need were for respite care (35%), family counseling or mental health services (23%) and mental health services for the child (22%).¹⁶⁸

Fewer parents of CSHCN in Medi-Cal (61%) compared to those with private insurance (86%) report that their child's needs are met by insurance benefits, based on the UCLA study. Parents of 18% of CSHCN in Medi-Cal said that the benefits "never" meet their child's health care needs.¹⁶⁹

The National Survey of CSHCN showed that 25% of CSHCN families in California who needed respite care, genetic counseling and/or mental health services did not receive all the support

services that were needed (vs. 23% nationwide, difference not significant). Nationally, there were no statistically significant differences in unmet needs for family support services by race. In California, the sample is too small to detect any significant differences.¹⁷⁰

Access

In California, 28% of CSHCN who need specialty care have problems getting a referral (vs. 22% nationwide, difference not significant).¹⁷¹

In general, parents of CSHCN in Medi-Cal report experiencing more access problems than parents of CSHCN in other state Medicaid programs, as demonstrated in the UCLA study. Parents of CSHCN in Medi-Cal more frequently report difficulty obtaining a referral (54%) if their child is significantly affected by their medical condition. Most children eventually get needed specialty care even when they have problems with referrals. Parents of 9% of the CSHCN who needed a specialist (about 44,000 children) said that the child did not receive the needed care, with no differences between children in Medi-Cal (10%) and children in private insurance (8%).¹⁷²

CSHCN in California and nationwide with a medical home were significantly more likely than those without a medical home to report having no problems getting referrals for needed specialty care (100% with medical homes in California and national vs. 55% of CSHCN in California and 59% nationwide without a medical home). California rates did not differ significantly from national rates.¹⁷³

In both California and nationally, CSHCN who have inadequate insurance were significantly more likely to report having problems getting a referral for needed specialty care (42% for California and 33% nationally) than were CSHCN with adequate insurance (19% in California, 15% nationally).¹⁷⁴

Based on data from CMS Net on 54 counties, average waiting times from CCS program referral to authorization vary from 55 to 227 days, with an average of 127 days. In 26% of counties, average waiting time is between 55 to 98 days; in 41% of counties, average waiting time is between 99 to 141 days; in 24% of counties, average waiting time is between 142 to 184 days; and in 9% of counties, average waiting time is between 185 to 227 days (*See Appendix 12*). Numerous factors are involved in this process, but clearly internal procedures should be reviewed and modified to make the system more effective in assuring that eligible children get to medical services and more family-friendly.¹⁷⁵

Average wait time between request for and CCS authorization of in-home support services ranges from 0 to 1469 days, with average being 24 days, the mode (most frequent value) being 0 days and the median (middle value) being 5 days.¹⁷⁶

Average wait time between request for and CCS authorization of equipment (wheelchairs) ranges from 0 to 1838 days, with average being 29 days, the mode (most frequent value) being 0 days and the median (middle value) being 12 days.¹⁷⁷

The length of time between when a provider application is received in the CMS Branch and when it is approved for paneling is 5 to 7 weeks. This time frame is based on the assumption that the provider has an active Medi-Cal number in good standing along with all the required documentation to fully complete the provider's paneling application review.¹⁷⁸

Screening

In California, all newborns are screened for 4 conditions: phenylketonuria (PKU), congenital hypothyroidism, galactosemia, and sickle cell disease. Nationwide, the number of screenings that states mandate range from 4 to 36. California is currently expanding its program to include over 40 additional metabolic conditions detectable via Tandem Mass Spectrometry (MS/MS), as well as classical congenital adrenal hyperplasia.

California has high rates of screening for the 4 conditions that have been mandated: 99.9% in 2001, 99.0% in 2002, and 98.5% in 2003. Follow-up is very successful, with 100% of those needing treatment for PKU, congenital hypothyroidism, and galactosemia in 2003 receiving it. Rates for receiving needed treatment of sickle cell disease are slightly lower and have been increasing for the last three years: 2001 – 94%, 2002 – 95.9%, 2003 – 97.6%. In 2003, California identified 275 infants with congenital hypothyroidism, 34 with PKU, 6 with galactosemia, and 84 with sickle cell disease.¹⁷⁹

In California, all newborns born at CCS-approved hospitals are required to be offered hearing screening and all infants in CCS-approved NICUs must be screened. In 2003, approximately 74% of all newborns born in the state were delivered at a CCS-approved hospital. Ninety-one percent (91%) of newborns in CCS-approved hospitals received hearing screening at birth in 2003, and 94% received hearing screening in 2004. Screening rates in well-born nurseries (WBN) in CCS-approved hospitals that were certified to participate in the NHSP were 97% in 2003 and 2004. Screening rates in CCS-approved neonatal intensive care units (NICU) that were certified to participate in the NHSP were 86% in 2003 and 91% in 2004.¹⁸⁰

The incidence in 2004 of hearing loss in infants screened in CCS-approved WBN was 0.9/1000, and 5.5/1000 of those screened in CCS-approved NICU.¹⁸¹

Organization of Services

In order for services to be of value to CSHCN and their families, the system must be organized in such a way that needs can be identified, and services provided in accessible and appropriate contexts, and that there is a family-friendly mechanism to pay for them. Thus, effective organization of services is a key indicator of systems development.

Based on California data from the National Survey of CSHCN, the National MCHB outcome of service systems organized so families can use them easily was successfully achieved for 66% of CSHCN (vs. 74% nationally, difference is not significant). Nationally, this outcome is more likely to be achieved for Whites (77%) than for Hispanics (66%), Blacks (65%), or Other (59%). In California, the sample size is very small, but generally reflects the pattern of the national data.¹⁸²

The UCLA study found that parents of CSHCN in Medi-Cal reported more difficulty in navigating the system of services and obtaining the health care benefits needed by the child than did parents of CSHCN in other state Medicaid programs.¹⁸³

Care coordination involves sharing of medical information between providers as well as helping parents navigate service systems. Parents of children with complex conditions often need help coordinating multiple appointments and services. The health needs of many CSHCN

are also relevant to their ability to attend school or child care as well as their need for referral to public programs such as early intervention, CCS, and Regional Centers.

Based on findings in the UCLA study, most parents who received professional care coordination were generally satisfied with it, suggesting that professional care coordination based at public programs, health plans and even provider offices is helping children access needed care.¹⁸⁴

Foster Care

Fewer than one-third of agencies report that judges review a child's health plan when making decisions about a child's placement.¹⁸⁵

Family-Centered Care

Families are the constants in the child's life and are pivotal in making any system work. Family members, including those representative of the culturally diverse communities served, must have a meaningful, enduring, and leading role in the development of systems at all levels of policy, programs, and practice. Family voices must be heard and families should be at each table in which decision making occurs. Thus, the involvement of families is a key indicator of systems development.

The MCHB core outcome for families of CSHCN to partner in decision-making and be satisfied with the services they receive, was successfully achieved for 58% of CSHCN nationwide, and for 48% in California. This difference is almost statistically significant.¹⁸⁶

The achievement of this outcome varies considerably by race/ethnic group. Nationally, only 44% of Hispanic CSHCN, 48% of Black CSHCN, and 44% of Other CSHCN successfully achieved this outcome. Compared to Whites (63% achieved the outcome), Hispanic, Black, and Other CSHCN are significantly less likely to achieve this outcome. In California, the data reflect a similar pattern with even smaller percentages of Hispanic (29%), Black (34%), and Other CSHCN (22%) for whom this outcome is achieved. However, there are very small numbers in the California sample for this item and only Hispanic CSHCN differ significantly from White CSHCN (29% vs. 62%).¹⁸⁷

The county CCS programs report to the CMS Branch a summary performance measure that is designed to assess the degree to which the CMS program demonstrates family participation. The measure combines responses to 6 questions regarding family member participation on advisory committees or task forces, offering of financial support for parent activities or groups, providing opportunities for family members to provide feedback regarding their satisfaction with services received through the CCS program, involving family members in in-service trainings of CCS staff and providers, hiring family advocates for their expertise as paid staff or consultants to the CCS program, and involving family members of diverse cultures in all the above activities.

Based on the annual reports from 51 California counties, the percentage of points received on this measure ranged from 0 to 100% with an average of 41% of possible points. Only 6% of counties scored 80% or more of possible points; 40% of counties scored between 40 and 79% of possible points; 29% of counties scored between 20 and 39% of possible points; and 26% of counties scored less than 20% of possible points.¹⁸⁸

The UCLA study found that 73% of parents of CSHCN in Medi-Cal report that they have enough information about how their child's health insurance plan works, compared to 92% of parents of privately insured children. Among parents of the children most severely affected by their condition, 56% of those in Medi-Cal report having enough information about their health insurance plan compared to 92% of privately insured children.¹⁸⁹

Nearly half (46%) of families surveyed by Family Voices did not know whether their child is in a managed care plan, though most (72%) are in fact in a plan with at least one managed care feature, such as a network of doctors or required primary care doctor.¹⁹⁰

Forty-four percent (44%) of families reported in the Family Voices survey they are "very satisfied" with their child's primary plan; 42% are "somewhat satisfied", 12% are "somewhat dissatisfied," and 2% are "very dissatisfied." Parents of children in Medi-Cal managed care plans are most satisfied with their doctor's overall quality of care compared to those in private managed care plans. However, most parents are dissatisfied with the lack of "family-centeredness" of their primary health plan. Parents are most dissatisfied with the lack of information or newsletters about issues of interest or resources outside of their plan. Many are dissatisfied with or do not know whether their plan offers parent support groups or gives parents an opportunity to give advice to the plan.¹⁹¹

Research generally shows that a good interpersonal relationship between the provider and parent/child improves adherence to medical advice, patient satisfaction, self-rated access to care, fewer unmet needs and fewer emergency department visits. Fewer children in Medi-Cal (62%) than with private insurance (82%) are reported in the UCLA study to have enough time with their providers. Most indicators show lower parent ratings of how well the child's provider understands the child's unique needs and provides the information needed by the family about the child's condition.¹⁹²

The Family Voices survey found that parents who responded in Spanish are less satisfied in terms of overall quality of care from their doctors, their doctor's overall communication with the family, and their waiting times. Spanish respondents are more satisfied with their doctor's respect for their child and the family than those responding in English.¹⁹³

Transition to Adulthood

There is not much data available to evaluate services for CSHCN who are transitioning to adult services at age 21 years. Of the CCS cases that were active as of 3/15/05, there are a total of 2746 clients 20 years of age. These clients are transitioning out of CCS on their 21st birthday. Within 52 California counties, the percentages of these clients with insurance range from 0 to 100% with an average of 22% having insurance (*See Appendix 13*). This will dramatically affect their ability to receive health care services once they are no longer eligible for the CCS program. Some of these clients will be able to transition into GHPP if they have eligible conditions, such as cystic fibrosis, hemophilia, or sickle cell disease.¹⁹⁴

CSHCN CAPACITY ASSESSMENT

The CMS Branch administers the CCS program, California's Title V Children with Special Health Care Needs program, which is one of six programs managed by the Branch. The others include the Child Health and Disability Prevention (CHDP) program, Medically Vulnerable Infant Program (MVIP), Health Care Program for Children in Foster Care (HCPCFC), Newborn Hearing Screening Program (NHSP), and Genetically Handicapped Persons Program (GHPP). Through these programs, the Branch provides a comprehensive system of health care for children through preventive screening, diagnostic, treatment, rehabilitation, and follow-up services.

The focus of the CMS Branch has primarily been on the provision of direct services for targeted populations. Some programs, such as CHDP, NHSP, and HCPCFC, have components that address infrastructure building and population-based services. The Branch is planning to expand its programmatic emphasis to include more infrastructure building activities. The capacity assessment identified weaknesses in this arena.

The Branch decided to utilize the Capacity Assessment for State Title V (CAST-5), Second Edition, to structure this aspect of the needs assessment. Eight of the ten MCH Essential Services were evaluated, but they were narrowed in focus for children in general or CSHCN in particular. Managers and program staff were selected to participate in this process. They received the Process Indicator sheets for the relevant MCH Essential Services to review. A meeting was held in which the selected tools were reviewed and the Branch's strengths, weaknesses, challenges, and strategies were enumerated for each Essential Service.

The results of the capacity assessment are shown below.

Essential Service #1 - Assess and monitor the health status of children and CSHCN to identify and address problems.

Strengths

There are numerous data sources that are available to the CMS Branch, including:

- CMS Net data
- Paid claims data for the CCS program, CHDP, and Medi-Cal program (through the Management Information System/Decision Support System (MIS/DSS))
- CMS/Child Welfare Services data from the Department of Social Services
- Health Plan Employer Data and Information Set (HEDIS) data from the Medi-Cal managed care plans, specifically data on immunizations and asthma
- Nutritional assessment data through the Pediatric Nutrition Surveillance system (PEDSNSS)
- Newborn Hearing Screening Program (NHSP) data
- Neonatal data from the CCS-approved NICUs, CCS program, and the California Perinatal Quality Care Collaborative (CPQCC)
- PICU and pediatric cardiac data from the CCS-approved hospitals

The Branch can use Business Objects software to run reports from selected data sets. More staff need training in how to access and manipulate this resource. This could be a powerful tool if it were utilized for all of the data sets that are currently available.

The Branch receives information from county programs about problems that are identified anecdotally from local experiences. A systematic process for assessing the magnitude of these problems and quantifying the specifics is lacking.

Weaknesses

The most significant weakness related to assessment and monitoring activities is the lack of research and epidemiological staff to analyze the data that are currently available or to develop new data resources. There is no capacity within the Branch to analyze the state and national data on CSHCN that are available.

Additional data are being collected in California on the target population to which the CMS Branch currently does not have access. These include:

- Healthy Families data through the Managed Risk Medical Insurance Board (MRMIB)
- Encounter and aggregate data from Medi-Cal Managed Care
- Patient-specific clinical and demographic data on children who are reported to the Childhood Lead Poisoning Prevention Branch
- Hospital and planning data from the Office of Statewide Health Planning and Development (OSHPD)
- Encounter and aggregate data from the Department of Mental Health
- Encounter and aggregate data from the California Department of Education (CDE)
- Data on children who are referred or are enrolled in the Early Start program and receiving services through the Department of Developmental Services, Regional Centers, CDE, and local education agencies
- Data from CCS-approved Special Care Centers
- Encounter, clinical, and aggregate data from the High Risk Infant Follow-up clinics

California has no population-based data on the CSHCN population. The Branch has no capacity to link existing data (CMS Net) with other Public Health data sets (eg., Birth Defects Monitoring Program, Genetic Disease Branch, Immunization Registries). The MIS/DSS data is available, but there are no staff in the Branch trained in using this system.

Essential Service #3 - Inform and educate the public and families about pediatric and CSHCN health issues.

Strengths

CMS has developed numerous resources to inform and educate families and providers:

- CMS website, with links to other websites
- Numerous program brochures in several languages
- The Branch has several staff who are available to provide presentations at community meetings on programmatic issues
- Program staff provide education to providers and families through exhibits at numerous conferences
- Various staff participate in meetings with community and parent/family advocates
- The Children's Regional Integrated Service System (CRISS) group evaluates county activities with respect to family-centered care
- Counties have parent advisory groups that impact the content and methodology of parent education efforts
- Counties hire parents and/or have contracts with Family Resource Centers for family support activities

- The CMS Branch participates on the State Interagency Coordinating Council for Early Start

Weaknesses

- There is no parent voice at the Branch level
- There are no standardized parent materials for the Medical Therapy Program (MTP)
- Website links are not updated or verified on an ongoing basis

Potential Strategies

- Encourage professional CMS staff to develop expertise in specific areas and serve as liaisons with parent groups
- Encourage counties to develop and/or provide parent education programs in conjunction with Special Care Centers
- Hire a parent consultant in the Branch
- Formulate an advisory group of families to develop and standardize materials for the MTP and to get input on program activities
- Hire a Webmaster to maintain and update the CMS website as well as the program websites

Essential Service #4 - Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve CSHCN problems.

Strengths

The CMS Branch has relationships with many partners to address issues affecting CSHCN, including:

- State Interagency Coordinating Council for Early Start, active member
- Special Education, California Department of Education
- Bay Area Foster Care Task Force
- Oral Health Access Council
- MRMIB, the agency overseeing the Healthy Families program, California's State Children's Health Insurance Program (SCHIP)
- Children's Specialty Care Coalition, a coalition of pediatric specialty and subspecialty physicians
- CPQCC and the Perinatal Quality Improvement Panel (PQIP)
- California Children's Hospital Association
- California Association of Neonatologists
- AAP
- Hemophilia Foundation
- Family Voices
- Community Integrated Service Systems (CISS) project (funded to develop integrated services in the Bay Area and Los Angeles)
- Champions for Progress grant (stakeholder group is composed of the same organizations and individuals used for the CMS needs assessment process)
- Infant Mental Health Project
- Local youth collaboratives
- CRISS group
- Regional Perinatal Programs of California (RPPC)
- California Palliative Care Association

- The Department of Health Services Nutrition and Physical Activity (NUPA) initiative to address the childhood obesity epidemic

Weaknesses

Despite the varied and numerous collaborative relationships of which the CMS Branch is a part, there is no infrastructure in which the Branch has a leadership role in facilitating discussion and coordinating the activities among these diverse groups.

There are some communities with which the Branch does not yet benefit from a collaborative working relationship, including the dental and orthopedic communities.

Potential Strategies

- Include Community Based Organizations in linking families with services
- Evaluate the CMS Branch's internal organization regarding community participation
- Build the expertise within the Branch to provide leadership in steering collaborative groups to address common issues.

Essential Service #5 - Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of children.

Strengths

The CMS Branch has taken an active role in providing leadership for program activities. A new direction for the Branch is to provide leadership in the larger CSHCN community. Some of the current activities in this arena include:

- Direction to county programs to provide performance measures and narratives in their annual plans
- Initial meetings have occurred with county CCS medical consultants and administrators to begin looking at internal and external quality indicators for serving children and families in the CCS program
- The strategic planning process for the Title V five-year needs assessment, utilizing stakeholders, has begun. It will continue using the existing stakeholder group in collaboration with the Champions for Progress project
- The CMS Branch has committed to annual Stakeholders meetings to report on the progress in meeting the prioritized objectives and to obtain assistance in additional strategies and evaluation methodology
- The Branch maintains three Technical Advisory Committees (NICU, PICU, and Cardiac) for the development of standards and approval of new facilities.
- The CMS Branch issues Program Plan and Fiscal Guidelines for local CCS and CHDP programs
- The CMS Branch has produced the CHDP Local Program Guidance Manual and provided training for the local CHDP program staff
- The NHSP program has developed and continually updates the NHSP Tracking and Monitoring Procedure Manual for the Hearing Coordination Centers
- The CHDP program has developed and updates the Health Assessment Guidelines for CHDP providers
- The CMS Branch uses Business Objects software to identify priorities and to guide policy development

Weaknesses

The Branch still needs to develop capacity to provide the level of leadership in the larger CSHCN community that is envisioned. This will include staff resources, training, financial resources, and data analysis expertise. Some of the issues facing the Branch in this area include:

- There are no standards for health care organizations/commercial health plans regarding services, standards, and outcomes for CSHCN
- The Branch needs the capacity to collect and analyze data in order to identify priorities and measure progress
- The professional staff in the Branch currently have no available time to provide pediatric consultation to internal and external organizations, agencies, and collaboratives

Potential Strategies

Some of the strategies that can move the Branch forward in providing statewide leadership with respect to CSHCN are:

- To expand reports available to counties through Business Objects to increase their capacity to identify local issues
- To apply CCS standards to all health care organizations - this strategy is beyond the scope of the CMS Branch, but working with partners in the broader community may develop support for this approach
- Developing and facilitating a task force with all insurance providers may result in a population-based review of outcomes for CSHCN
- To evaluate the issues that need to be prioritize, and then collect and analyze the available data
- To increase cultural competency of state and local program staff
- To work with the stakeholder group to prioritize and develop strategies for data development

Essential Service #6 - Promote and enforce legal requirements and the application of standards and regulations to protect the health of children and CSHCN, and ensure public accountability for their well-being

Strengths

The CMS Branch has developed standards and program guidelines for the CCS, CHDP, and NHSP programs. Activities related to promoting the application of standards include:

- Provider application and on-site facility reviews for new providers
- Regional Offices perform local county program site reviews to assure that state policies are being followed
- Health Care Program for Children in Foster Care has developed guidelines for access and documentation of health care services
- County programs collaboratively review Corrective Action Plans that are submitted by providers to the Medi-Cal managed care health plans
- The Branch issues and updates the CHDP Health Assessment Guidelines
- The Branch monitors and analyzes proposed legislation
- The Branch has the opportunity to submit proposed legislative changes to the Department management

Weaknesses

Despite having standards and program guidelines, the Branch does not have the staff resources to monitor providers and assure that they are adhering to the standards and guidelines.

Moreover, since there are no regulations to implement the standards and guidelines, there is no authority to enforce the:

- Health Assessment Guidelines
- CCS hospital standards
- CCS NICU standards
- CCS Special Care Center standards
- NHSP Inpatient and Outpatient Screening Provider Standards

Additionally, the Branch does not have legislative or regulatory authority for oversight of services or outcomes for CSHCN

Potential Strategies

- Develop and implement regulations codifying program standards and guidelines
- Enhance the Branch capacity for oversight of provider compliance and evaluation of outcomes for all CSHCN

Essential Service #7 - Link children and CSHCN to health and other community and family services, and assure access to comprehensive, quality systems of care.

Strengths

One of the cornerstones for the CCS program is to assure that children receive multidisciplinary services at centers of excellence from providers who meet minimum professional requirements and expertise. The focus of all of the CMS programs is to link children with appropriate services.

- The CCS program requires that children with certain eligible conditions receive Special Care Center services
- The Health Care Program for Children in Foster Care assures that these vulnerable children receive appropriate medical services
- The CHDP Gateway program links children with public health insurance programs and provides coverage for an initial period of time
- The CCS program provides case management services for all enrolled children that assures they receive health care services from an appropriate provider in an appropriate facility
- The NHSP provides a single point of referral to link infants and toddlers with hearing loss to the Early Start program for early intervention services
- Each county CCS program has an “Early Childhood Liaison” to coordinate care and services among agencies for CCS clients who are younger than 3 years of age
- The local CHDP programs assure that children receive appropriate follow-up services for conditions identified on a preventive health care exam that need specialty referral
- Each county CCS Medical Therapy Program has a liaison with Special Education to assure compliance with agency regulations and delivery of services to CCS clients eligible for Special Education
- Most county programs have developed relationships with the local California Children and Families Commissions to partner in building local infrastructure to assure access to a multitude of services for children and their families
- Many county programs provide parent support activities through linkages with the local Family Resource Centers

Weaknesses

There is still much work to be done to assure that families receive the services that they need:

- Cultural competency of program staff must be improved
- Interagency agreements on the state and local levels need to be updated
- There should be better coordination with the Department of Mental Health and with the county mental health programs
- Better coordination with Regional Centers is critical
- The Branch should implement a toll-free telephone line
- Programs need to link with Medi-Cal/Healthy Families application assistors to improve the rate of application return by families who receive services through the CHDP Gateway

Essential Service #9 - Evaluate the effectiveness, accessibility, and quality of personal health and population-based services for CSHCN.

Strengths

The CMS Branch has performed some activities in this arena, but most of the resources have been directed toward the evaluation of program services. Some of the tools available are:

- The use of Business Objects software by the counties to evaluate CCS services provided to children in their area
- State and national NHSP data are available to evaluate infrastructure and outcomes
- State and national NICU data are available for comparison
- The National Survey of CSHCN is available on-line

Weaknesses

This has not been an area in which the Branch has focused. To adequately address these activities, the Branch would need:

- Grant writing resources to expand the data and research capacity and/or to fund discreet evaluation projects
- Preceptors for student interns to enhance capacity at lower cost
- Increase capacity to compare Special Care Center data (eg., Cystic Fibrosis, Hemophilia) with national standards
- Increase capacity to compare State PICU data with national data
- Access to and the resources to analyze the data sets to which the Branch currently does not have access, as identified in Essential Service #1 above

Potential Strategies

- Seek other funding sources to expand capacity for data analysis (eg., foundations, federal grants)
- Utilize student interns as a way to enhance analytic capacity
- Work with the stakeholder group to prioritize and develop strategies for data development

Essential Service #10 - Support research and demonstrations (professional consultation) to gain new insights and innovative solutions to pediatric and CSHCN problems.

Strengths

The CMS Branch has provided letters of support for community organizations and universities to apply for grant funding to research issues or outcomes for CSHCN.

Weaknesses

The CMS Branch has supported others in their attempts to receive funding for research, but has not originated any requests for internal research projects, despite having access to large data sets on huge numbers of clients. Although the CMS has assisted grantees in obtaining funding, the Branch has not received reports on the progress or outcome of these projects.

Potential Strategies

- Develop the capacity to pro-actively be involved in research as the principal investigator
- Develop the capacity to apply for research grants
- Develop a mechanism to obtain results and/or final reports from projects that been actively supported (either financially or with letters of support)

In summary, this exercise has proven useful in identifying critical gaps in the CMS Branch's organizational and resource capacity. The Branch must address these in order to effectively pursue population-based Public Health activities focusing on building infrastructure for improving services for all CSHCN in California. The key elements that have been identified include:

- Research, analytical, and epidemiological resources to analyze existing data and develop new data sources
- Development of leadership within the Branch to facilitate discussions and strategic planning in the broader CSHCN community
- Regulatory authority to enforce standards and to oversee services and outcomes for CSHCN
- Acquisition of parent expertise and input at the Branch level

CSHCN STAKEHOLDER INVOLVEMENT IN PRIORITIZATION OF NEEDS

The CMS Branch invited a diverse group of stakeholders to participate in this process. The group included representatives from county CMS and MCAH programs, CCS Technical Advisory Committees, American Academy of Pediatrics, hospital associations, pediatric provider groups, State Departments of Developmental Services, Education, Mental Health, Social Services, and the Managed Risk Medical Insurance Board (MRMIB), Regional Centers, Family Voices, CRISS, Medi-Cal, County executives, Protection and Advocacy, California Medical Home Project, Early Hearing Detection and Intervention, Medically Vulnerable Infant Program, and parents. It was important to the Branch to have parent input, but few were able to attend the meetings. FHOP contacted the parents over the phone, provided an orientation about the process and activities, and obtained their input on issues and problems. *(The complete list of stakeholders is included in Appendix 14.)*

Prior to the initial meeting, FHOP staff requested telephone interviews with all individuals on the original CCS stakeholders list to gain background information about their role in the CCS program, provide them with information about the CCS Needs Assessment process and role of the stakeholders, and to encourage their participation. A total of 32 interviews were conducted, ranging from ten minutes to one hour in length. (Most interviews took 20-30 minutes). These interviews included discussions with five parents of children with special health care needs, including two that would not be attending the meeting. One of the parents attended one of the stakeholders meetings and the other both meetings. In some cases, interviews were conducted with individuals who could not be at the meeting. Those individuals were asked to select an alternate from their organization to attend, and in most cases, an additional interview was conducted with the alternate. Only four individuals on the original stakeholders list were never reached for an interview.

Some interviews yielded suggestions of potential sources of data or indicators that could be used for the CCS needs assessment and identification of issues/needs of CSHCN. This information was integrated into the list of potential indicators reviewed by Stakeholders at the first meeting. The interviews provided FHOP staff with a general understanding of what issues might come up in discussion at the stakeholders meetings, and allowed FHOP staff the time to gather more information on these issues and how to address them prior to the meeting.

Many of the interviewees requested information about other stakeholders and their backgrounds. To provide this, meeting participants were asked to respond to an email requesting biographical information and a brief paragraph describing what they believed to be the top two issues facing the CCS program. Most (21) participants responded, and the information was compiled into a packet of participant biographies distributed at the first stakeholders meeting on January 27, 2005.

Two FHOP staff spent about two weeks, full time, gathering this background information. The process included preparation of the interview plan, calls and follow-up calls (often initially with the stakeholders' assistants), stakeholder interviews, collating the information and preparing handouts, and staff discussion of results for the purpose of integrating information into the broader issue and data identification effort.

There were two all day meetings of the stakeholders for the purpose of identifying CCS CSHCN issues/needs and setting action priorities among the identified issue areas. The first meeting was held on January 27, 2005 and the second on April 28, 2005. In addition to the two meetings, the stakeholders participated in telephone or e-mail follow-up communications as needed and reviewed a data packet.

During the January 27, 2005 stakeholders meeting, the group 1) received information about the CCS Title V 5-year needs assessment process, the stakeholder group's role and the process in which the group would participate to select CCS Action Priorities from among identified issues/problems; 2) participated in the selection and weighting of the criteria that this group would use during its second meeting to determine the action priorities; 3) was introduced to the indicator selection and data collection process by which CSHCN issues/problems would be identified; and 4) participated in either a Providers, County CCS, Family and Advocates, or Collaborating Agencies breakout group to assist CCS in the identification of issues/problems of concern to stakeholders, relevant data, and potential data sources (*See Appendix 15*). Also, a teleconference meeting was held to provide information to stakeholders who were unable to participate in the first meeting and wished to participate in the second meeting.

During the April 28, 2005 meeting, the group 1) reviewed the criteria they had developed and weighted at the first meeting and the definitions and rating scale developed by staff, 2) reviewed the list of identified issue/need areas, 3) saw a Powerpoint presentation of 15 identified issue/need areas and data relevant to those areas, 4) revised and agreed on a final issue/objective list, and 5) received orientation to and used a method of rating and ranking the identified issues/objectives (*See Appendix 16*). The resulting prioritized issues/objectives were presented, discussed and confirmed by the group.

To promote the success of this process, the State CCS program staff assured that representative stakeholders were invited, provided the best data available (within CCS resources and the timeframe) to FHOP, were available to FHOP and stakeholders to answer questions, and articulated CCS program commitment to using the results where funding and legislation permit. The Stakeholders were asked to be open to the process, to provide their expertise during discussions, use data and expert knowledge to inform their decision-making, and agree to honor the group outcome. FHOP's role was to provide the framework; review and analyze data and prepare a data packet and presentation; provide opportunities for stakeholder input; and facilitate a rational, inclusive stakeholder process.

Indicator/Issue Selection and Presentation of Data

The process of identifying and learning about issues/needs began with the review of available sources of information about the needs of CSHCN, including the National Survey of CSHCN; a scan of relevant websites; discussion with other State CCS Program Directors; interviews with CCS CSHCN stakeholders and a short e-mail survey of the stakeholders; and review and clarification of information recorded during the CCS stakeholder meeting breakout groups. Then indicators were selected using criteria (*see Appendix 17*).

A major source of data was "The National Survey of Children with Special Health Care Needs" (NS-CSHCN). In addition a data request was submitted to CMS staff who reviewed the request and provided the data that was available to FHOP. CMS Net and the State Performance Measures data were the primary sources of CCS specific data. Several published UCLA reports

as well as “Family Voices” were also sources. These data sources are described in the Data Report section. The data were analyzed and summarized for stakeholder review. It was organized, using the six federal core CSHCN outcomes, into data summary sheets. A data packet was sent to the Stakeholders prior to the prioritization meeting. CMS and FHOP, based on available data and stakeholder input, identified 15 major issues/systems problems affecting CCS and CCS-eligible children and families. CMS wanted to promote a positive action-oriented process; therefore, the issue/need areas were framed into objectives. Performance measures will be identified later, when the strategies to achieve the objectives have been developed.

Prioritization of Indicators/Issues

The Stakeholders individually used the weighted criteria they had developed together (*see Appendix 18*) and a tool provided by FHOP to rate each of the objectives (*see Appendix 19*). The individual rating scores were then summed resulting in an aggregate score used to rank the objectives.

Two overarching principles were identified by the group.

- CCS will address disparities in impact and outcomes by gender, age, geographic location and race/ethnicity issues when developing strategies and tracking priority objective outcomes (from the first Stakeholder meeting).
- The CCS program shall ensure that children participating in CCS have access to and receive services from appropriately trained pediatric providers and shall develop and apply standards of care intended to lower morbidity and mortality rates among eligible children (from the second Stakeholder meeting).

The top five priorities that were discussed and agreed upon with the stakeholders follow. The complete ranking result is included in *Appendix 20*. There are three objectives ranked as number four (4), as the aggregate scores were within a few points of each other. The top three priorities will be included as Title V CSHCN priorities. CMS will address other priority objectives as resources and opportunities permit.

Rank	Priority Objectives
1	Expand the number of qualified providers participating in the CCS program, e.g., medical specialists, audiologists, occupational and physical therapists, and nutritionists

One of the main problems with access to services for CCS children is the long wait to see the dwindling number of pediatric specialty and subspecialty providers who are willing to participate in the CCS program. There are several variables that impact the provider pool, some of which are not easily resolved by the CMS Branch. The most critical factor is reimbursement through the Department’s fiscal intermediary. Payment of claims is often delayed or denied, despite CCS authorization of the services.

2 **Coordinate to develop and implement a system of timely referral between mental health, developmental services, social services, special education services and CCS**

This represents a new leadership activity for the CMS Branch. Most of the resources in the past have been focused on addressing service issues within the CMS programs. This priority provides an opportunity for CMS to take an active role in building systems with community and state partners for the broader population of CSHCN. The internal capacity assessment revealed that this is an area in which additional resources and training are required.

3 **Increase the number of family-centered medical homes for CSHCN and the number/% of CCS children who have a designated medical home**

A true medical home can dramatically improve the coordination and quality of services that are received by a child and family. Unfortunately, the data that are available in the CCS program on this variable do not accurately measure receipt of this service. Having a PCP identified in the record is a poor proxy for the services that should be performed by a medical home. Training and support are necessary for the provider community to understand what services should be provided through a medical home and how to accomplish that. Reimbursement for provider time that is spent communicating with the family, coordinating care, and overcoming barriers must be addressed.

4 **Increase access of CCS children to preventive health care services (e.g., primary care providers, well child care, immunizations, screening) as recommended by the AAP**

Information about this indicator is not currently available. It is not collected in the CMS Net data base. CCS programs do not case manage preventive services. And CMS Net is not currently linked with data from the CHDP program. Meeting this objective will be enhanced by improving access to appropriate medical homes (Priority #3).

4 **Increase family access to educational information and information about accessing CCS services, including availability of and access to services offered by health plans**

This objective addresses outreach for CCS, educating families whose children are enrolled in CCS about the services, developing family-friendly materials that are provided in a family-centered manner, and building bridges with Medi-Cal and commercial health plans. Many families are confused about the services that their children are eligible to receive through the CCS program. Enhancing the relationship between CMS and Medi-Cal managed care health plans and developing relationships with commercial health plans provides an opportunity for the Branch to address the broader population of CSHCN in California. Developing the referral systems in Priority #2 will assist in meeting this objective.

4 **Increase access to services for CCS youth, 17-21 years of age**

Some of the providers and Special Care Centers that serve the CCS population prefer to see younger children and tend to discharge the patients from their practice as they reach adulthood. It is becoming increasingly difficult to find appropriate specialty care for these clients as they age. Recruiting specialists who will serve this population and provide care using a multidisciplinary team is a challenge. This is an issue that will require a collaborative solution between the current Special Care Centers and the providers who will follow these young adults.

5 **Decrease the time between referral to CCS and receipt of CCS services**

There is considerable variation among counties in the time between program referral and when a child receives services authorized by CCS. This is a multifactorial issue that will need to be approached using several strategies. Delays occur in the application process, receipt of medical reports, determination of program eligibility, issuance of authorizations, provider appointment scheduling, and availability of appointments.

SELECTION OF STATE PRIORITY NEEDS

MCAH/OFP Branch priorities were selected based on multiple considerations – the results from the local jurisdiction needs assessment reports, the input from external stakeholders as well as input from Branch staff, the assessment of capacity at the state level, the review of published data, state-level surveillance data, and Healthy People 2010 objectives. In recognition of the inter-connectedness of many issue areas among the MCAH population, a decision was made to combine MCAH priority areas into seven priority statements that, in part, reflect inter-related topics of interest.

The CMS Branch priorities for CSHCN were taken directly from the output of the stakeholder process, using the top three prioritized needs. The stakeholders will also be involved in developing the strategies and action plan to impact these priority issues. The group will identify data sources and develop outcome/performance measures to evaluate the State's progress in meeting these objectives.

The priority statements are listed below (not in order of importance):

Priority Statements

- **Enhance preconception care and work toward eliminating disparities in infant and maternal morbidity and mortality. (MCAH)**

California's infant and maternal mortality rates remain higher than the goals set by Healthy People 2010. Large race/ethnic disparities exist, with African American women and infants at particularly high risk. Analysis of infant deaths by Perinatal Periods of Risk identifies maternal health as the major contributor to infant mortality.

- **Promote healthy lifestyle practices among MCAH populations and reduce the rate of overweight children and adolescents. (MCAH)**

The percent of children and adolescents who are overweight is higher than the goal set by Healthy People 2010, with the trend increasing over the past seven years for all age and race/ethnic groups. Persons who have unhealthy lifestyle practices are at increased risk of becoming overweight or obese. The importance of obesity is, in part, due to its link to a number of health conditions during childhood and subsequently during adulthood such as diabetes, depression, hypertension, and a number of cardiovascular diseases.

- **Promote responsible sexual behavior in order to decrease the rate of teenage pregnancy and sexually transmitted infections. (MCAH)**

Although the teen birth rate in California has decreased in recent years, rates remain much higher than most industrialized countries and are higher for certain race/ethnic groups, particularly Latinas. With the female teen population projected to increase over the coming years, teen pregnancy prevention efforts must be maintained or increased in order to continue the overall trend in declining teen birth rates.

Consistent with promoting responsible sexual behavior is reducing rates of sexually

transmitted infections, which can cause AIDS, pelvic inflammatory disease, infertility, and other complications. These infections are increasing at an alarming rate, especially among adolescents and young women, with significant disparities by race/ethnicity.

- **Improve mental health and decrease substance abuse among children, adolescents, and pregnant or parenting women. (MCAH)**

There has been increasing recognition of mental health concerns among children, adolescents, and women of reproductive age, including the acknowledgement that these issues may differ by population group as well as by specific mental condition. Many major mental health problems during childhood, particularly those left untreated, may persist into adulthood, influencing functioning in the social, familial, and occupational areas of life. These problems in women represent additional concerns because of their links to the development or health of the fetus and child.

Substance abuse is often related to, and can cause, mental health and social problems. In California, MCAH/OFP Branch concerns over the use of alcohol or illicit drugs are centered primarily on adolescent and perinatal substance use.

- **Coordinate to develop and implement a system of timely referral between mental health, developmental services, social services, special education services and CCS. (CSHCN)**

This represents a new leadership activity for the CMS Branch. Most of the resources in the past have been focused on addressing service issues within the CMS programs. This priority provides an opportunity for CMS to take an active role in building systems with community and state partners for the broader population of CSHCN. The internal capacity assessment revealed that this is an area in which additional resources and training are required.

- **Improve access to medical and dental services, including the reduction of disparities. (MCAH)**

Access to care is a complex issue with many dimensions, such as the lack of health insurance, provider supply, transportation, bilingual staff, and cultural sensitivity. California children are less likely than children in the nation to have health insurance. Additionally, children and pregnant women are less likely to have dental insurance than health insurance. Lack of access to dental care is particularly important because dental decay is the most common chronic childhood disease. Poor oral health, in adults as well as children, can impede healthy eating, speaking, learning, and is associated with many serious chronic diseases.

- **Expand the number of qualified providers participating in the CCS program, e.g., medical specialists, audiologists, occupational and physical therapists, and nutritionists. (CSHCN)**

One of the main problems with access to services for CCS children is the long wait to see the dwindling number of pediatric specialty and subspecialty providers who are willing to participate in the CCS program. There are several variables that impact the provider

pool, some of which are not easily resolved by the CMS Branch. The most critical factor is reimbursement through the Department's fiscal intermediary. Payment of claims is often delayed or denied, despite CCS authorization of the services.

- **Increase the number of family-centered medical homes for CSHCN and the number/% of CCS children who have a designated medical home. (CSHCN)**

A true medical home can dramatically improve the coordination and quality of services that are received by a child and family. Unfortunately, the data that are available in the CCS program on this variable do not accurately measure receipt of this service. Having a PCP identified in the record is a poor proxy for the services that should be performed by a medical home. Training and support are necessary for the provider community to understand what services should be provided through a medical home and how to accomplish that. Reimbursement for provider time that is spent communicating with the family, coordinating care, and overcoming barriers must be addressed.

- **Decrease unintentional and intentional injuries and violence, including family and intimate partner violence. (MCAH)**

Although California's rate of injuries in general has remained stable, the rate of injuries among those aged 15-24 has increased significantly over the most recent five-year period. One of the most striking increases in unintentional injuries has been the rate of motor vehicle crashes that resulted in deaths in this age group.

Intentional injury and violence – whether directed at a child, spouse, or partner and whether committed at home or in the school – is a core MCAH issue because of its consequences to the individual's overall functioning in life. The percent of adult women reporting intimate partner violence has remained relatively stable, while the percent of children exposed to child abuse in California remains above Healthy People 2010 goals. Homicide rates for African American teens are three times higher than the state rate.

- **Increase breastfeeding initiation and duration. (MCAH)**

Breastfeeding is associated with many health benefits, including lower rates of infant diarrhea, ear infections, and lower respiratory illness. Although rates of any in-hospital breastfeeding initiation has increased, rates of exclusive in-hospital breastfeeding initiation have steadily declined during the past six years and the rate of breastfeeding duration continues to fall below HP 2010 goals. Large race/ethnic disparities exist for both exclusive breastfeeding initiation and breastfeeding duration.

NEEDS ASSESSMENT SUMMARY

The priority needs selected for this 2006-2010 Needs Assessment and those from the 2001-2005 Needs Assessment are included in Table 23 below.

Since the last needs assessment was conducted, California's population has continued to grow and become increasingly diverse – one indicator of this diversity is the fact that nearly half of Medi-Cal and Health Families recipients in 2003 spoke a language other than English. California's economy has suffered during the same period, resulting in budget cuts that have affected some Title V programs.

Many of the same concerns are present in both sets of priority needs, but the ways in which the priorities are grouped have changed, reflecting a shift in emphasis and in the thinking as to how the problems might be addressed. For example, concerns about infant mortality were present in both needs assessments, but in 2005 there is a concentration on enhancing preconception and interconception care as a means to alleviate disparities. The Centers for Disease Control (CDC) sponsored a National Summit on Preconception Care in Atlanta in June, 2005. While past public health efforts have greatly improved pregnancy outcomes, promoting the health and wellness of women prior to pregnancy translates into more favorable outcomes. The CDC calls preconception care "a great opportunity for further improvement of pregnancy outcomes."¹⁹⁵

The issue of race/ethnic disparities continues to be a concern overall. "Disparities" is not a priority need in itself; rather, it was and continues to be a problem that exists in virtually every measure of maternal, child and adolescent health. Throughout the local needs assessments, MCAH jurisdictions reported overriding concerns about health disparities, particularly between race/ethnic groups.

Maternal mortality was included in the 2000 priority needs under "promote safe motherhood," but in 2005 this need is combined with infant mortality, as the health of both mother and infant are linked to good preconception/ interconception care. Race/ethnic disparities are especially high for maternal mortality.

Promoting a healthy lifestyle for MCAH populations continues to be a priority, but in 2005 there is added emphasis given to the issue of child and adolescent overweight. This issue was the one most commonly cited by local MCAH jurisdictions, and trend data show that the problem is worsening sharply due to poor diet and inadequate exercise.

Teen birth rates and incidence of sexually transmitted infections (STIs) are closely related, as both result from risky sexual behavior. Teen birth rates have declined in California in recent years, but demographic projections suggest that they may increase in the future. STIs are on the rise among teens and young adults, particularly the incidence of chlamydia among females.

The priority need "Decrease mental health problems and substance abuse among children and pregnant and parenting women" is new in 2005. Many local MCAH jurisdictions reported in their needs assessments that both mental health and substance abuse are of increasing concern. Perinatal substance abuse in particular was frequently cited, but adolescent problems were widely reported as well. Most of these reports were qualitative, coming from community-level stakeholders and service providers who work directly with the MCAH population and perceive an increase in both substance abuse and mental health needs.

Access to both health and dental care emerged as an important issue in 2005. In 2000, oral health was combined with other “healthy lifestyle practices,” but information in the recent needs assessment suggests that one obstacle to good dental (as well as health) care is lack of access. Uninsurance is a problem in both cases, along with the availability of health care professionals and a range of other factors.

Injuries and violence are combined in 2005, whereas they were listed separately in 2000. Injury and violence is one of the HP 2010 leading health indicators and continues to be a problem in California. Breastfeeding is once again a priority in 2005, with an added emphasis on encouraging duration as well as on in-hospital initiation of exclusive breastfeeding.

All three of the CSHCN priority needs are related to quality and access to services. Having an appropriate provider network, coordinating with other programs to assure timely referral, and improving coordination of services through a medical home will greatly enhance the quality and timeliness of medical care for these children and their families. These are very similar to the priority needs identified in 2000. The main difference is the near completion of the implementation of CMS Net, the statewide case management and data collection system. The system is in use in all but three counties, which are expected to come on-line within the next year.

The methodology for determining the current MCAH priority needs built upon the experience of the 2000 needs assessment. In 2000, the Branch did receive input from local needs assessment reports and stakeholders, but in 2005 the process was expanded to include explicit guidelines and the provision of local-level data to local MCAH jurisdictions. In 2005, the Branch encouraged local jurisdictions to gather and analyze more qualitative data as well.

In planning for the 2005 needs assessment, MCAH/OFP Branch staff stressed the importance of a bottom-up approach, gathering both qualitative and quantitative information from the local jurisdictions. The local jurisdictions, in turn, relied on partnerships with community organizations and other stakeholders to collaboratively analyze their needs and capacity strengths and weaknesses.

The MCAH/OFP Branch also received input from statewide stakeholders and a variety of staff members. The 2005 MCAH stakeholder meeting was attended by close to 50 representatives from public and private organizations interested in maternal, child and adolescent health. The attendees discussed the possible needs based on the local needs assessments, criteria by which to rank them, and collectively made recommendations for priority needs.

The CMS Branch used a much more interactive and collaborative process to identify the 2005 priorities, compared to previous processes. In 2000, input was requested from stakeholders through a written survey process. The 2005 priority objectives were determined after analyzing data, most of which came from national surveys, following a framework for prioritization, and two all-day meetings with stakeholders in which they identified issues, framed objectives, ranked priorities, and reached consensus on the final list. The process laid the groundwork for a continuation of this collaboration in developing the strategies to achieve these objectives and the performance measures to evaluate our success.

To meet the objectives that have been prioritized, the CMS Branch will need to engage in more infrastructure building activities than it has in the past. CMS will need to become a leader and facilitator to improve coordination with other state departments for timely referral. The Branch will need to collaborate with partners in the public and private arenas, including managed care plans, to expand the CCS provider network. Partnering with professional organizations, advocacy groups, and parents will be critical in educating primary care providers in the medical home model and assuring that coordination activities occur. This will be a challenge, but presents the CMS Branch with an opportunity to develop capacity in these areas and become a leader in CSHCN health issues in the state.

Table 23. Comparison of priority needs from the 2006-2010 and 2001-2005 California Needs Assessments

	2006-2010 Priority Needs	2001-2005 Priority Needs	State Performance Measure 2001-2005
MCAH/OFP Branch Priority Needs	1. Enhance preconception care and work toward eliminating disparities in infant and maternal mortality and morbidity.	1. Eliminate racial and ethnic disparities in infant health, including gaps in the infant mortality rate and the proportion of low and very low birthweight infants.	#1. The percent of children whose family income is less than 200 percent of the Federal Poverty Level who received at least one preventive medical exam during the fiscal year.
	2. Promote healthy lifestyle practices among MCAH populations and reduce the rate of overweight children and adolescents.	2. Promote healthy lifestyle practices among children and adolescents with emphasis on smoking prevention, adequate nutrition, regular physical activity, and oral health.	#2. The percent of low-income children who are above the 95th percentile of weight-for-length (less than 2 years) or BMI-for-age (2-12 years), or overweight. #9. The percent of youth aged 12-17 years who report smoking cigarettes in the past 30 days.
	3. Promote responsible sexual behavior to decrease teen pregnancies and sexually transmitted infections.	3. Reduce the adolescent birth rate.	
	4. Decrease mental health problems and substance abuse among children and pregnant and parenting women.		
	5. Improve access to medical and dental services, including the reduction of disparities.	4. Promote safe motherhood by improving early access to and the quality of maternal health care for all women.	

Table 23. Comparison of priority needs from the 2006-2010 and 2001-2005 California Needs Assessments (*continued*)

	2006-2010 Priority Needs	2001-2005 Priority Needs	State Performance Measure 2001-2005
MCAH/OFPP Branch Priority Needs	6. Decrease intentional and unintentional injuries and violence, including family and intimate partner violence.	5. Decrease intentional and unintentional injury death rates among children and adolescents.	#3. The rate of deaths per 100,000 children aged 1 through 4 years caused by drowning in swimming pools.
			#4. The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by homicide.
			#5. The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries
			6. Reduce the prevalence of community, family, and domestic violence.
	7. Promote and increase breastfeeding initiation and duration.	7. Increase breastfeeding rates among newborns.	
CMS Branch Priority Needs	8. Expand the number of qualified providers participating in the CCS program.	8. Improve coordination and outreach with other health programs to facilitate delivery of health care services to Children with Special Health Care Needs.	
	9. Coordinate to develop and implement a system of timely referral between Mental Health, Developmental Services, Special Education, Social Services and CCS system for CCS eligible children.	9. Continue to expand the CCS statewide automated case management and data collection system, CMS Net, to improve tracking and monitoring of services and outcomes for Children with Special Health Care Needs.	#7. The percent of California Children's Services (CCS) enrolled children registered in CMS Net, the statewide automated case management and data collection system for CCS.
	10. Increase the number of family-centered medical homes for children with special health care needs and the number and percent of CCS children who have a designated medical home.	10. Improve access to quality primary and specialty care providers, including dental, for all children, particularly Children with Special Health Care Needs.	

NEXT STEPS

MCAH/OFP Branch Next Steps

While the seven MCAH priority needs will remain in place for the next five years from 2006-2010, the MCAH/OFP Branch is making plans for an ongoing needs assessment process. The goal is to have continuously updated knowledge of the needs, problems, and capacity of local MCAH jurisdictions and the MCAH/OFP Branch.

Action Plans

During the next year, the Branch will determine the action plans that will best respond to each of the seven priority needs. The capacity assessments will be considered, along with the selected priority needs, in the design of the action plans. This process will be facilitated by those in the MCAH/OFP Branch most familiar with the administration and function of Branch programs. The assigned committee will use the CAST-5 Action Planning Worksheet.

State Performance Measures

Concurrent with the development of the Action Plans, the Branch will determine new State Performance Measures (SPMs) that respond to the problems and goals reflected in the seven new priority needs. This process will include a review of existing data sources and the development of new data sources.

Other ongoing steps

A draft report summarizing the results of the Five Year Needs Assessment has been prepared for distribution to the local MCAH jurisdictions and stakeholders. Data and other information for each of the priority areas will be prepared and posted on the MCAH/OFP Branch web site for public use.

The Branch will partner with local jurisdictions to improve ongoing needs and capacity assessment efforts. The Branch will also obtain feedback from local MCAH jurisdictions about the Needs Assessment process. What worked well? What could be improved? This feedback will be used in the planning of the next needs assessment in 2010.

The Needs Assessment process strengthened relationships between the Branch and local jurisdictions, stakeholders, and other state agencies. For example, the Branch is working in partnership with the Department of Mental Health to identify a validated depression module to add to the California Women's Health Survey in 2006. This will provide a population-based indicator of the rate of depression among the state's adult female population.

CMS Branch Next Steps

CMS Branch will be working in partnership with the Champions for Progress project to develop an action plan to address the priority areas identified in this needs assessment process. The same stakeholder group will be utilized to formulate this strategic plan and to develop performance measures and evaluation methodology. In addition, the California Medical Home Project has recently received an Integrated Services Grant from HRSA that will allow the Branch to continue to oversee the progress of these efforts.

One of the outcomes of this needs assessment process is identifying the need for data development. Several problems were encountered in conducting the needs assessment, including limited data available specific to the CCS enrolled and eligible population, lack of standard definitions and consistency in the entry of data in CMS Net data fields, and lack of availability of data on the CCS population over time and across the multiple agencies serving these children. There were also the differences between the Federal HRSA definition of CSHCN and California's narrower focus on the CCS subset of CSHCN, and in defining a medical home.

CMS is currently working on expanding and improving the CMS Net information system. At the April 28, 2005 meeting, the stakeholders were asked to identify data issues and data development recommendations relevant to the priority objectives that were identified at the meeting. At the conclusion of the data development discussion, it was agreed that the first CCS data development step will be to develop a matrix of the data available for children covered by CMS/CCS. The notes from the meeting are included as *Appendix 21*.

The following data development recommendations are based on the experiences and challenges of this year's needs assessment process:

CMS Net Data

Examine data and monitor service delivery disparities by race and age

- As noted in the National Survey of CSHCN, there are often disparities between different race/ethnic and age groups when it comes to having a medical home or having services organized in a way that makes them easy to access or use. It is important to examine CMS Net data by race/ethnic groups to identify, address, and monitor race/ethnic disparities in care for CCS children.
- Anecdotal data indicates there is an access problem for older teens and young adults, ages 17-21 years. Unfortunately, the data sources used for this needs assessment do not evaluate this issue. It may be possible to analyze CMS Net data by age to identify delays in accessing services for this population. Data sources to monitor progress in this area need to be developed.

Regularly update diagnosis data

- It is difficult to get an accurate picture from the CMS Net data of the medical conditions affecting CSHCN because the diagnosis fields are not consistently updated when diagnoses are modified or when new conditions are identified. These fields should be updated on a regular basis to reflect changes in medical condition or a new diagnosis.

Implement AAP Medical Home definition and expand data collection fields

- To achieve the goal of all CSHCN having a medical home, it will be important to implement the AAP definition of medical home and train county personnel and those

doing data entry for CMS Net to use the AAP definition. Separate fields in CMS Net for primary care physicians, specialists, and medical home should be created in recognition that having a medical home is not the same as having a primary care provider and that many physicians are not providing the level of care coordination necessary to meet the AAP definition of medical home. There should also be a mechanism for regularly updating medical home information.

Collect data on the percent of children participating in the CCS program who receive preventive services (e.g., immunization, well child exams)

- For this current needs assessment, there were no data available to evaluate the regularity at which children served by the CCS program are receiving regular preventive services.

State Performance Measures

Implement the AAP definition of Medical Home in State Performance Measures

- Implement the AAP definition of medical home and have State Performance Measure #5 reflect that definition. It would be useful to expand the number of items used to assess whether or not a child has a medical home, as is done in the National CSHCN Survey.

Develop measures to monitor timely authorizations and eligibility determinations

- Consider creating a new performance measure based on to-be-established goals for times between determination of eligibility and authorization for services and from referral to determination of eligibility for services (i.e., eligibility determination shall be made within one week). Then, for future needs assessments, the data can be examined by County to see what percentage of CCS cases met this goal.

CCS-Paneled Physicians

Restructure and regularly update the database

- Standardize the database of CCS-paneled physicians in terms of county names and specialties. Establish a mechanism to indicate whether or not each CCS-paneled physician is willing to take new clients. Regularly update the database and determine why there is so little consistency with the list of Board Certified Physicians in California.

Future Needs Assessments

Increase the California sample size for the National CSHCN Survey

- To better understand how well California is meeting the needs of all its CSHCN, it would be useful to have additional respondents in California to the National Survey of CSHCN so that data may be examined for specific subsets of the population (i.e., different race/ethnic groups).

Establish baseline data

- Utilize the data collected for the current needs assessment as baseline measures to be used for comparisons and analysis of trends in future needs assessments. When implementing new data elements/fields, establish a baseline as soon as possible.

Develop and monitor outcomes data

- Identify measurable outcomes to monitor the quality of services for CCS enrolled children.

GLOSSARY OF ACRONYMS AND ABBREVIATIONS

<u>A</u>	AAA	Associate Administrative Analyst
	AAP	California District of the American Academy of Pediatrics
	AB	Assembly Bill
	AC	Account Clerk
	ACIP	National Advisory Committee on Immunization Practices
	ACOG	American College of Obstetrics and Gynecology
	AFP	Alpha Feto Protein
	AFLP	Adolescent Family Life Program
	AGPA	Associate Governmental Program Analyst
	AHC	Adolescent Health Collaborative
	AHPA	Associate Health Program Advisor
	AIDS	Acquired Immune Deficiency Syndrome
	AIHHI	American Indian Infant Health Initiative
	AIM	Access for Infants and Mothers
	ALL	Acute lymphoblastic (lymphocytic) leukemia
	AMCHP	Association of Maternal and Child Health Programs
	APN	Advanced Practice Nursing Program
	ASPPP	Adolescent Sibling Pregnancy Prevention Program
	AT	Account Technician
	ATS	Asthma Treatment Services
	AVSS	Automated Vital Statistics System
<u>B</u>	BEST-PCP	Behavioral, Emotional, and Social Screening and Treatment for Primary Care Providers
	BFHI	Baby Friendly Hospital Initiative
	BIH	Black Infant Health
	BMI	Body Mass Index
	BT	Bioterrorism
	BTS	Back to Sleep
	BWSP	Battered Women Shelter Program
<u>C</u>	CA	State of California
	CA EXEC	California Executive Branch
	CAA	Certified Application Assistants (for Medi-Cal & Healthy Families)
	CAI	Childhood Asthma Initiative`
	Cal Works	California's cash assistance program for children and families
	CalPERS	California Public Employees Retirement System
	Cal-SAFE	California School Age Families Education
	CAN	California Association of Neonatologists
	CATS	Common Application Transaction System
	CBDMP	California Birth Defects Monitoring Program
	CCCIP	California Center for Childhood Injury Prevention
	CCFC	California Children and Families Commission
	CCG	Community Challenge Grants
	CCHA	California Children's Hospital Association
	C-CHIP	County Children's Health Insurance Program
	CCLDMCA	California Conference of Local Directors of Maternal, Child & Adolescent Health
	H	
	CCLHO	California Conference of Local Health Officers
	CCS	California Children's Services
	CDAPP	California Diabetes and Pregnancy Program
	CDC	Centers for Disease Control and Prevention
	CDDPP	Children's Dental Disease Prevention Program

CDE California Department of Education
 CDHI Children's Dental Health Initiative
 CDRT Child Death Review Team
 CHCA California Health Care Association
 CHDP Child Health and Disability Prevention
 CHEAC County Health Executives Association of California
 CHIS California Health Interview Survey
 CHKS California Healthy Kids Survey
 CHLA Children's Hospital Los Angeles
 CIPP Childhood Injury Prevention Program
 CIPPP Center for Injury Prevention Policy and Practice
 CISS Community Integrated Services System
 CLASP California Liaisons for Adolescent Suicide Prevention
 CLPP Childhood Lead Poisoning Prevention program
 CMA California Medical Association
 CMAC California Medical Assistance Commission
 CMS Children's Medical Services
 CNM Certified Nurse Midwife
 COHP California Oral Health Partnership
 COPI California Obesity Prevention Initiative
 CPCA California Primary Care Association
 CPeTS California Perinatal Transport Systems
 CPHW Comprehensive Perinatal Health Worker
 CPQCC California Perinatal Quality Care Collaborative
 CPSP Comprehensive Perinatal Services Program
 CQI Continuous Quality Improvement
 CRISS Children's Regional Integrated Service Systems
 CSHCN Children with Special Health Care Needs
 CSS California Student Study
 CSTS California Student Tobacco Survey
 CWHS California Women's Health Survey
 CY Calendar Year

D DARE Data Analysis, Research and Evaluation
 DDS Department of Developmental Services
 DHF Dental Health Foundation
 DHS Department of Health Services
 DMH Department of Mental Health
 DOE Department of Education
 DOF Department of Finance
 DOT Department of Transportation
 DSS Department of Social Services
 DTP/DtaP/ Diphtheria and tetanus toxoids and pertussis vaccine/diphtheria and tetanus toxoids
 DT
 DUI Drinking under the influence
 DV Domestic Violence

E EHIB Environmental Health Investigations Branch
 EIS Epidemic Intelligence Service Officer
 EPIC Epidemiology and Prevention for Injury Control Branch
 EPO Emergency Preparedness Office
 EPSDT Early and Periodic Screening, Diagnosis and Treatment

F Family Family Planning, Access, Care & Treatment

	PACT.	
	FASD	Fetal Alcohol Spectrum Disorder
	FCC	Family Centered Care
	FFY	Federal Fiscal Year (October 1 - September 30)
	FHOP	Family Health Outcomes Project
	FIMR	Fetal Infant Mortality Review
	FPL	Federal Poverty Level
	FRCN	Family Resource Center Network
	FY	State Fiscal Year (July 1 - June 30)
<u>G</u>	GDB	Genetic Disease Branch
	GHPP	Genetically Handicapped Persons Program
	GIS	Geographic Information Systems
	GPRA	Government Performance and Results Act
<u>H</u>	HA	Health Assessment
	HAGs	Health Assessment Guidelines
	HCC	Hearing Coordination Center
	HCCA	Healthy Child Care America
	HCFA	Health Care Finance Agency
	HCPCFC	Health Care Program for Children in Foster Care
	HEC	Health Education Consultant
	HEDIS	Health Plan Employer Data and Information
	HF	Healthy Families -- California's State Children's Health Insurance Program
	HHSA	Health and Human Services Agency
	Hib	Haemophilus Influenzae type b vaccine
	HIPAA	Health Insurance Portability and Accountability Act
	HIPC	Health Insurance Plan of California
	HIV	Human Immunodeficiency Virus
	HMO	Health Maintenance Organization
	HP	Healthy People
	HPM	Health Program Manager
	HPS	Health Program Specialist
	HRIF	High Risk Infant Follow-up
	HRSA	Health Resources and Services Administration
	HS	Healthy Start
	HSCI	Health Status Capacity Indicator
<u>I</u>	I&E	Information and Education Program
	ICD	International Classification of Diseases
	IPODR	Improved Perinatal Outcome Data Reports
	IPP-DV	Intimate Partner Physical Domestic Violence
	ISIS	Integrated Statewide Information System
	ITS	Information Technology Section
	IZ	Immunization Branch, DHS
<u>L</u>	LBW	Low Birthweight (<2500 grams)
	LEP	Limited English Proficiency
<u>M</u>	M&T	Maintenance and Transportation
	MCAH	Maternal, Child, and Adolescent Health
	MCH	Maternal and Child Health
	MCHB	Maternal and Child Health Bureau (Federal Agency)
	MCAH-Epi	MCAH/OFP Branch Epidemiology and Evaluation Section

MCAH/OFP Maternal, Child and Adolescent Health and Office of Family Planning Branch
MCMC Medi-Cal Managed Care
MCV Measles-containing vaccine
MHSA Mental Health Services Act
MIHA Maternal and Infant Health Assessment
MIP Male Involvement Program
MIS Management Information System
MMCD Medi-Cal Managed Care Division
MOD March of Dimes
MOU Memorandum of Understanding
MQC Maternal Quality Collaborative
MQI Maternal Quality Improvement
MRMIB Managed Risk Medical Insurance Board
MS/MS Tandem Mass Spectrometry
MTC Medical Therapy Conference
MTP Medical Therapy Program
MTUs Medical Therapy Units
MVIP Medically Vulnerable Infant Program

N NAHIC National Adolescent Health Information Center
NBS Newborn Screening
NC Nurse Consultant
NCHAM National Center for Hearing Assessment and Management
NHSP Newborn Hearing Screening Program
NHTSA National Highway Traffic Safety Administration
NICU Neonatal Intensive Care Unit
NIS National Immunization Survey
NPM National Performance Measure
NTD Neural Tube Defect
NUPA Nutrition and Physical Activity

O OA Office Assistant
OBRA Omnibus Budget Reconciliation Act
ODHS Office of Dental Health Services
OFP Office of Family Planning
OHAI Oral Health Access Initiative
OHC Other Health Coverage
OHNA Oral Health Needs Assessment
OMDS Office of Medi-Cal Dental Services
OOH Office of Oral Health
OSHPD Office of Statewide Health Planning and Development
OSS Office Services Supervisor
OT Occupational Therapy
OT Office Technician
OTS Office of Traffic Safety

P PANCC Physical Activity and Nutrition Coordinating Committee
PCFH Primary Care and Family Health Division
PCI Preconception Care Initiative
PCP Primary Care Provider
PDS Program Development Section
PedNSS Pediatric Nutrition Surveillance System
PHI Public Health Institute
PICU Pediatric Intensive Care Unit

PHMA Public Health Medical Administrator
 PHMO Public Health Medical Officer
 PHNC Public Health Nurse Consultant
 PHNs Public Health Nurses
 PHSWC Public Health Social Work Consultant
 PKU Phenylketonuria
 PL Public Law
 POE Perinatal Outreach and Education
 POS Program Operation Section
 PPOR Perinatal Periods of Risk
 PQIP Perinatal Quality Improvement Panel
 PRAMS Pregnancy Risk Assessment Monitoring System
 PS Prevention Specialist
 PSQA Program Standards and Quality Assurance
 PSS Program Support Section
 PT Physical Therapy

R RA Research Analyst
 RFA Request for Application
 RM Research Manager
 ROS Regional Operations Section
 RPPC Regional Perinatal Programs of California
 RPS Research Program Specialist
 RS Research Scientist

S SCCs Special Care Centers
 SCHIP State Children's Health Insurance Program
 SDSU San Diego State University
 SECCS State Early Childhood Comprehensive Systems
 SED Serious Emotional Disturbance
 SELPA Special Education Local Planning Areas
 SHC School Health Connections
 SIDS Sudden Infant Death Syndrome
 SIIS Statewide Immunization Information System
 SMI Serious Mental Illness
 SPM State Performance Measure
 SPS Statewide Programs Section
 SRI School Readiness Initiative
 SRO Sacramento Regional Office
 SSA Staff Services Analyst
 SSDI State System Development Initiative
 SSI Supplemental Security Income
 SSM Staff Services Manager
 STD Sexually Transmitted Disease
 SIT State Interagency Team
 STT Steps to Take

T TAC Technical Advisory Committee
 TANF Temporary Assistance to Needy Families
 TASK Team of Advocates for Kids
 TCS Tobacco Control Section
 TSO Teen Smart Outreach

U UAP University of Southern California University Affiliated Program

	UC	University of California
	UCB	University of California, Berkeley
	UCD	University of California, Davis
	UCLA	University of California, Los Angeles
	UCSF	University of California, San Francisco
	USC	University of Southern California
	USPHS	United States Public Health Service
	U/U	Unserved/Underserved
<u>V</u>	VFC	Vaccines for Children
	VLBW	Very Low Birthweight (<1500 grams)
	VOSP	Vehicle Occupant Safety Program
<u>W</u>	WIC	Women, Infants, and Children Supplemental Nutrition Program
	WISH	Workshop for Interagency School Health
	WPT	Word Processing Technician
<u>Y</u>	YMAC	Young Mothers Advisory Council of San Mateo County
	YPP	Youth Pilot Program
	YRBS	Youth Risk Behavior Survey

APPENDICES

California MCH Five Year Needs Assessment

Guidelines & Indicator List for MCAH Jurisdictions

State of California Department of Health Services, Maternal and Child Health
Branch
Family Health Outcomes Project, University of California San Francisco

Contact

Geraldine Oliva, M.D., M.P.H.
fhop@itsa.ucsf.edu
<http://www.ucsf.edu/fhop>
(415) 476-5283

Maternal and Child Health Community Health Assessment and Local Plan Development Guidance August, 2003

I. Background

The Federal Maternal and Child Health (MCH) Bureau requires all states receiving Title V Block Grant funding to submit a statewide needs assessment every five years. The MCH population that this assessment process addresses includes: (1) pregnant women, mothers, and infants up to age one; and (2) children (including adolescents).

California is unique among the states in terms of its size and diversity of population, geography, and maternal and child health needs. Therefore, the State MCH Branch depends on receiving input from all of its 61 local MCH jurisdictions in order to produce a comprehensive analysis that describes the State's various public health issues and unmet needs, some of which may be specific to a given area. The purpose of this document is to help your local MCH jurisdiction to produce a succinct yet thorough needs assessment and action plan for meeting those needs.

Your local assessment is to be completed under the direction of the MCH Director in collaboration with the Health Officer, MCH program coordinators, and all appropriate public and private organizations. The local MCH community needs assessment report for the next five year cycle (2005-2009) must be submitted to the Family Health Outcomes Project by **June 30, 2004**.

After completion of the needs assessment, each jurisdiction is responsible for preparing an action plan that maps out the steps to address the identified needs. Your progress toward those goals will be monitored as part of the justification for program activities in the annual MCH Application for Allocation. Supplemental guidelines for the action plan will be forthcoming. The action plan is due **June 30, 2005**.

II. Guidelines and Technical Assistance

The Family Health Outcomes Project (FHOP) will provide you with health status indicator data to minimize the local jurisdiction data collection burden and to ensure standardized reporting and analysis. In order to support the completion of your five year needs assessment, FHOP will:

- Serve as the contact to respond to questions and provide technical assistance related to the five year needs assessment and action plan;
- Provide feedback on draft assessments and plans;
- Provide on its website standardized data for the indicators that the jurisdictions are required to review;
- Provide on its website the revised [Developing an Effective Planning Process: A Guide for Local MCH Programs \(March 2003\)](#). The guide provides a step-by-step process of community assessment and plan development;
- Provide updates in the FHOP newsletter on newly available data and assessment tools;

- Continue to provide training relevant to the assessment and planning process.

FHOP contact information

Central telephone: (415) 476-5283
FAX number: (415) 502-0848
E-mail: fhop@itsa.ucsf.edu
Website: <http://www.ucsf.edu/fhop>

III. The Planning and Assessment Process

The five year needs assessment document should not exceed 32 pages, plus any additional priority problem analyses and appendices. We urge MCH Directors and staff to refer to and use the FHOP website frequently during the process in order to access data, the planning guide [Developing an Effective Planning Process: A Guide for Local MCH Programs \(March 2003\)](#)^{*}, and other helpful materials and tools.

See the attached MCH Five Year Needs Assessment Report Outline for the required report content and format. We recommend preparing the report, as much as possible, as the assessment process proceeds and produces data and decisions.

^{*}[Developing an Effective Planning Process: A Guide for Local MCH Programs \(March 2003\)](#) is referred to throughout this guidance as “the planning guide.” Where a “Chapter” is referred to, it is a chapter of the planning guide.

MCH Five Year Needs Assessment Report Outline

The following is an outline of the recommended content and format for the MCH Five Year Needs Assessment Report. Voluminous narrative reporting is not encouraged; rather, use tables and bulleted information wherever appropriate. Suggested page limits are included. The planning guide¹ chapter references are included to provide additional guidance as needed. In some sections a paragraph is included to describe the planning process that would contribute to the content of the section.

The report should have seven sections:

- I. Summary/Executive Report
- II. Description of the MCH Community Health Assessment Process
- III. MCH Planning Mission Statement and Goals
- IV. MCH Community Assessment
- V. Priority MCH Problems/Needs in the Jurisdiction
- VI. Preliminary Problem Analysis for the Identified Local Priority Problems
- VII. Appendices

Section details:

I. *Summary/Executive Report (1-2 pages)*

This section should include:

- A. Purpose of the assessment
- B. Description of the assessment and prioritization process
- C. Mission and goals agreed upon by the planning group
- D. Highlights of the assessment findings
- E. Priority MCH problems/needs

II. *Description of the MCH Community Health Assessment Process (1-3 pages)* ***Reference: Chapter I***

This section should:

- A. Describe the planning group/how it was recruited/selected
- B. Describe what or how partnerships/collaborations were used
- C. Briefly describe the planning processes
- D. Describe how community input was obtained

Process: Convene a planning group to conduct an inclusive assessment and planning process. Local jurisdictions are required to obtain public input into its MCH assessment, including input from citizens and family members. The jurisdiction may obtain this input in several ways. A broadly representative planning group or collaborative of stakeholders that includes consumers and advocates is recommended to meet this requirement. Alternatively, the local MCH program

¹Developing an Effective Planning Process: A Guide for Local MCH Programs (March 2003) is referred to throughout this guidance as “the planning guide.” Where a “Chapter” is referred to, it is a chapter of the planning guide.

may be able to partner or build upon other collaborative efforts to assess community needs. See Chapter I for guidance about forming and facilitating a planning group and for alternative options.

III. *MCH Planning Mission Statement and Goals (1 page) Reference: Chapter I*

This section should:

- A. Briefly describe the process for developing the Mission and Goals
- B. Present the MCH Mission and Goals

Process: The planning group should review any previous mission and goals and establish the current MCH mission and goals to guide the work of the assessment.

IV. *MCH Community Assessment (25 page maximum) Reference: Chapter II*

This section should include:

A. *Community health profile (2-5 pages) Reference: Chapter II*

1. The profile should include indicators of the overall population's socio-demographic status, health status, health risk factors, and access to health and social services. It provides the context in which MCH population health needs will be identified and will highlight factors (e.g., geographic, political or social) that need to be considered when responding to health problems.
2. Some jurisdictions may be conducting an assessment of community assets to identify the resources and strengths within a community. If a community assets assessment has been done, summarize the findings. Alternatively, if your local Public Health Department is implementing the "Mobilization for Action through Planning and Partnership (MAPP)" planning process you may wish to use the process and data specific to the MCH community profile in this section.
3. See Chapter II for guidance on content and the FHOP website for community health profile examples.

B. *Community resources assessment (1-4 pages) Reference: Chapter II*

1. For each of the two MCH populations: 1) pregnant women, mothers, and infants up to age one; and 2) children (including adolescents):
 - a. Identify concerns regarding access to health care and health-related services from the perspectives of financial access, cultural acceptability, availability of prevention and primary care services, and availability of specialty care services when needed.
 - b. Assess and describe the availability of care. Discuss, as appropriate, shortages of specific types of health care providers, such as primary care physicians, nutritionists, public health or visiting nurses, etc. This should not be a list of providers and services, but rather should identify gaps and needs. A table, chart or map of the resources can be included as an appendix. See Chapter II for guidance on content and the FHOP website for examples.
 - c. One way to do this would be to update the previous MCH Five Year Needs Assessment "Health Services Systems Profile" or a description of community resources recently done in the county for another purpose. Alternatively, if your local Public Health

Department is implementing the “Mobilization for Action through Planning and Partnership (MAPP)” planning process you may wish to use the process/data specific to the MCH community resources assessment in this section.

C. Review the State required MCH indicators (See Appendix A) (2-7 pages)

1. Provide a list and a discussion of the required indicators (Appendix A) that you identify as local MCH problem areas based on quantitative and qualitative analyses.
 - a. Quantitative Analysis. For each indicator, review the data available under *California MCH Data* on the FHOP website for the jurisdiction. Using this data:
 - i. For each indicator, compare your local values with the standards provided, which will be the Healthy People 2010 goal and/or Statewide data. Include a test for statistical significance (as small number limitations allow). Complete and include, in an appendix to this section, the required form comparing local data to Healthy People 2010 or Statewide data. (The required form will be available on the FHOP website in August.)
 - ii. Analyze the data for significant differences among subgroups or trends over time. In the report, comment on the significance of observed trends and any differences observed in age or racial subgroups for each required indicator. At least five years of data are required to assess trends. Refer to FHOP’s new guidelines [Do We Have a Trend? A Beginner’s Guide to Analysis of Trends in Community Indicators](#) that is posted on the FHOP web site under Reports/Guidelines. This document describes how to review indicator data over time, use an EXCEL function to select an appropriate trend line, and determine the significance of a trend. In the fall, FHOP will begin to post EXCEL tables that contain updated information for the required indicators overall and for age and race/ethnic subgroups where possible and relevant, along with rates and confidence intervals. For the major summary indicators (e.g. infant mortality, LBW) trend graphs with confidence intervals will be produced. In addition, FHOP’s EXCEL data templates can be used to analyze indicator data and produce graphics for those indicators not included in the FHOP tables, or for subgroups in the tables for which trend graphs were not produced. **NOTE** that counties with fewer than 10 cases over three years for any of the indicators should not use the templates for those indicators and will not be able to adequately assess trends. These counties can use raw numbers and case review or qualitative data to describe the situation in the county regarding these areas
 - iii. Indicators that are significantly worse than the standard, or that have significant downward trends, should be included in the list of MCH problems from which the planning group selects the local priority problems. If available, data from other sources, such as locally conducted surveys, can also be considered in the quantitative analysis.
 - b. Qualitative Analysis

- i. Include a review of any qualitative data collected from individuals and organizations with an understanding of the health needs of the community and the barriers to obtaining better public health. Report the results of qualitative needs analysis methods and describe how these results confirm, conflict with, or enhance the results of the quantitative analysis.

D. *Optional Topics (1-4 pages) Reference: Chapter II*

1. Provide a list and discussion of additional MCH indicators or topics, such as those listed at the end of Appendix A, that you identify as local problem areas as a result of the local community planning group's process or other method (see Chapter II). Include a summary analysis for each identified area. Include identified issues in the list of MCH problems.

E. *Assessment of MCH capacity (1-4 pages) Reference: FHOP Website*

1. Provide a summary description of your local MCH program capacity. Determine the capacity of the local MCH program for carrying out the core MCH activities. These include the ability to:
 - a. monitor local MCH population health status;
 - b. diagnose and investigate MCH problems in the community;
 - c. inform, educate and empower people about MCH issues;
 - d. mobilize community partnerships to identify and solve MCH-related problems;
 - e. develop policies and plans that support MCH related health efforts;
 - f. link women and children to needed health and social services;
 - g. evaluate the effectiveness, accessibility and quality of MCH population-based health services.
2. Assess the cultural competency of your MCH program.
3. Briefly describe current issues in the public and/or private health care sector that have an impact on the MCH program's roles.
4. We recommend using the tool provided on the FHOP website (available in September) to assist your assessment. If your local Public Health Department is implementing the "Mobilization for Action through Planning and Partnership (MAPP)" planning process you may wish to summarize the process/data specific to the MCH capacity assessment in this section.

F. *Identification of the Problems/Unmet Needs of the Local MCH Population (1-3 pages) Reference: Chapter II*

1. Synthesize the findings from sections A-E above.
 - a. This should include assessment of major morbidity, mortality, health and other related risk factors, protective factors, gaps and disparities.
 - b. Identify major problem areas within the MCH population as a whole and for significant sub-populations. Where possible, examine issues by race/ethnicity, age, health insurance status, type of health insurance, socioeconomic status and/or subcounty geographic area (zip code or census).
 - c. Identify the unmet needs/problems of:
 - i. pregnant women, mothers, and infants;
 - ii. children, including adolescents.
 - d. Present major findings in a bulleted or other summary format.

Process: Generally, MCH staff will develop the community profile, the community resource assessment and the local MCH capacity assessment. We recommend that where possible you begin with previous MCH profiles or assessments or those recently done in the county for another purpose. Staff (this may be in conjunction with a workgroup of the planning group) should review the State's list of required MCH indicators and optional indicator/assessment areas. For each required indicator, review the jurisdiction's data as described above. The results of the analysis of the indicator data should be reviewed by the planning committee and included in the local assessment report. The planning group may identify additional MCH indicators relevant to local problems/needs or conduct assessments such as surveys to assist in assessing community health and health systems status. Both quantitative and qualitative data may be collected. Refer to Chapter II for a complete description of the process of identifying and selecting indicators and for tools that may assist you. The results of the analysis of the data compiled should be organized in a user friendly presentation to be reviewed by the planning group and a summary of significant findings and decisions based on these findings included in the assessment report as outlined above.

V. Priority MCH Problems/Needs in the Jurisdiction (1-2 pages) Reference: Chapter II and its Appendix II-I

This section should:

- A. *Provide the final list of priority problems that will be addressed in the five year plan. Use clearly and plainly stated phrases, such as "The infant mortality rate for minorities should be reduced" or "Reduce the barriers to the delivery of care for pregnant women."*
- B. *Briefly describe the process and rationale used to set priorities among the unmet needs/problems identified*

Process: Set priorities among identified health problems. Present the health problem and service delivery data to the local planning group and have the group select the problems/needs that MCH will address as priorities during the next five year cycle. Use an inclusive process to set 2 to 7 priorities among the identified problems, as appropriate to the size and resources of the jurisdiction. Take into account your MCH program's capacity to achieve selected priorities. To set priorities among the identified problems, use an objective, systematic method such as the suggested prioritization process and tool included in Chapter II, and Appendix II-I. These priorities will receive targeted efforts for improvement and will be addressed in the action plan, the second component of the MCH assessment and planning process (due June 30, 2005).

VI. Preliminary Problem Analysis for the Identified Local Priority Problems. (2-3 pages for each priority problem) Reference: Chapter III

This section should include:

- A. A preliminary problem analysis for at least one identified priority problem. If time and resources permit, prepare a preliminary analysis for each of the priority problems. For each problem analysis done include the following:
 1. A brief statement of the problem and a preliminary problem analysis diagram. The diagram should identify direct precursors (causal factors), secondary precursors (personal, family, institutional and social risk

factors) and tertiary factors (societal factors, systems issues, policies) that contribute to the observed poor outcome or condition as identified in the staff group or a planning group subcommittee designated to review the data

2. Provide a list of the additional data/information the group identified as needed to understand the contributors to the problem or to identify effective interventions (i.e., additional data about the population most affected by or at risk for the problem or research about potential intervention points in the causal pathways and interventions) If there is a data collection/research plan include it as an appendix to this section
- B. If your group is able to compile the additional data and research and continue with the process during this assessment year, summarize the result of the problem analysis process. In this case, include the final problem analysis diagram showing the selected causal pathway or pathways and intervention points for which interventions will be developed. Include a summary explanation. If the group does not get this far along in the process, it will be included in your next year's report/plan.

Process: The planning group should be involved in developing a preliminary problem analysis for at least one of your priority problems. Refer to Chapter III to review the components of the facilitated problem analysis process. With your planning group, use the assessment data to draft the problem analysis diagram. Where data are not available, brainstorm other factors from the planning group member's experience or from review of research and best practices literature. Develop a plan to complete the data collection and to do a literature or web review of the problem, its precursors, and potential interventions. This will give you a head start on the planning activities you will have to complete in the next funding year.

VII. Appendices

Include appendices as indicated above and any other materials that you wish to be reviewed

Required Indicators

Birth

1. Number of births & fertility rates	Birth file
2. Number and teen birth rate per 1,000 females	Birth file
a) age 12-14	
b) age 15-17	
c) age 18-19	
d) age 15-19	
3. Number & percent low birth weight (live births)	Birth file
4. Number & percent very low birth weight (live births)	Birth file
5. Number & percent preterm births (less than 37 weeks gestation)	Birth file
6. Number & percent of births occurring within 24 months of a previous birth	Birth file
a) entire population	
b) age 12-19	
7. Number & percent of teen births to women who were already mothers	Birth file

Death

8. Perinatal death rate	Fetal Death & Death file
9. Neonatal deaths (#) and death rate (per 1,000 live births) [<i>birth - <28 days</i>]	Death file
10. Post-neonatal deaths (#) and death rate (per 1,000 live births) [<i>>=28 days - 1 year</i>]	Death file
11. Infant deaths (#) and death rate (per 1,000 live births) [<i>birth - 1 year</i>]	Death file
12. Deaths (#) and death rate per 100,000	Death file
a) age 1-14	
b) age 15-19	

Prenatal/postnatal care

13. Number & percent prenatal care in first trimester (live births)	Birth file
14. Number & proportion of women (age 15-44) with adequate prenatal care (Kotelchuck index)	Birth file
15. Percent of women exclusively breastfeeding at the time of hospital discharge	Genetic Disease

Health	
16. Percent of children and adolescents without health insurance (age 0-18)	CHIS
17. Percent of children without dental insurance (age 2-11)	CHIS
18. Percent of children who have been to the dentist in the past year (age 2-11)	CHIS
19. Percent of children and adolescents youths who are overweight	CHDP
a) age 5-11	
b) age 12-19	
20. Rate of children hospitalized for asthma per 10,000 children	OSHPD
a) age < 4	
b) age 5-18	
21. Rate per 1,000 women aged 15-19 with a reported case of chlamydia	STD Branch
22. Rate of children hospitalized for mental health reason per 10,000 children	OSHPD
a) age 5-14	
b) age 15-19	
Injuries	
23. Number and rate of hospitalizations for all non-fatal injuries, by age group	OSHPD
a) age <=14	
b) age 15-24	
24. Rate of non-fatal injuries due to motor vehicle accidents	OSHPD
a) age <= 14	
b) age 15-24	
Other	
25. Number of children living in foster care	DSS
26. Percent of children in poverty (age 0-19)	Census 2000 DOF
27. Percent of women 18 years or older reporting intimate partner physical abuse in the last 12 months	California Women's Health Survey

Optional Topics

MCH jurisdictions may want to consider including a discussion of other maternal and child health topics in your needs assessment reports. Examples of optional topics are shown below. FHOP is investigating data availability for some of these optional topics; if and when these data become available, jurisdictions will be notified. If your jurisdiction has done research or surveillance on these or other topics that are locally important, a discussion of the findings would be very helpful to the State in its Statewide assessment.

1. Percent of children/adolescents who report at least 20 minutes of physical activity 3 or more days per week.
Note: The California Department of Health Services Physical Activity Guidelines for Children, Youth and Adults recommends that "Elementary school children should accumulate at least 30-60 minutes of age and developmentally appropriate physical activity on all or most days of the week," and "Adolescents should engage in at least 60 minutes of moderate to vigorous physical activity per day on most days of the week. Thirty minutes of physical activity per day should be viewed as a minimum. One hour per day represents a more favorable level."

2. Number & percent of children 19 to 35 months of age who have received full schedule of age appropriate immunizations.

3. Incidences of vaccine-preventable diseases.

4. Indicators of mental health problems, e.g., suicide, depression, etc.

5. Rates/issues regarding perinatal substance abuse.

6. Rates/issues regarding gestational diabetes.

7. Issues regarding oral health, such as rates of sealant application in children, access to dental care, rate of children who have seen a dentist prior to starting school, etc.

8. Indicators of youth resiliency, such as a close relationship with a caring adult, high expectations, and opportunities for meaningful participation.

9. Others?

Data Source Glossary

CHIS: California Health Interview Survey

OSHPD: Office of Statewide Planning and Development

DSS: Department of Social Services

DOF: Department of Finance

Appendix 2:

10 MCH Essential Services and Public MCH Program Functions (Detailed List)

1. Assess and monitor maternal and child health status to identify and address problems.
 - A. Develop frameworks, methodologies, and tools for standardized MCH data in public and private sectors.
 - B. Implement population-specific accountability for MCH components of data systems.
 - C. Prepare and report on the descriptive epidemiology of MCH through trend analysis.
2. Diagnose and investigate health problems and hazards affecting women, children, and youth.
 - A. Conduct population surveys and publish reports on risk conditions and behaviors.
 - B. Identify environmental hazards and prepare reports on risk conditions and behaviors.
 - C. Provide leadership in maternal, fetal/infant, and child fatality reviews.
3. Inform and educate the public and families about maternal and child health issues.
 - A. Provide MCH expertise and resources for informational activities such as hotlines, print materials, and media campaigns, to address MCH problems such as teen suicide, inadequate prenatal care, accidental poisoning, child abuse and domestic violence, HIV/AIDS, DUI, helmet use, etc.
 - B. Provide MCH expertise and resources to support development of culturally appropriate health education materials/programs for use by health plans/networks, MCOs, local public health and community-based providers.
 - C. Implement, and/or support, health plan/provider network health education services to address special MCH problems – such as injury/violence, vaccine-preventable illness, underutilization of primary/ preventive care, child abuse, domestic violence – delivered in community settings (e.g., schools, child care sites, worksites).
 - D. Provide families, the general public, and benefit coordinators reports on health plan, provider network, and public health provider process and outcome data related to MCH populations based on independent assessments.
4. Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.
 - A. Provide needs assessment and other information on MCH status and needs to policymakers, all health delivery systems, and the general public.
 - B. Support/promote public advocacy for policies, legislation, and resources to assure universal access to age-, culture- and condition-appropriate health services.
5. Provide leadership for priority-setting, planning, and policy development to support community efforts to assure the health of women, children, youth and their families.
 - A. Develop and promote the MCH agenda using the Year 2000 National Health objectives or other benchmarks.
 - B. Provide infrastructure, communication structures and vehicles for collaborative partnerships in development of MCH needs assessments, policies, services, and programs.

- C. Provide MCH expertise to, and participate in the planning and service development efforts of, other private and public groups and create incentives to promote compatible, integrated service system initiatives.
6. Promote and enforce legal requirements that protect the health and safety of women, children and youth, and ensure public accountability for their well-being.
- A. Ensure coordinated legislative mandates, regulation, and policies across family and child-serving programs.
 - B. Provide MCH expertise in the development of a legislative and regulatory base for universal coverage, medical care (benefits), and insurer/health plan and public health standards.
 - C. Ensure legislative base for MCH-related governance, MCH practice and facility standards, uniform MCH data collection and analysis systems, public health reporting, environmental protections, outcomes and access monitoring, quality assurance/improvement, and professional education and provider recruitment.
 - D. Provide MCH expertise/leadership in the development, promulgation, regular review and updating of standards, guidelines, regulations, and public program contract specifications.
 - E. Participate in certification, monitoring and quality improvement efforts of health plans and public providers with respect to MCH standards and regulations.
 - F. Provide MCH expertise in professional licensure and certification processes.
 - G. Monitor MCO marketing and enrollment practices.
 - H. Provide MCH expertise and resources to support ombudsman services.
7. Link women, children and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.
- A. Provide a range of universally available outreach interventions (including home visiting), with targeted efforts for hard-to-reach MCH populations.
 - B. Provide for culturally and linguistically appropriate staff, materials, and communications for MCH populations/issues, and for scheduling, transportation, and other access-enabling services.
 - C. Develop and disseminate information/materials on health services availability and financing resources.
 - D. Monitor health plan, facility, and public provider enrollment practices with respect to simplified forms, orientation of new enrollees, enrollment screening for chronic conditions/special needs, etc.
 - E. Assist health plans/provider networks and other child/family-serving systems (e.g., education, social services) in identifying at-risk or hard-to-reach individuals and in using effective methods to serve them.
 - F. Provide/arrange/administer women's health, child health, adolescent health, Children with Special Health Care Needs (CSHCN) specialty services not otherwise available through health plans.
 - G. Implement universal screening programs – such as for genetic disorders/metabolic deficiencies in newborns, sickle cell anemia, sensory impairments, breast and cervical cancer – and provide follow-up services.
 - H. Direct and coordinate health services programming for women, children and adolescents in detention settings, mental health facilities and foster care, and for families participating in welfare waiver programs that intersect with health services.
 - I. Provide MCH expertise for prior authorization for out-of-plan specialty services for special populations (e.g., CSHCN).

- J. Administer/ implement review processes for pediatric admissions to long-term care facilities and CSHCN home- and community-based services.
 - K. Develop model contracts to provide managed care enrollees access to specialized women's health services, pediatric centers of excellence and office/ clinic-based pediatric subspecialists and to community-site health services, (school-based health clinics, WIC, Head Start, etc).
 - L. Provide expertise in the development of pediatric risk adjustment methodology and payment mechanisms.
 - M. Identify alternative/ additional resources to expand the fiscal capacity of the health and social services systems by providing MCH expertise to insurance commissions and public health care financing agencies, pooling categorical grant funding, and pursuing private sector resources.
8. Assure the capacity and competency of the public health and personal health workforce to effectively and efficiently address maternal and child health needs.
- A. Provide infrastructure and technical capacity and public health leadership skills to perform MCH systems access, integration, and assurance functions.
 - B. Establish competencies, and provide resources for training MCH professionals, especially for public MCH program personnel, school health nurses and school-based health center providers, care coordinators/ case managers, home visitors, home health aides, respite workers, and community outreach workers.
 - C. Provide expertise, consultation, and resources to professional organizations in support of continuing education for health professionals, and especially regarding emerging MCH problems and interventions.
 - D. Support health plans/networks in assuring appropriate access and care through providing review and update of benefit packages, information on public health areas of concern, standards, and interventions, plan/ provider participation in public planning processes and population-based interventions, technical assistance, and financial incentives for meeting MCH-specific outcome objectives.
 - E. Analyze labor force information with respect to health professionals specific to the care of women and children (e.g. primary care practitioners, pediatric specialists, nutritionists, dentists, social workers, CNMs, PNP's, FFNP's, CHN's/PHN's)
 - F. Provide consultation/ assistance in administration of laboratory capacity related to newborn screening, identification of rare genetic diseases, breast and cervical cancer, STDs, and blood lead levels.
9. Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal and child health services.
- A. Conduct comparative analyses of health care delivery systems to determine effectiveness of interventions and to formulate responsive policies, standards, and programs.
 - B. Survey and develop profiles of knowledge, attitudes and practices of private and public MCH providers.
 - C. Identify and report on access barriers in communities related to transportation, language, culture, education, and information available to the public.
 - D. Collect and analyze information on community/ constituents' perceptions of health problems and needs.
10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related problems.

- A. Conduct special studies (e.g., PATCH) to improve understanding of longstanding and emerging (e.g., violence, AIDS) health problems for MCH populations.
- B. Provide MCH expertise and resources to promote “best practice” models, and to support demonstrations and research on integrated services for women, children, adolescents, and families.

Appendix 3:

**Maternal, Child and Adolescent Health
Needs Assessment Stakeholder Meeting
Invited organizations**

Wednesday, April 6, 2005

Group or Area of focus

Adolescent Family Life Program
American Academy of Pediatrics
American College of Obstetricians and Gynecologists
Birth Defects Monitoring Program
Black Infant Health Program
California Adolescent Health Collaborative
California Conference of Local Health Officials
California Dental Association Foundation
California Family Health Council
California Health Care Foundation
California Hospital Association
California Nursing Association
California Perinatal Quality Care Collaborative
California Public Health Association
California Department of Alcohol and Drug Programs
California Department of Developmental Services
California Department of Education
California Department of Rehabilitation
California Department of Mental Health
California Department of Social Services, Children and Family Services Division
Center for Healthier Children, Families and Communities, UCLA
Center for Injury Prevention Policy and Practice, San Diego State University
Charlotte Maxwell Newhart & Associates
Child Death Review Team
Children Now
Department of Family & Community Medicine, UC San Francisco
Domestic Violence Programs
Epidemiology & Prevention for Injury Control Branch
Fetal and Infant Mortality Review
First 5 Commission
Genetic Disease Branch
Immunizations Branch
Indian Health Program
Institute for Health Policy Studies, UC San Francisco
Kaiser Family Foundation
March of Dimes
MCAH Action Executive Committee
Medi-Cal, SCHIP
Medi-Cal, Oral Health

Office of AIDS
Office of Multicultural Health
Office of Family Planning (OFP)
Office of Women's Health Advisory Group
Office of Oral Health
Pacific Business Group on Health
Planned Parenthood
Primary and Rural Health Care Systems Branch
Regional Perinatal Program Directors
School of Public Health, UC Berkeley
State Council on Developmental Disabilities
STD Control Branch
Sudden Infant Death Syndrome
The ARC of California
Women, Infants and Children (WIC) Branch

Appendix 4:

Maternal, Child and Adolescent Health Needs Assessment Stakeholder Meeting

**Multipurpose Room, 1st Floor,
Secretary of State Building
1500 11th Street (Corner of 11th and O Streets), Sacramento**

Wednesday, April 6, 2005

Agenda

8:15—8:30	Coffee and Refreshments	
8:30—8:45	Overview of the day & Introduction	Gerry Oliva, <i>Family Health Outcomes Project (FHOP)</i>
8:45—9:00	Welcome & Background	Catherine Camacho, <i>Deputy Director, Primary Care and Family Health Division</i>
9:00—9:45	Overview of the Title V Needs Assessment process	Shabbir Ahmad, <i>Maternal, Child and Adolescent Health/Office of Family Planning (MCAH/OFP)</i>
	Description of MCAH Jurisdiction involvement in the Title V Needs Assessment Process	Mike Curtis, <i>MCAH/OFP</i>
9:45—10:00	Description of the methods to be used for selecting and applying criteria	<i>FHOP</i>
10:00—12:30	Criteria for selection of recommended 7 priority needs	<i>Stakeholders/FHOP</i>
12:30	Working lunch served	
12:30—2:15	Data on the potential MCAH priority needs	<i>FHOP</i>
2:15—4:45	Application of criteria to the potential needs	<i>Stakeholders/FHOP</i>
4:45—5:00	Wrap-up	<i>MCAH/OFP Staff</i>

Appendix 5:

MCAH Criteria (April 6, 2005)

1. Criterion Name: Problem has serious health consequences

Weight:

Definition/Concepts: This means that the problem identified could result in severe disability or death.

Rating Scale: 3

- 1= Problem is not life threatening or disabling to individuals or community
- 2= Problem is not life threatening but is sometimes disabling
- 3= Problem can be moderately life threatening or disabling
- 4= Problem can be moderately life threatening but there is a strong likelihood of disability
- 5= Problem has a high likelihood of death and disability

2. Criterion Name: A large number of Individuals are affected by the problem

Weight: 2

Definition/Concepts: This criterion considers the absolute number of people (the MCAH population) affected. It includes the concept that targeting a problem affecting a large number of individuals could have a greater impact on the health of the community than one affecting a relatively small number of people. This criterion is intended to provide a balance for a situation in which a few occurrences of a particular problem in a small group can result in a high rate but in reality the condition may only affect a few individuals in the community, e.g., a geographic area with a very small population and few births that has one teenage pregnancy will result in a high teen pregnancy rate for that geographic area.

Rating Scale:

- 1= Relatively few individuals affected
- 2= Moderate number of individuals affected in particular subgroups
- 3= Moderate number of individuals affected across the entire population
- 4= Large number of individuals affected in particular subgroups
- 5= Large number of individuals affected across the entire population

3. Criterion Name: Disproportionate effects among subgroups of the population

Weight: 2

Definition/Concepts: This means that one or more population subgroups as defined by race, ethnicity, income, insurance status, gender or geography have *statistically* significantly worse indicator values of illness or condition when compared to another group

- 1= No group is disproportionately affected by the problem
- 2= It appears that one or more groups is disproportionately affected by the problem, but differences are not statistically significant
- 3= Statistically significant differences exist in one group and the disadvantaged group is at least 1.25 to 1.75 times more likely to have a poor outcome
- 4= Statistically significant differences exist in more than one group
- 5= Statistically significant differences exist in one or more groups and at least one of the disadvantaged groups is greater than 1.75 times more likely to have a poor outcome

4. Criterion Name: Problem results in significant economic/ social cost

Weight: 1

Definition/Concepts: If problem is not addressed the result will be increased monetary costs, e.g., health care and/or social services costs to society and costs to employers, and or loss of productive individuals because of chronic illness, disability or premature death.

Rating Scale:

- 1= Economic/ societal cost is minimal
- 2= There is some potential increased costs
- 3= There is likely to be moderate increased costs
- 4= There is likely to be substantial increased costs
- 5= There will be great economic and societal cost

5. Criterion Name: Problem is cross-cutting to multiple issues/ life span effect

Weight: 3

Definition/Concepts: Problem at one life stage has long term impact in later life and/or problem is a proxy for a set of other related behavioral or social problems.

Rating Scale:

- 1= Problem limited to one life stage and is not associated with other problems
- 2= Problem minimally impacts entire life course and is associated with multiple problems
- 3= Problem moderately impacts entire life course and is associated with multiple problems
- 4= Problem severely affects either entire life course or is associated with multiple problems
- 5= Problem severely impacts entire life course and is associated with multiple problems

Appendix 6:

MCAH Priority Rating Tool

CRITERION #1: PROBLEM/ISSUE HAS SEVERE HEALTH CONSEQUENCES	CRITERION #5: PROBLEM IS CROSS-CUTTING TO MULTIPLE ISSUES/ LIFE SPAN EFFECT							
CRITERION #2: LARGE # OF INDIVIDUALS ARE AFFECTED BY THE PROBLEM								
CRITERION #3: DISPROPORTIONATE EFFECTS AMONG SUBGROUPS OF THE POPULATION								
CRITERION #4: PROBLEM RESULTS IN SIGNIFICANT ECONOMIC/ SOCIAL COST								
Problem/Issue	In the line below each criterion number (e.g. C1), the assigned weight is Then, For each problem, score each criterion (1 through 5) and multiply the score by the assigned weight. Add weighted criterion scores to obtain Total Score for Problem.							Total Score For Problem
	C1	C2	C3	C4	C5	C6		
	3	2	2	1	3			
1. Overweight								
2. Substance Abuse								
3. Domestic Violence								
4. Prenatal Care								
5. Access to Care								
6. Birth Outcomes/Mortality								
7. Teen Births								
8. Breastfeeding								

CRITERION #1: PROBLEM/ISSUE HAS SEVERE HEALTH CONSEQUENCES	CRITERION #5: PROBLEM IS CROSS-CUTTING TO MULTIPLE ISSUES/ LIFE SPAN EFFECT							
CRITERION #2: LARGE # OF INDIVIDUALS ARE AFFECTED BY THE PROBLEM								
CRITERION #3: DISPROPORTIONATE EFFECTS AMONG SUBGROUPS OF THE POPULATION								
CRITERION #4: PROBLEM RESULTS IN SIGNIFICANT ECONOMIC/ SOCIAL COST								
Problem/Issue	In the line below each criterion number (e.g. C1), the assigned weight is Then, For each problem, score each criterion (1 through 5) and multiply the score by the assigned weight. Add weighted criterion scores to obtain Total Score for Problem.							Total Score For Problem
	C1	C2	C3	C4	C5	C6		
	3	2	2	1	3			
9. Oral Health								
10. Injuries								
11. Asthma								
12. Mental Health								
13. Chlamydia Infections								
14.								
15.								
16.								
17.								
18.								

Appendix 7:

Framework for Identifying and Prioritizing the Title V Health and Health Systems Access and Capacity Needs of CCS Eligible Children and their Families

Background:

Title V of the Social Security Act is a federal-state partnership that provides for programs to improve the health of all mothers and children, including children with special health care needs. California currently receives approximately \$48 million in federal Title V funds that are jointly administered by Maternal and Child Health (MCH) Branch and the California Medical Services (CMS) Branch. Three population groups are served through Title V: pregnant women and infants less than 1 year of age; children ages 1 to 21 years; and children with special health care needs (CHSCN). The California Children's Services (CCS) program, California's CSHCN program, provides case management and payment of services for program-eligible CSHCN and promotes family-centered, community-based, coordinated care for these children.

CMS has established its CCS Needs Assessment Stakeholders Group, and contracted with Family Health Outcomes Project (FHOP) to assist in identifying needs related to CCS eligible children and their families and facilitating the process of problem identification and prioritization of those problems/needs. The process being used is an inclusive and systematic process of data presentation and analysis, identification of problems and setting priorities. This process has been used successfully for work with large planning groups with a diverse membership.²

Purposes of the Problem Identification and Prioritization Process

- Promote rational allocation of resources
- Create a systematic, fair and inclusive process
- Focus decision-making if there are many problems/issues identified
- Challenge participants to objectively and critically review data
- Document the process and results

The outcome of this process will be a 5 year needs assessment report and the selection of statewide performance measures to evaluate the results of our interventions. The report will be submitted in July 2005, as part of California's 2005-06 Title V Maternal and Child Health Block Grant application. CCS is committed to addressing the selected priorities, within our budgetary and legislative constraints.

Description of the Problem Identification and Prioritization Process

There will be two meetings of the CCS Needs Assessment Stakeholders Group for the purpose of setting priorities among identified needs. The first meeting is on January 27, 2005 and the second is planned for April or early May, 2005. In addition to the two meetings, the group members will review documents and participate in telephone or e-mail communications in the

² The process is adapted from a method included in the University of North Carolina, Program Planning and Monitoring Self-Instructional Manual, "Assessment of Health Status Problems" and described in the University of California at San Francisco Family Health Outcome Project (FHOP) "Developing an Effective MCH Planning Process: A Guide for Local MCH Programs".

time period between the two large group meetings to review data, and provide input to assist in identifying significant problems. After reviewing and analyzing data on selected indicators, identified problems/issue will be submitted to the group for consideration in the overall prioritization process. During the April 2005 meeting, the full group will review the list of identified problems, review data about these problems/issues, agree on a final problem list, and receive orientation to and use a method of rating and ranking the identified problems. The results will be presented, discussed and confirmed by the group. The table below shows the steps of the process.

Steps in the CCS Needs Assessment Stakeholder Group Process for Prioritizing Problems/Needs	
I.	Meeting January 27, 2005
	Introductions/Share information
	CMS / FHOP present overall objectives of the Needs Assessment, scope, background and the recommended process for prioritization
	FHOP facilitates process of selecting up to 7 criteria that will be used by the Group members to assist in the ranking/prioritization of problems <ul style="list-style-type: none"> - Develop criteria - Develop criteria rating scales - Determine weights for each criterion (how important each criterion is relative to the other criterion)
	FHOP reviews criteria for selecting indicators with the group, receives input, and orients group to how data will be presented for their review.
	FHOP asks participants (key informants) to divide into groups. Groups will discuss how the core outcomes and issues identified through FHOP's indicator research, brief interviews with Stakeholders and e-mail survey can be assessed (e.g., suggests possible indicators, instruments, data sources). Their input is recorded and shared with the larger group, and this will be incorporated into the identification of the final list of indicators.
II.	Work is done by the Group in the months between meetings (can be accomplished by e-mail, phone or smaller group meetings):
	Review and input by Group Members of data collected and analyzed by FHOP/CMS Review and input by Group members of problem/issue list developed based on data
III	Meeting in April or early May, 2005:
	Group members agree on the final problem/issue list to be prioritized
	The Group sets priorities among the final problem list. These priorities will be the focus of the Title V, 5 Year Action Plan. <ul style="list-style-type: none"> • Group Participants use the agreed upon weighted criteria to score problems • Sum participants' scores / rank problems • Discuss and confirm results

Appendix 8:

Number and Percent of Children Served by CCS in 2004

County	CCS Clients 2004	POPULATION Age 0- 21	% of Children 0-21 CCS served in 2004
Alameda	4,818	1,463,995	0.3%
Alpine	2	342	0.6%
Amador	81	8,510	1.0%
Butte	800	61,311	1.3%
Calaveras	111	10,416	1.1%
Colusa	148	6,868	2.2%
Contra Costa	2,775	285,014	1.0%
Del Norte	119	7,880	1.5%
El Dorado	414	46,164	0.9%
Fresno	7,220	296,865	2.4%
Glenn	175	9,229	1.9%
Humboldt	784	36,206	2.2%
Imperial	1,157	51,246	2.3%
Inyo	121	4,901	2.5%
Kern	4,539	241,952	1.9%
Kings	553	43,827	1.3%
Lake	357	15,744	2.3%
Lassen	95	8,818	1.1%
Los Angeles	55,632	3,087,090	1.8%
Madera	935	41,976	2.2%
Marin	482	55,998	0.9%
Mariposa	68	4,316	1.6%
Mendocino	728	25,422	2.9%
Merced	2,165	82,950	2.6%
Modoc	47	2,681	1.8%
Mono	104	3,457	3.0%
Monterey	2,253	132,700	1.7%
Napa	342	34,841	1.0%
Nevada	301	24,208	1.2%
Orange	11,676	884,659	1.3%
Placer	665	74,305	0.9%
Plumas	44	5,389	0.8%
Riverside	9,326	535,996	1.7%
Sacramento	5,471	387,743	1.4%
San Benito	224	19,354	1.2%
San Bernardino	9,941	632,457	1.6%
San Diego	11,961	859,189	1.4%
San Francisco	2,241	135,781	1.7%
San Joaquin	4,868	201,836	2.4%
San Luis Obispo	870	69,792	1.2%
San Mateo	1,709	184,945	0.9%
Santa Barbara	1,584	125,010	1.3%
Santa Clara	7,159	481,297	1.5%
Santa Cruz	1,235	75,082	1.6%
Shasta	807	49,474	1.6%
Sierra	9	920	1.0%
Siskiyou	251	12,250	2.0%

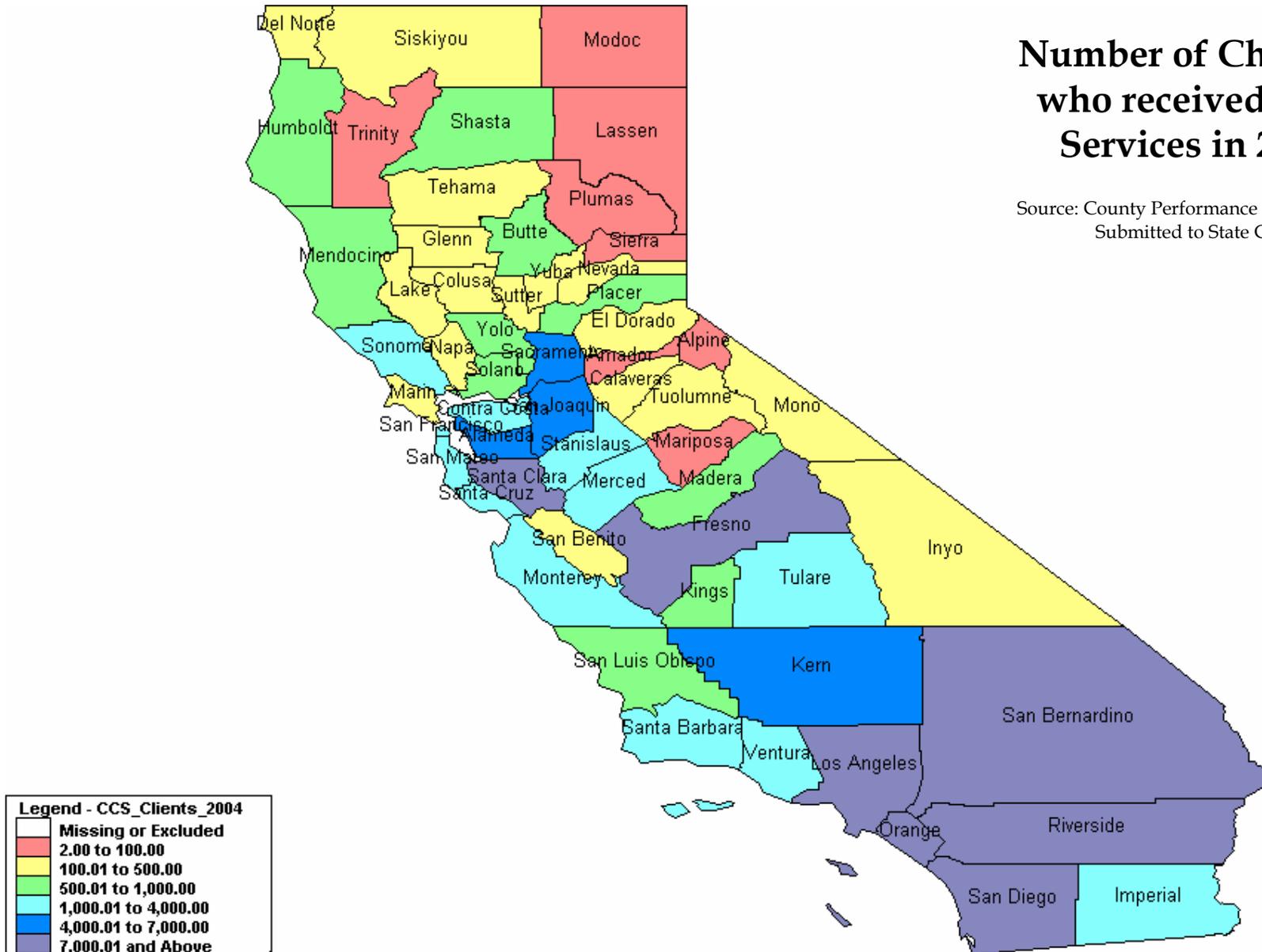
Solano	818	127912	0.6%
Sonoma	1,527	131038	1.2%
Stanislaus	2,903	159593	1.8%
Sutter	485	26226	1.8%
Tehama	310	17547	1.8%
Trinity	70	3331	2.1%
Tulare	3,328	142703	2.3%
Tuolumne	255	13222	1.9%
Ventura	2,846	245225	1.2%
Yolo	582	57713	1.0%
Yuba	389	21589	1.8%
Total	170,880	7,594,934	2.2%

Source: County CMS Performance Measures 2004 submitted to State CMS

Appendix 9:

Number of Children who received CCS Services in 2004

Source: County Performance Data for 2004
Submitted to State CMS



Appendix 10:

Percent of Children served by CCS in 2004 with a Medical Home

County	%
Alameda	58%
Alpine	0%
Amador	76%
Butte	85%
Calaveras	83%
Colusa	86%
Contra Costa	69%
Del Norte	45%
El Dorado	23%
Fresno	100%
Glenn	88%
Humboldt	98%
Imperial	51%
Inyo	45%
Kern	63%
Kings	23%
Lake	87%
Lassen	6%
Los Angeles	
Madera	61%
Marin	90%
Mariposa	12%
Mendocino	100%
Merced	63%
Modoc	23%
Mono	95%
Monterey	72%
Napa	91%
Nevada	61%
Orange	58%
Placer	94%
Plumas	74%
Riverside	19%
Sacramento	73%
San Benito	52%
San Bernardino	1%
San Diego	53%
San Francisco	94%
San Joaquin	41%
San Luis Obispo	91%
San Mateo	17%

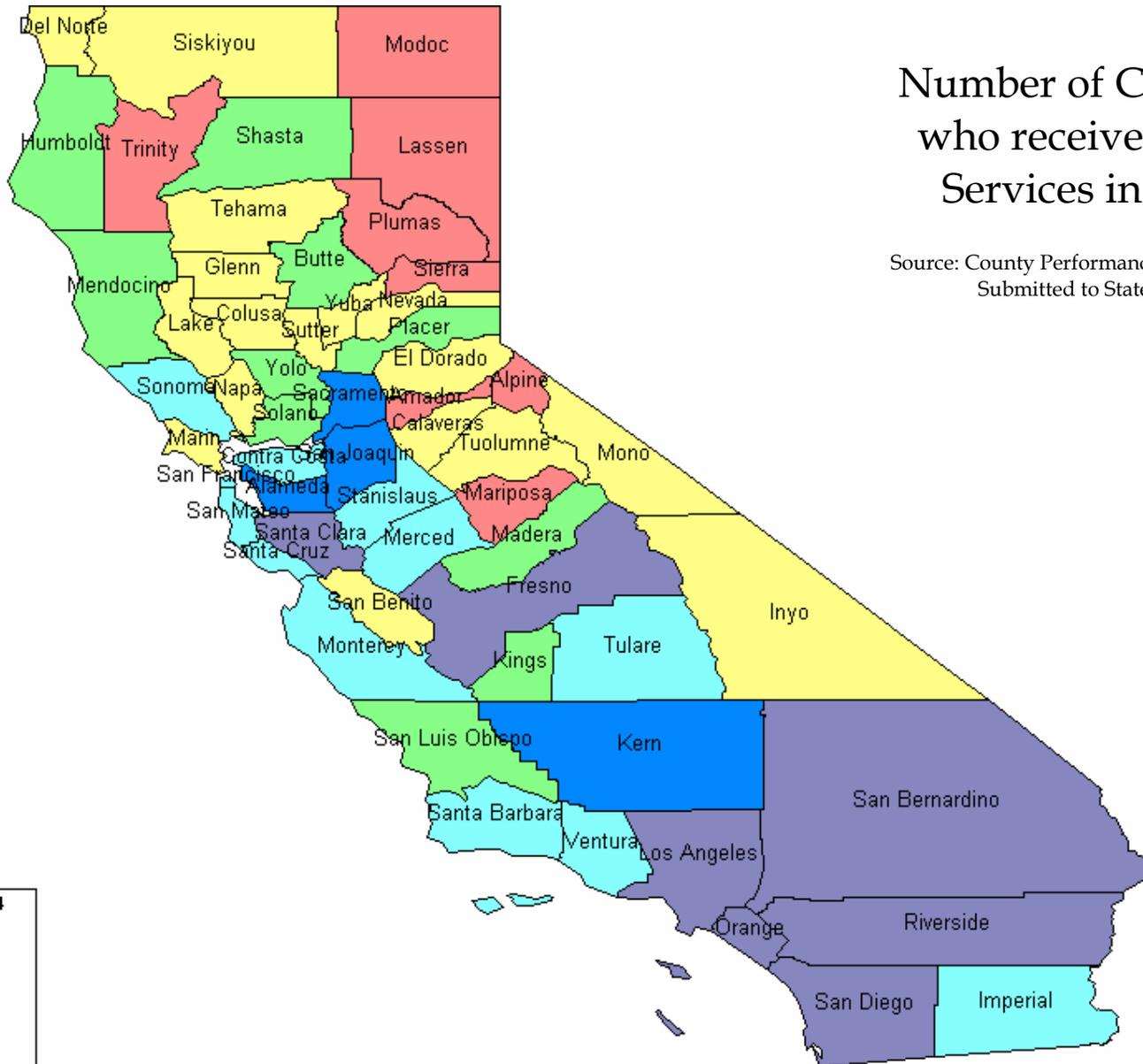
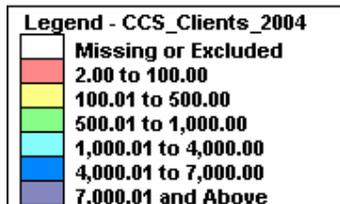
Santa Barbara	97%
Santa Clara	9%
Santa Cruz	76%
Shasta	75%
Sierra	0%
Siskiyou	93%
Solano	48%
Sonoma	86%
Stanislaus	54%
Sutter	60%
Tehama	44%
Trinity	57%
Tulare	54%
Tuolumne	66%
Ventura	71%
Yolo	98%
Yuba	90%

Source: Data from CMS Net, 2004 (except Sacramento and Orange County which gave % to State CCS)

Appendix 11:

Number of Children who received CCS Services in 2004

Source: County Performance Data for 2004
Submitted to State CMS



Appendix 12:

**Average Number of Days between Referral to
CCS and Authorization for Services**

County	Average
Alameda	113
Alpine	85
Amador	55
Butte	68
Calaveras	157
Colusa	107
Contra Costa	73
Del Norte	137
El Dorado	124
Fresno	79
Glenn	160
Humboldt	133
Imperial	227
Inyo	111
Kern	189
Kings	133
Lake	146
Lassen	140
Los Angeles	16
Madera	208
Marin	92
Mariposa	196
Mendocino	99
Merced	95
Modoc	114
Mono	67
Monterey	133
Napa	160
Nevada	123
Orange	14
Placer	123
Plumas	68
Riverside	79
Sacramento	37
San Benito	168
San Bernardino	130
San Diego	136
San Francisco	86
San Joaquin	146
San Luis Obispo	94

Statewide
County Average = 57 days

San Mateo	116
Santa Barbara	113
Santa Clara	107
Santa Cruz	90
Shasta	162
Sierra	84
Siskiyou	153
Solano	205
Sonoma	149
Stanislaus	
Sutter	131
Tehama	159
Trinity	108
Tulare	136
Tuolumne	137
Ventura	153
Yolo	149
Yuba	153

Source: Data from CMS Net for referral dates 7/1/03-6/30/04 (except Sacramento, Orange, and Los Angeles Counties that gave averages to State CCS)

Appendix 13:

Number and % of CCS Clients Age 20 with Insurance

County	Total CCS Clients Age 20	Age 20 with insurance	% Age 20 with Insurance
Alameda	154	27	18%
Alpine	1	1	100%
Amador	2	1	50%
Butte	33	5	15%
Calaveras	3	0	0%
Colusa	6	1	17%
Contra Costa	66	19	29%
Del Norte	5	0	0%
El Dorado	16	1	6%
Fresno	295	42	14%
Glenn	6	0	0%
Humboldt	25	9	36%
Imperial	60	7	12%
Inyo	4	1	25%
Kern	159	21	13%
Kings	11	1	9%
Lake	12	0	0%
Lassen	3	1	33%
Los Angeles	1254	1137	91%
Madera	24	4	17%
Marin	18	5	28%
Mariposa	6	2	33%
Mendocino	19	4	21%
Merced	82	13	16%
Modoc	1	0	0%
Mono	4	3	75%
Monterey	58	14	24%
Napa	10	2	20%
Nevada	11	1	9%
Orange			71%
Placer	16	7	44%
Plumas			
Riverside	241	14	6%
Sacramento	220	70	32%
San Benito	11	4	36%
San Bernardino	213	15	7%
San Diego	196	20	10%
San Francisco	70	13	19%
San Joaquin	189	23	12%
San Luis Obispo	21	4	19%
San Mateo	47	4	9%
Santa Barbara	36	10	28%
Santa Clara	163	25	15%
Santa Cruz	50	13	26%
Shasta	31	6	19%
Sierra			
Siskiyou	18	6	33%
Solano	12	6	50%

Sonoma	53	14	26%
Stanislaus	78	16	21%
Sutter	14	2	14%
Tehama	9	4	44%
Trinity			
Tulare	99	11	11%
Tuolumne	6	0	0%
Ventura	62	16	26%
Yolo	12	6	50%
Yuba	5	0	0%

Source: CMS Net Business Objects active data effective 3/31/05

Appendix 14:

Stakeholders for CMS Title V Needs Assessment

Organization	Contact name	
Stakeholders		
Los Angeles County CCS	Cherie Todoroff	
Orange County CCS	Linda Boyd	
Sacramento County CCS	Sue Nisbet	
NICU TAC	Frank Mannino, M.D.	UCSD Medical Center
PICU TAC	Lorry Frankel, M.D.	Lucille Packard Children's Hosp
Cardiac TAC	Thomas Klitzner, M.D.	UCLA School of Medicine
CPQCC	Jeffrey Gould, M.D.	UCB, Neonatal & Developmental Med
Children's Specialty Care Coalition	Erin Aaberg-Givans	
CA Children's Hospital Assn	Sue Maddox	
American Academy of Pediatrics	Kris Calvin	
American Academy of Pediatrics	Marc Lerner, M.D.	University of California, Irvine
California Healthcare Association	Sheree Kruckenberg	
Dept. of Developmental Services	Rick Ingraham	Children and Family Services
Designee for 1/27 pm	Eileen McCauley	
Regional Center of Orange County	Arleen Downing, M.D.	
California Dept of Education	Jim Bellotti	Special Education Division
Designee for process		Special Education Division
Department of Mental Health	Penny Knapp, M.D.	
Designee for 1/27	Luis Zanartu	
Dept of Social Services	Pat Aguiar	Child & Youth Permanency Branch
CCS Executive Committee		
Solano County CCS	Pam Sakamoto	
Alameda County CCS	Marge Deichman	
Monterey County CCS	Dyan Apostolos	
Santa Clara County CCS	Heidi Hudson	
Santa Barbara County CCS	Elizabeth Kasehagen	
Family Voices of California	Juno Duenas	
CRISS	Laurie Soman	
Parent Links	Sandy Harvey	
California Medical Home Project	Kathryn Smith	
Department of Health Services	Linda Rudolph, M.D.	Medi-Cal Managed Care Division
Designee	Penny Horper	
MRMIB	Lesley Cummings	
Designee for Process	Valetta Lewis	
Medically Vulnerable Infant Prog.	Arlene Cullum	
EHDI	Shirley Russ, MBChB	Cedars-Sinai Medical Center
CHEAC (County Administrators)	Judith Reigel	

Designee	Iantha Thompson	
MCAH Directors	Troy Jacobs, M.D.	
Protection and Advocacy	Marilyn Holle	
Designee	Dale Mentink	
Parents		
	Mara McGrath	
	Diana Vergil-Bolling	
	Yolanda Parie-Jones	
	Sandra West	
(alternate)	Debra Capers	
MCH Branch Staff (mailings)		
	Shabbir Ahmad, DVM	
	Gretchen Caspary	
	Mike Curtis	
CMS Branch Staff		
Acting Branch Chief	Marian Dalsey, M.D.	
Medical Consultant	Hallie Morrow, M.D.	
Medical Consultant	Kathy Chance, M.D.	
Program Stds & Quality Assur.	Sheryl Gonzalez	
Program Support Section	Erin Whitsell	
Program Operations Section	Maggie Petersen	
Program Operations Section	Maurice Robertson	
Information Technology Section	Bill White	
Northern CA Regional Office	Annette Irving	
Southern CA Regional Office	Linda Torn	

Appendix 15:

AGENDA
CCS NEEDS ASSESSMENT STAKEHOLDERS GROUP
January 27, 2005
10:00 a.m. - 3:00 p.m.

Registration 9:45 – 10:00 a.m.

1. Welcome and Introductory Remarks –(Dr. Dalsey)
2. Participant Introductions
3. Objectives and Scope of the Needs Assessment and CCS Program Overview, (Dr Dalsey)
4. Champions Proposal (Kathryn Smith)
5. Overview of the Problem Identification and Prioritization Process (FHOP)
6. Development of Criteria for Selection of CCS 5-Year Action Priorities (FHOP/Group)
(Short break midway through this process to get lunch-- Working Lunch)
7. Indicator Selection Criteria and Process for Data Review (FHOP)
8. Breakout Groups: Identifying Possible Indicators and Data Sources (FHOP/Group)
9. Next Steps
10. Feedback and Closing Remarks

Appendix 16:

**Agenda
CCS Stakeholders Meeting
April 28, 2005**

Meeting Objectives:

- Prioritize among identified issue/objective areas
- Begin identification of data development agenda
- All stakeholders will have an understanding of and accept the prioritized areas
- Lay ground work for next steps in the planning process

Please arrive on time, as we have a full agenda and will begin on time

9:00 – 9:15 Sign-in

9:15 – 9:45 Welcome and introductions – (Marian Dalsey)

9:45 – 10:15 Agenda/Meeting objectives, process to date, review of prioritization criteria and presentation of systems issues / objectives list (Gerry Oliva)

10:15 – 11:45 Data Presentation (Jennifer Rienks)

11:45 – 12:15 Final Systems issues / Objectives List -- Review/Discussion
(Jennifer Rienks / Judith Belfiori / Stakeholders)

12:15 – 12:30 Working lunch (time for participants to get lunch)

12:30 – 12:45 Review rating method/tool (Judith Belfiori)

12:45 – 2:15 Rating of Issues / Objectives (Stakeholders)

2:15 – 2:45 Discussion of prioritization results (Judith Belfiori)

2:45 – 3:30 Data development discussion (Judith Belfiori / Jennifer Rienks)

3:45 – 4:00 Next steps for the Title V process / Closing remarks (Marian Dalsey)

Appendix 17:

CSHCN Needs Assessment Indicator Selection Criteria

The Family Health Outcomes Project (FHOP), in consultation with the CMS Staff, will be selecting a finite number of indicators for which data can be collected, analyzed and presented to the Stakeholders group for prioritization and subsequently included in the Children with Special Health Care Needs (CSHCN) portion of the Maternal Child and Adolescent (MCAH) Assessment and 5 Year Plan. These indicators will be defined as population-based measures of either the entire population or a defined population subgroup that may assess general health status, a particular health condition, health access, or health system effectiveness and are measured at a specified point in time. Where possible they will be compared to a standard or benchmark, such as the national CSHCN outcome measures or Healthy People 2010 goals. The following criteria will be used by FHOP to identify the final set of indicators:

The indicator is a valid measure of access to or utilization of CCS services

Indicator data is easily available and is either representative of the general population, or taken from a representative sample of CSHCN, or the CCS eligible or CSN population in question

The indicator is relevant and informative to stakeholders. (“relevant” and “informative” means that the stakeholders can use the indicator to monitor services and outcomes for CSHCN and their families)

The indicator data provides information on conditions or service limitations that lead to functional constraints among the CCS-eligible and/or CCS served population

The indicator reveals disparities in service access and/or delivery to CCS-eligible children

The indicator relates to one of the core national or State CSHCN performance outcomes

Appendix 18:

**CCS Stakeholder Criteria, Definitions and Rating Scales
for prioritizing among identified CSHCN issues/objectives
(April 28, 2005)**

1. Criterion Name: Problem has great impact on families (quality of life, functionality)

Weight: 3

Definition/Concepts: This means that the child and the family's quality of life and functionality are affected by the problem. Examples are a parent cannot work; a child cannot go to school.

Rating Scale: 3

- 1= Problem is not affecting the quality of life or functionality of the family
- 2= Problem is minimally or occasionally affecting the quality of life or functionality of the family
- 3= Problem is moderately and/or frequently affecting the quality of life or functionality of the family
- 4= Problem is negatively impacting the family's quality of life and functionality most of the time.
- 5= Problem is severely negatively impacting the family's quality of life and functionality most or all of the time

2. Criterion Name: Addressing the problem is important to consumers

Weight: 3

Definition/Concepts: Addressing the problem is important to the recipients or potential recipients of services: child, siblings, parents, extended family

Rating Scale:

- 1= Addressing the problem is not important to consumers
- 2= Addressing the problem is of some importance to consumers
- 3= Addressing the problem is of moderate Importance to consumers
- 4= Addressing the problem is important to consumers
- 5= Addressing the problem is a very high priority for consumers

3. Criterion Name: Problem results in great cost to program and/or society, there is a significant fiscal impact of not addressing it

Weight: 2

Definition/Concepts: If problem is not addressed the result will be increased monetary costs, e.g., health care and/or social services costs to the CCS program or to society and loss of education and productivity of individuals because of chronic illness, disability or premature death.

Rating Scale:

- 1= Economic / societal cost is minimal
- 2= There is some potential increased costs
- 3= There is likely to be moderate increased costs
- 4= There is likely to be substantial increased costs
- 5= There will be great economic and societal cost

4. Criterion Name: Addressing the problem maximizes opportunity to leverage resources and relationships for effective system change.

Weight: 2

Definition/Concepts: There is opportunity for Agencies or Collaborative Partners to plan together or pool resources to address the problem and/or there is opportunity to build new relationships. Allows us to take advantage of opportunities to leverage resources and relationships to affect systems change

Rating Scale:

- 1= No known opportunity to collaborate
- 2= There may be opportunities to collaborate
- 3= There are opportunities to collaborate
- 4= There are opportunities to collaborate and some collaboration is already occurring
- 5= Major collaborative efforts are already underway

5. Criterion Name: Addressing the problem would increase equity and fairness

Weight: 2

Definition/Concepts: Definition/Concepts: This means that one or more population subgroups as defined by race/ethnicity, income, insurance status, gender or geography, diagnosis are more impacted than the general group. Addressing the problem or issues would promote equity and reduce disparities.

Rating Scale:

- 1= No group is disproportionately affected by the problem
- 2= It appears that one or more groups is disproportionately affected by the problem, but differences are not statistically significant
- 3= Statistically significant differences exist in one group
- 4= Statistically significant differences exist in more than one group
- 5= Very large statistically significant differences exist in one or more groups

6. Criterion Name: There is likelihood of success. Problem is amenable to prevention or intervention, and/or there is political will to address it

Weight: 1

Definition/Concepts: This means that there is a good chance that the strategies used to intervene in the identified problem will result in an improvement in outcomes. The intervention strategies are shown in research literature, by experts or by National, State or program experience to be effective or promising. The group also indicated this criterion would incorporate political will, e.g., the problem is a national or regional priority

- 1= No known intervention available
- 2= Promising intervention with limited impact (not effecting a wider array of problems), little political will
- 3= Proven intervention with limited impact, moderate political will
- 4= Promising or proven intervention with broad impact and moderate political will
- 5= Proven intervention with broad impact and strong political will

Appendix 19:

CCS Stakeholder Issue/Objective Prioritization Rating Tool

CRITERION #1: PROBLEM HAS GREAT IMPACT ON FAMILIES (QUALITY OF LIFE, FUNCTIONALITY)				CRITERION #5: ADDRESSING THE PROBLEM WILL INCREASE EQUITY AND FAIRNESS				
CRITERION #2: ADDRESSING PROBLEM IS IMPORTANT TO CONSUMERS				CRITERION #6: LIKELIHOOD OF SUCCESS / AMMENABLE TO INTERVENTION AND POLITICAL WILL				
CRITERION #3: PROBLEM RESULTS IN GREAT COST TO PROGRAM AND/OR SOCIETY (FISCAL IMPACT)								
CRITERION #4: ADDRESSING PROBLEM MAXIMIZES OPPORTUNITY TO LEVERAGE RESOURCES								
Issue/Objective	In the line below each criterion number (e.g. C1), the assigned weight is Then, For each issue area score each criterion (1 through 5) and multiply the score by the assigned weight. Add weighted criterion scores to obtain Total Score for Issue/objective.							Total Score For Issue / Objective
	C1	C2	C3	C4	C5	C6		
	3	3	2	2	2	1		
19. Children have medical homes								
20. Families have educational and access to services information								
21. Family partnership in decision-making and satisfaction with services								
22. Newborns receive hearing screening services								
23. Access to qualified providers (#)								
24. Access to preventive health services (primary care, screening)								
25. Higher financial eligibility limit								
26. Access to services for youth ages 17-21								
27. Timely referral of foster care children to CCS								
28. Time between referral to and receipt of CCS services								

CRITERION #1: PROBLEM HAS GREAT IMPACT ON FAMILIES (QUALITY OF LIFE, FUNCTIONALITY)				CRITERION #5: ADDRESSING THE PROBLEM WILL INCREASE EQUITY AND FAIRNESS				
CRITERION #2: ADDRESSING PROBLEM IS IMPORTANT TO CONSUMERS				CRITERION #6: LIKELIHOOD OF SUCCESS / AMMENABLE TO INTERVENTION AND POLITICAL WILL				
CRITERION #3: PROBLEM RESULTS IN GREAT COST TO PROGRAM AND/OR SOCIETY (FISCAL IMPACT)								
CRITERION #4: ADDRESSING PROBLEM MAXIMIZES OPPORTUNITY TO LEVERAGE RESOURCES								
Issue / Objective	In the line below each criterion number (e.g. C1), the assigned weight is Then, For each issue area, score each criterion (1 through 5) and multiply the score by the assigned weight. Add weighted criterion scores to obtain Total Score for Problem.							Total Score For Issue / Objective
	C1	C2	C3	C4	C5	C6		
	3	3	2	2	2	1		
29. Time between referral to & receipt of Medical Therapy Program services								
30. Uniform application of CCS authorization and referral policies								
31. System of standards of service delivery (all payors and share data)								
32. Timely referral between mental health and CCS								
33. Local CCS program capacity to transition adolescents to adult services								
34.								
35.								
36.								
37.								
38.								
39.								

Appendix 20:

California Children's Services (CCS) Title V Stakeholders Meeting
 Priority Objectives (Ranked Scores)
 April 28, 2005

Overarching Principles:

- CCS will address disparity issues when developing strategies and tracking priority objective outcomes.
- The CCS program shall ensure that children with CCS eligible health care needs have access to and receive services from appropriately trained pediatric providers and shall develop and apply standards of care intended to lower morbidity and mortality rates among eligible children.

Rank	Score	Proposed Objective
1	1200	Expand the number of qualified providers participating in the CCS program, e.g., medical specialists, audiologists, occupational and physical therapists, and nutritionists
2	1088	Coordinate to develop and implement a system of timely referral between mental health, developmental services, social services, special education services and CCS
3	1033	Increase number of family-centered medical homes for CSHCN and the number / % of CCS children who have a designated medical home
4	1018	Increase access of CCS children to preventive health care services (primary care providers, well child care, immunizations, screening) as recommended by the AAP
4	1017	Increase family access to educational information and information about accessing CCS services, including availability of and access to services offered by health plans
4	1015	Increase access to services for CCS youth, 17-21 years of age
5	991	Decrease the time between referral to CCS and receipt of CCS services
6	980	Implement a system of standards of service delivery for all children with CCS medically eligible conditions regardless of payor source, including sharing of data
7	972	Increase capacity of local CCS programs to develop and implement transition plans for adolescents transitioning to adult services
8	968	Increase family partnership in decision-making and satisfaction with services
9	961	Facilitate the timely referral of foster care children with CCS eligible medical conditions to CCS services
10	934	Improve the uniform application of CCS authorization and referral policies across the state
11	901	Decrease the time between referral to the Medical Therapy Program and receipt of MTP services
12	884	Increase the % of infants born in California who receive newborn hearing screening services
13	840	Increase access to CCS services by increasing the financial eligibility limit (\$40,000 limit)

Appendix 21:

Data Development Notes from CCS Title V Needs Assessment Stakeholder Meeting April 28, 2005

Stakeholders were asked to identify data issues and data development recommendations relevant to the priority objectives identified during the priority-setting portion of the meeting. At the conclusion of this discussion, *it was agreed that the first CCS data development step will be to develop a matrix of data available for children covered by CMS/CCS (Troy Jacobs offered to assist with this process).*

The three priority objectives identified by the group were:

- Expand the number of qualified providers participating in the CCS program, e.g., medical specialists, audiologists, occupational and physical therapists and nutritionists
- Coordinate to develop and implement a system of timely referral between mental health, developmental services, social services, special education services and CCS
- Increase the number of family-centered medical homes for CSHCN and the number/% of CCS children who have a designated medical home

The group's input on data development issues and recommendations relevant to these priorities is documented below. Other comments (made verbally and in written notes) were collected during the meeting and have also been included in the data issues/development sections below.

Assessing Access to Providers

- Availability of providers (paneled and non-paneled) by county and by region (use health care region) broken down by sub-specialties and how many paneled providers are accepting CCS enrolled children
- Assess need vs. availability of providers (paneled and non-paneled, by county and by health care region): number of CCS children, diagnostic breakdown, number of providers by pediatric specialty, number of orthodontists, etc.
- Clean up the provider list so the data becomes meaningful – eliminate dead, moved, retired providers from the list; identify the providers that are taking new patients
- Send approved providers copies of their CCS applications annually to have them review and update their information (e.g., address, specialties, accepting patients)
- Restructure CCS-paneled provider data base (Counties in rows, types of providers in columns – use standardized provider types across all counties)
- Collect/enable analysis of event vs. person data
- In progress – Business Objects to help access data. Need user friendly access, by county
- Assess waiting times between referral, eligibility determination, authorization and services received
- Map flow patterns of where children go to receive care (can get from OSHPD data set for hospitalizations, claims paid data (*Tom Klitzner* offered to help with methods))
- Track barriers to provider access. Can local programs identify problem areas with access? Can CMS keep track of these?
- Collect complaints data

- Implement survey to assess CCS clients' satisfaction with providers, such as the CAHPS survey questions for CSHCN
- Quality of care data, mortality statistics need to be looked at when considering lowering standards to increase provider participation

Developing a Coordinated System of Timely Referrals Among Programs Serving CCS Children

- Develop a MATRIX of available data across existing CSHCN programs (*Troy Jacobs*, offered to help with developing the method/matrix for obtaining this information)
- Link data across programs, i.e., track CCS children across systems. Work towards establishing common program fields across state programs – *Juno Duenas* may be helpful. Use identifying information. Consider using a uniform confidentiality form across programs.
- Look at other states and see what they do to collect data across programs

Assessing Access and Function of a Medical Home

- Need to define medical home; who decides; levels; types of medical home, services medical home provides. Use and compare continuity of care scores for children in medical homes – and those not in medical homes
- Agree upon and institute a consistent definition of medical home, consistent recording of information across counties
- Important once definition is established to get baseline data on “medical home” in order to monitor progress towards accomplishment of the medical home objective
- How many CCS children/adolescents have an AAP medical home?
- Make sure that those who are authorized as medical home providers know what they are supposed to be doing
- How are counties completing the “medical home” field? Make it a required field
- Every system should be required to identify the patient's medical home
- Use connections with other state groups to work on establishing medical homes
- Monitor whether/when children get comprehensive assessments
- Medical Home: roundtables to do case management across medical homes – collect data via roundtables
- Medical Home index
- Continuity of care scores
- Problem of tracking patients as they change medical homes
- Collect / Analyze data regarding medical homes and related outcomes: school attendance, lost days of work by parents, hospitalizations and rehospitalization; need *baseline data* first
- Consider using the national medical home survey questions to gather California data – may help guide counties to ask appropriate questions

Data on Children with Special Health Care Needs (CSHCN)

- Explore possibility of Increasing California sample size for National CSHCN SURVEY
- Get data support (data, demonstration funds) from federal MCHB – look across CSHCN diagnostic and eligibility criteria

Overarching and Other Data Development Concerns and Recommendations

- CMS Net data should be collected and analyzed by age and race
- Assess accuracy of diagnostic codes / how to increase accuracy
- Need accurate numbers of pediatric specialists (total vs. paneled)
- Assess duplication of patient data
- Need data on CSHCN from health plans—can we get it?
- Need to document other types of service-related data available, e.g., various audits to document care and provider surveys
- Need data regarding provision of non-CCS services by providers
- Clarify encounter data in both fee-for-service and capitated delivery systems – look at encounter data in Medi-Cal Managed Care (MCMC)
- Look to “outside” agencies for assistance in collecting data (e.g., MCMC, Specialists, AAP, Children’s Hospitals)
- Look at what/how data is collected across programs in other States
- Collect and analyze all data by counties / jurisdictions to extent possible
- What % of children in Healthy Families has CCS vs. what % of children in Medi-Cal has CCS coverage? Is the Healthy Families population underrepresented in CCS? Are providers making referrals to CCS?

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