SECTION 3 – SCOPE OF WORK AND PERFORMANCE MEASURES

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Children's Medical Services (CMS) Branch used Fiscal Year 2002-03 to transition from an annual individualized reporting format to a continuous quality improvement format to evaluate and improve the performance of both local CMS programs and the CMS Branch. The guiding principles used to complete this transition were the CMS Branch Mission and Vision Statements.

Mission: Assuring the health of California's children.

Vision Statement: Children's Medical Services is the leader in assuring the health of California's children through access to services for all children, in an environment committed to excellence, in partnership with families and communities, as supported by information and communication.

During Fiscal Year 2002-03, a statewide workgroup assembled to review and revise the CMS Scope of Work and to incorporate performance measures in the context of our mission and vision statement. The five CMS broad goals, used over the past several years as a way of providing focus for local programs, were condensed into four. The workgroup considered the former CMS goal 1 "Children will receive quality medical, dental, and support services across all provider settings" duplicated concepts in the other goal statements.

Four goal statements continue to provide the foundation for program components and activities that move local California Children's Services (CCS), Child Health and Disability Prevention (CHDP), Health Care Program for Children in Foster Care (HCPCFC) programs toward meeting the CMS Mission and Vision Statement.

CMS Goals

Goal 1: Families, children, and providers will be assisted in how to use new and ongoing CMS program services, and access and navigate changing health care systems to assure effective, continuous care delivery.

Goal 2: Health and support services for children with special physical, emotional and social health needs will be addressed efficiently and effectively by qualified CMS providers, private and public offices and clinics, special care centers, regional centers, medical therapy programs and through home health agencies.

Goal 3: Clinical preventive services will be provided to children eligible for CMS programs.

Goal 4: CMS outreach activities will be conducted to assure that all eligible children and their families are informed of program services in a manner that is culturally and linguistically competent.

CMS Program Components – Scope of Work

The day-to-day operations of the CCS, CHDP, and HCPCFC programs have been outlined in Program Components with associated activities. These Program Components are the basic required activities that must be performed to meet Federal and State requirements. The Program Components and activities are the CMS Branch Scope of Work.

I. Program Planning and Administration

A. Develop CMS plans and updates reflective of CCS, CHDP, and HCPCFC programs according to guidelines distributed by the CMS Branch. Submit these plans according to the date specified in the Plan Guidelines. Review and update quarterly for their application locally.

1. CCS, CHDP, and HCPCFC staff meet a minimum of two times a year to develop a CMS plan, identify priorities, and evaluate resources for a multi-year scope of work.

    a. Identify and prioritize health department and community programs with whom CMS staff will meet, e.g., Tuberculosis, Immunizations, WIC, Dental, Maternal and Child Health, Public Health Nursing, Lead, Injury Prevention, HIV Program, Perinatal Services Program, Family Planning, Rural Health, Migrant and Indian Health, Mental Health, Head Start, Child Care Facilities, Regional Centers, Special Care Centers, Paneled Hospitals, and Providers.

    b. Identify and evaluate mutual activities and areas of implementation. Participate as CMS Administrators in arranging for the development of special services as necessary, e.g., orthodontic screening, Medical Therapy Conferences at the MTU, primary care, foster care resources, dental care.

    c. Identify and implement program activities to maintain services as necessary.

2. Meet at least once each year with the staff of other health department and community programs working on behalf of children to discuss goals and activities for/with these populations.

3. Collaborate with the CMS Branch on standards, guidelines, and policies through participation in statewide and regional meetings. Include reporting mechanism to local program so that State information flows back to the local level.

4. Evaluate program outcome data to plan more effective use of program resources.

B. Develop and monitor the CCS, CHDP, and HCPCFC yearly budgets and invoices according to the format and time frames established by the CMS Branch.

1. Expend funds according to approved budgets.

2. Develop budget revisions as necessary.

3. Prepare and submit quarterly invoices to the State *no later than 60 days after the end of each quarter*. Track timeliness of, and invoiced payments for CCS services.

4. Prepare and submit expenditure reports reallocating or requesting additional funds as appropriate and as requested by the CMS Branch.

5. Use all equipment purchased with designated State program funds for the specified program purposes only.

6. Complete and retain daily time studies a minimum of one month each quarter according to State provided guidelines.

7. Maintain an audit trail for all expenditures for three years after the current fiscal year unless an audit has been announced or is in process.

C. Assure a competent public health workforce for CMS Programs (CCS, CHDP, and HCPCFC).

1. Recruit, orient, supervise, provide ongoing training, and evaluate personnel responsible for implementing the Plan/Program.

2. Assure sufficient adequately trained staff for performing the required activities in accordance with CMS standards.

3. Develop and review with personnel their duty statements and their performance of allowable enhanced/nonenhanced functions pertinent to their classification.

4. Provide comprehensive orientation and updates that should include information on all three programs.

5. Provide **annual** update to **all local CMS staff** on the Plan (i.e., the budget, scope of work, performance measures) and its progress.

D. Develop and obtain signed Intra/Interagency Agreements (IAA) and Memoranda of Understanding (MOU) with agencies/organizations serving California's children.

E. Develop, implement, and monitor working relationships with Medi-Cal Managed Care Plans and between Health Families and the CCS program. Reflect these working relationships in an MOU between local CHDP and CCS programs and Managed Care Plan(s). Reflect the scope and responsibilities of both parties in the MOU, including but not limited to outreach, provider training, referral tracking and follow-up, health education, data management, and quality assurance and problem resolution.

F. Develop an IAA between the Department of Social Services (DSS), Juvenile Probation Department, and the HCPCFC program according to the model IAA provided by the CMS Branch.

G. Develop an MOU, for implementing responsibilities in the HCPCFC program, among the local CHDP program, local Child Welfare Agency of the County

Department of Social Services, and the Juvenile Probation Department according to the outline provided by the CMS Branch.

H. Develop and maintain an IAA between:

1. CMS and the local Head Start program,

2. The MTP and the Local Educational Agency (LEA), and

3. CMS and the Early Start program.

I. Discuss with other departments, agencies, and organizations ways and means to inform and empower families about obtaining and utilizing quality health care services.

1. Make available current, comprehensive listings and resources of agencies and organizations providing services to children related to CHDP and Prevention Services, Foster Care, and/or CCS. Listing would include official and voluntary agencies, serving health, social, and related issues to assist families in understanding services available and how to obtain them.

2. Develop and maintain a collaborative working relationship among health department programs serving children, e.g., Lead; Maternal and Child Health; Black Infant Health; Public Health Nursing; Comprehensive Perinatal Services; Immunizations; Women, Infants, Children (WIC), Children and Families Commission. Prepare a written agreement with WIC and other programs, as needed.

3. Maintain a liaison with public and private schools and Head Start/State Preschools to ensure:

   a. Dissemination of CMS information.

   b. Participation in CMS services among eligible children.

   c. Coordination of applicable health care and related services to support school readiness.

   d. Provision of in-services for school personnel on CHDP standards and services according to the provisions in the California Health and Safety Code, 124025-124110 and the applicable sections in the California Code of Regulations, Title 17.

   e. Implementation of school reporting requirements.

      CHDP Program Letter No.: 05-01 documents changes brought about by AB2855, Chapter 895, Statutes of 2004 included amendments to the Health and Safety (H & S) Code Section 124100. The amended H & S Code no longer require every public school district and private school in California to report data on the number of children receiving health screening examinations at school entry. Therefore, public school districts and private schools are NOT required to submit the CHDP Annual School Report (PM 272) to the CHDP Program within the local

health department and there will be no reimbursement provided. Private schools and public school districts may continue to gather and share this information at their discretion.

Local CHDP programs continue to have the responsibility to work collaboratively with schools to inform and empower families about obtaining and utilizing quality health care services. The activities involved in maintaining a liaison with public and private schools will help to support school readiness and ensure healthy children ready to learn.

For those private schools and public school districts that will continue to report:

1) Review the local school compliance statistics. Develop specific activities to increase the compliance rate of any school falling below the statewide average.

2) Analyze the proportion of waivers and certificates for complete health examinations. Identify causative factors for the schools with a high incidence of waivers and develop strategies to increase the number of complete health examinations among school entrants when the factors are not based on personal/religious beliefs.

f. Provision of lists of CHDP providers biannually to Head Start/State Preschool programs.

g. Provide an overview of eligibility requirements to school personnel regarding the CCS Program.

J. Develop and maintain a collaborative relationship with the Medi-Cal Program: (i.e., Field Offices, In-Home Operations, and Medi-Cal Managed Care Plans).

K. Develop and maintain collaborative relationships with the regional Hearing Coordination Center to facilitate the process of newborn referral and testing for hearing loss; and the diagnostic testing and follow-up care for infants identified with suspected hearing loss through the Newborn Hearing Screening Program (NHSP).

L. Establish a process in counties/cities for CMS programs to participate in the MCH Title V planning process.

II. Resource Development - Provider Relations, Recruitment, Maintenance, and Quality Assurance

A. Recruit, orient, and maintain a collaborative relationship with CMS providers serving all eligible children.

1. Facilitate CMS provider application process.

2. Train/orient all CMS providers to program responsibilities.

3. Provide on-going information, assistance, resources, and support necessary to ensure quality program implementation including, but not limited, to Provider Notices sent by CMS Branch and returning Reports of Distribution (DHS 4504) to the CMS Branch.

B. Develop and implement a quality assurance plan to ensure CMS children receive quality care.

1. Conduct periodic formal and informal review of CMS providers' compliance with program standards.

2. Support providers in development and implementation of corrective action plans when indicated.

III. Case Coordination/Case Management, Tracking, and Quality Improvement in Public Health Services

A. Implement care coordination/case management to assure children known to CMS programs use available services.

1. Receive or initiate referrals among:

a. CCS,

b. CHDP,

c. HCPCFC/Child Welfare Services (CWS),

d. Outside agencies/individuals,

e. Managed care plans, and

f. Health care providers.

2. Inform the family about health care/services in their community and how to access these services.

3. Determine eligibility and link all eligible members of a household to health services by inquiring of each child's health status, health care coverage, and need for health care services.

4. Facilitate all necessary services within program standards and guidelines.

5. Document and report the results of care coordination/case management in accordance with program standards and guidelines.

B. Implement and maintain a data/file tracking system(s) to assure data retrieval and recovery in accordance with program standards and guidelines for a period no less than three years or until the completion of any federal audit in progress, including but not limited to:

1. Referrals,

2. Health status,

3. Care coordination/case management activities,

4. Services utilization,

5. Informing activities,

6. Documentation, and

7. Reports.

C. Develop, implement, and maintain a quality improvement system to assure CMS programs assist children receive quality medical, dental, and support services across all provider settings.

1. Develop measures to gauge quality of care coordination/case management including:

a. Timely services delivery,

b. Completeness and accuracy of documentation,

c. Effective interdisciplinary/interagency collaboration,

d. Culturally and linguistically competent care,

e. Family centered care,

f. Service delivery outcomes, and

g. Access to a medical home.

IV. Outreach and Education

A. Employ a multifaceted approach working with community agencies; informal networks; residents; health, education, human service, and legal systems; providers; and policy makers to increase value and understanding of, access to, and participation in, primary and specialty health services in accordance with CMS standards, for all children, including children with special health care needs (CSHCN), across the continuum of care.

1. Address those population groups known to have low utilization or high incidence patterns of conditions that are of local concern.

2. Determine ways and means to inform and encourage families about obtaining health care coverage and utilizing quality health care services.

3. Establish contacts and inform the community where CMS services are not known, understood, and/or not utilized.

4. Review, coordinate distribution, and promote the utilization of health education and CMS program materials.

5. Develop, arrange, and/or conduct educational programs regarding health care needs of children.

Using and Reporting Performance Measures in CMS Programs

The use of performance measures to evaluate the effectiveness and success of public health program interventions and activities is part of public health practice. With time, effective program activities enable the attainment of CMS goals and outcomes.

Reporting on the CMS performance measures is a Scope of Work requirement. Starting in Fiscal Year (FY) 2002-03, CMS local programs have been using tracking systems and other data collection methods to measure their work with communities, provider networks, and target populations.

Accountability is determined in three ways:

1. by having budget and expenditure figures;

2. by measuring the progress towards successful implementation and achievement of individual performance measures; and ultimately,

3. by having a positive impact on the desired outcomes of the program. These outcome measures are the CMS goals. If program activities are effective and successful, the CMS goals/outcomes will be accomplished.

While improvement in outcome measures is the long-term aim, more immediate success may be demonstrated through performance measures that are shorter term, incremental, intermediate, and/or precursors for the outcome measures. To that end, in Fiscal Year (FY) 2002-03 the CMS Branch introduced the use of performance measures to track the success of the programs over time.

The following performance measures were selected by a statewide workgroup of State and local program staff to represent the focus of CMS programs. Data are to be reported annually for each performance measure through FY 2006-07.

Directions for Completing the Report of Performance Measures

Reporting on the CMS performance measures is a Scope of Work requirement. Starting in FY 2002-03, local CMS programs have been using tracking systems and other data collection methods to measure their work with communities, provider networks, and target populations.

The following outlines the requirements for reporting annually **by November 30th**. One original and three copies of the CMS Report of Performance Measures are to be sent to the local program's CMS Regional Administrative Consultant.

I. CCS, CHDP, and HCPCFC programs under **joint** administrations are to submit a **single joint** performance report when submitting to the CMS Branch.

II. CCS, CHDP, and HCPCFC programs under **separate** administrations are to collaborate to ensure coordination of services and resources and cooperatively submit **one single** report when reporting performance measure progress to the CMS Branch.

III. Performance measures should be reported in the appropriate format identified for each performance measure. Be sure to include raw data that helped to define a percentage for the performance measure or to achieve the score presented. For performance measure three, data submitted for the numerator should be an unduplicated count so that the resulting percentage is not greater than 100 percent.

IV. Performance and monitoring of the performance measures that began with the baseline data collection in FY 2002-03 are to be continued through FY 2006-07.

V. The Annual Report of the Performance Measures is to be comprised of two elements.

A. The first element is the result of the intervention and monitoring activities related to the performance measure as indicated by the definition and the report form for each performance measure.

B. The second element for the Report of Performance Measures is a brief narrative **not to exceed three pages**. The narrative should outline the ways that each program or joint administration approached the task of ensuring improvement from the last fiscal year, collecting information and data and the selected time period for the measurement.

Information must:

a. Include any steps taken to validate the data to ensure the initial elements were being tracked correctly.

b. Describe decisions made regarding any changes in interventions and monitoring activities reported in the baseline for FY 2002-03 that were implemented based on review of the previous year's data and performance.

c. Describe plans to enhance performance and ongoing monitoring to report performance measures each fiscal year.

d. Describe any significant changes in activities that have resulted from performance measures.

Performance Measure Profile

Performance Measure Number	Fiscal Year 2002-03	2003-04	2004-05	2005-06	2006-07
1					
2 (Optional)					
3					
4					
5					
6					
7 (Optional)					

Performance Measure 1

The degree to which local CCS, CHDP, and HCPCFC programs maintain collaborative relationships internally and externally.

Definition: This measure is to be scored using a scale from 0-3 and based on six characteristics of a collaborative relationship. Please indicate the score based on the level of implementation.

Numerator: The total score of the six characteristics.

Denominator: 18

Data Source/Issue: County programs.

Reporting Form: See Section 3 – Page 15

Reporting Form for Performance Measure 1

Six characteristics documenting collaborative relationships with other departments, agencies and organizations.

0 ☐	1 ☐	2 ☐	3 ☐	1. Memoranda of Understanding are signed between the local CMS programs and the Department of Social Services, Probation Office, WIC program, Medi-Cal managed care plans and Healthy Families health plans.
0 ☐	1 ☐	2 ☐	3 ☐	2. Local programs meet at least quarterly with Medi-Cal managed care plans, Healthy Families health plans and other agencies and/or departments.
0 ☐	1 ☐	2 ☐	3 ☐	3. A problem resolution process is documented and implemented.
0 ☐	1 ☐	2 ☐	3 ☐	4. A liaison has been designated to be the point of contact for health plans, agencies and other departments.
0 ☐	1 ☐	2 ☐	3 ☐	5. Management level staff meets at least annually to identify policy issues and discuss overall program satisfaction.
0 ☐	1 ☐	2 ☐	3 ☐	6. Collaborative activities have resulted in positive outcomes.

0 = Not Met 1 = Partially Met 2 = Mostly Met 3 = Completely Met

Total the numbers in the boxes (possible 0-18) and enter the number as a total score for this performance measure.

Performance Measure 2

- OPTIONAL -

The percent of children entering first grade in public and private school by school district reporting a "Report of Health Examination for School Entry" (PM 171 A) or "Waiver of Health Examination for School Entry" (PM 171 B).

Definition: The percent of children entering first grade with a health exam certificate or waiver.

Numerator: Among those private and public school districts continuing to report: The total number of children entering first grade with a:

a. Certificate and

b. Waiver.

Denominator: Among those private and public school districts continuing to report: The total number of children enrolled in first grade in public and private school.

Data Source/Issue: Public school districts and private schools serving first grade students.

Reporting Form: Local program/area tracking report form.

Performance Measure 3

The percentage of CHDP providers with evidence of quality improvement monitoring by the local CHDP program through:

I. an orientation and/or training

II. an office visit which includes a chart review and a facility review

III. a desktop review (defined by selected review of PM 160s by provider and/or other quality improvement documentation e.g. consumer complaints, parent satisfaction surveys, managed care plan reports).

Definition: The percentage of CHDP providers for whom local program staff has done:

a. an orientation and/or training, or

b. site visit, or

c. a desktop review.

Numerator: The number of provider sites for whom:

a. orientations and/or training's done, or

b. site and/or office visits done, or

c. desktop reviews done.

Denominator: The number of active provider sites in the county or city.

Data Source/Issue: Local program/area tracking report system.

Reporting Form: Local program/area tracking report form.

Performance Measure 4

The degree to which the CMS program demonstrates family participation.

Definition: This measure is to be scored using a scale from 0-3 and based on six characteristics that document family participation in the CCS program. Please indicate the score based on the level of implementation.

Numerator: Total score of six characteristics.

Denominator: 18

Data Source/Issue: Local CCS program.

Reporting Form: See Section 3 – Page 19

Reporting Form for Performance Measure 4

Six characteristics documenting family participation in the CCS program.

0 ☐	1 ☐	2 ☐	3 ☐	1. Family members participate on advisory committees or task forces and are offered training, mentoring, and reimbursement, when appropriate.
0 ☐	1 ☐	2 ☐	3 ☐	2. Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.
0 ☐	1 ☐	2 ☐	3 ☐	3. Family members are offered an opportunity to provide feedback regarding their satisfaction with the services received through the CCS program by participating in such things as surveys, group discussions, or individual consultation.
0 ☐	1 ☐	2 ☐	3 ☐	4. Family members are involved in in-service training of CCS staff and providers.
0 ☐	1 ☐	2 ☐	3 ☐	5. Family advocates, either as private individuals or as part of an agency advocating family centered care, who have experience with children with special health care needs, are hired or contracted as paid staff or consultants to the CCS program for their expertise.
0 ☐	1 ☐	2 ☐	3 ☐	6. Family members of diverse cultures are involved in all of the above activities.

0 = Not Met 1 = Partially Met 2 = Mostly Met 3 = Completely Met

Total the numbers in the boxes (possible 0-18) and enter the number as a total score for this performance measure.

Performance Measure 5

The degree to which local CCS, CHDP, and HCPCFC programs provide effective case management to eligible children.

Definition: This measure is to be scored using a scale from 0-3 and based on seven characteristics that demonstrate effective case management in CMS programs. Please indicate the score based on the level of implementation.

Numerator: Total score of seven characteristics.

Denominator: 21

Data Source/Issue: Local tracking mechanisms for each characteristic.

Reporting Form: See Section 3 – Page 21

Reporting Form for Performance Measure 5

Characteristics that demonstrate that the CCS, CHDP, and HCPCFC programs provide effective case management to eligible children.

0 ☐	1 ☐	2 ☐	3 ☐	1. Children enrolled in CCS have documented medical homes/primary care providers.
0 ☐	1 ☐	2 ☐	3 ☐	2. Children in out-of-home placement have documented primary care provider.
0 ☐	1 ☐	2 ☐	3 ☐	3. Children in out-of-home placement supervised by Child Welfare Services or Probation Department have a preventive health and dental exam within the past year documented in the Health and Education Passports.
0 ☐	1 ☐	2 ☐	3 ☐	4. Children referred to CCS have their program eligibility determined within the prescribed guidelines per the CCS Administrative Procedures Manual published in July 2001.
0 ☐	1 ☐	2 ☐	3 ☐	5. Children enrolled in CCS whose conditions require CCS Special Care Center services are seen at least annually at appropriate Special Care Centers.
0 ☐	1 ☐	2 ☐	3 ☐	6. Fee-for-Service Medi-Cal eligible children whose CHDP screening exams reveal a condition requiring follow-up care (coded 4 or 5 on the PM 160) receive follow up care.
0 ☐	1 ☐	2 ☐	3 ☐	7. Non-Medi-Cal eligible children whose CHDP screening exams reveal a condition requiring follow up care (coded 4 or 5 on the PM 160) receive follow up care.

0 = Not Met 1 = Partially Met 2 = Mostly Met 3 = Completely Met

Total the numbers in the boxes (possible 0-21) and enter the number as a total score for this performance measure.

Performance Measure 6

Identify the prevalence of children, by age, at-risk of being overweight and who are overweight according to CHDP program (County/City) data in the Pediatric Nutrition Surveillance System (PedNSS) Annual Report from the Center for Disease Control (CDC).

Definition: The prevalence of children, by age, who are at-risk of being overweight and who are overweight, and the local CHDP program use of County/City PedNSS data with other agencies and organizations.

***Numerator:** The number of children reported in County/City PedNSS data who are identified at-risk of being overweight (85th<95th percentile) and who are overweight ($\geq 95^{th}$ percentile) according to PedNSS age groups.

* The numerator is derived by multiplying the percent of identified children in the age category by the total number of children in the same age category.

Denominator: The total number of children, by age, reported in County/City PedNSS data.

Data Source/Issue: Most current CDC's Pediatric Nutrition Surveillance System Annual Report, County/City Specific Data, Table 16B: Growth Indicators by Race/Ethnicity and Age (most values are obtained from the last column of Table 16B; please attach your county/city Table 16B to your submission.

Reporting Forms: See Section 3 – Page 23

Reporting Forms for Performance Measure 6

Prevalence of Children At-Risk for Overweight and Overweight by Age[1]

TOTAL ALL RACE/ETHNIC GROUPS*	At-risk for overweight (85th - <95th%)	Overweight (≥95th%)
0 - 11 Months	NOT APPLICABLE	
12 - 23 Months	NOT APPLICABLE	
24 - 59 Months		
5 - 8 Years		
9 - 11 Years		
12 - 14 Years		
15 - 19 Years		
TOTAL (AGES 5 <20 YEARS)		

*This table is intended to collect County/City percentages of age groups only. This means all race & ethnic groups are combined within each age category. Report the prevalence rate that is identified as "Total All Race/Ethnic Groups". When the number of children for any age or ethnic category is less than 100, CDC does not provide prevalence data. It is "optional" for counties with less than 100 children in any of the above categories to report their data. A hand (manual) count will be accepted but this is an "optional" activity.

Two characteristics documenting use of County/City PedNSS program data:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 1. Local County/City program reports and shares PedNSS data with advisory committees, task forces, medical providers and/or obesity collaboratives.

0 ☐ 1 ☐ 2 ☐ 3 ☐ 2. Local County/City program uses PedNSS data in conjunction with other reports to focus prevention/intervention efforts.

0 = Not Met 1 = Partially Met 2 = Mostly Met 3 = Completely Met

Total the numbers in the boxes (possible 0-3) and enter the number as a total score for this performance measure. (Standards are not defined for the above 0-3 rankings.)

[1] Center for Disease Control Pediatric Nutrition Surveillance System Annual Report, County/City Specific Data Table 16B: Growth Indicators by Race/Ethnicity and Age

Optional Performance Measure

Clinical preventive services for CHDP eligible children and youth are expected in accordance with the CMS/CHDP Health Assessment Guidelines. The delivery of those services is documented on the Confidential Screening/Billing Report (PM 160). Examples of evidence-based performance of these services includes:

- Number and percent of children 2-years old fully immunized,
- Number and percent of children 1 to 2 years old given a blood lead test referral,
- Number and percent of children 1 to 2 years old receiving a blood lead test,
- Number and percent of age appropriate children given a WIC referral,
- Number and percent of age appropriate children screened for asthma, and
- Number and percent of age appropriate children given a dental referral.

Examples of other optional performance measures:

- Number and percent of children in out-of-home placement receiving a physical or dental exam within 30 days of placement, and
- Number and percent of children in out-of-home placement receiving annual medical and dental exams.

This performance measure allows county programs to identify and track services that are focused on areas that are of particular concern to them.

Performance Measure 7

-Optional-

The degree to which the health needs of children and youth are being detected and addressed through clinical preventive services in the CHDP program.

Definition: To be defined by the local program based on their needs and priorities.

Numerator: To be determined.

Denominator: To be determined.

Data Source/Issue: Local program/area tracking system