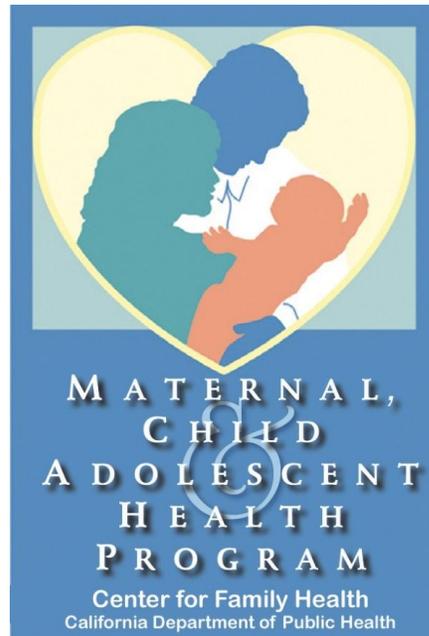


CALIFORNIA GRANT APPLICATION
AND ANNUAL REPORT FOR THE
MATERNAL AND CHILD HEALTH SERVICES
TITLE V BLOCK GRANT PROGRAM



MATERNAL, CHILD, AND ADOLESCENT HEALTH DIVISION
DEPARTMENT OF PUBLIC HEALTH
&
SYSTEMS OF CARE DIVISION
DEPARTMENT OF HEALTHCARE SERVICES

STATE OF CALIFORNIA

June 7, 2013 DRAFT
APPLICATION/ANNUAL REPORT

State Narrative for California

**Application for 2014
Annual Report for 2012**

DRAFT 06/01/2013

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II. Needs Assessment Summary

Reference to Children's Medical Services (CMS) is gradually being phased out and replaced by Systems of Care Division (SCD). Emerging issues and changes to SCD programs and system capacity as they relate to priority needs are described below.

> Modify the California Children's Services (CCS) program, with appropriate funding, to cover the whole child.

The 1115 Bridge to Reform waiver" implementation has begun. Five project demonstration sites were selected with 4 different models of care through which CCS-enrolled children will have all their care needs met through a single coordinated health system. The Medi-Cal Managed Care (MCMC) Health Plan model was implemented on April 2013. Key milestones including establishment of a capitated monthly reimbursement rate, ensuring member/ consumer rights, and maintaining the functions of core CCS program in counties where the CCS Demonstration will be implemented.

The CCS Demonstration pilot programs will be evaluated through the University of California at Los Angeles (UCLA), Center of Health Policy Research. This work is overseen by the 1115 Evaluation Oversight Committee, a team of key CCS leaders, Medical Consultants, and stakeholders representing facilities, providers and family advocacy groups.

> Expand the number of qualified providers of all types in the CCS program.

An on-going CCS Program challenge is to improve access to pediatric subspecialty physicians and the number of CCS approved Hospitals and Special Care Centers. SCD has reinvested in a concerted effort to increase production of processing applications from facilities to become CCS-approved providers.

The passage of the Affordable Care Act (ACA) resulted in a significant increase in physician reimbursement for pediatric primary and subspecialty care. The State anticipates a significant increase in access to health care for all CSHCN, including enrollees in CCS and Medi-Cal. The State is also examining the potential integration of nurse practitioners into the CCS Program.

In addition, CCS is implementing Assembly Bill (AB) 415, enacted in 2012 with the goal of removing barriers from Telehealth use and increasing access. CCS and Medi-Cal are actively developing policies to implement the provisions of AB 415, while maintaining CCS standards for proper multidisciplinary care, and integrating "best practice."

≥ CCS will work with appropriate partners to define, create, and implement standards for Medical Homes for CCS children.

CCS is obtaining information on the number of CCS children with a medical home through a performance measure that indicates whether each child in the CCS program has a medical home. In addition, CCS meets with stakeholders to gather consensus on essential elements of a medical home, and have a standardized definition of a medical home shared with all groups. CCS is looking into expanding the family satisfaction survey used for the 1115 waiver counties to administer statewide.

The CCS stakeholder group identified priority objectives where successful implementation can be assessed through a survey, assessing medical home status and family partnership in decision making. CCS continues to work with stakeholders to develop and implement a client/family satisfaction survey specific to the CCS population. CCS is looking into expanding the family satisfaction survey used for the 1115 waiver counties to administer statewide.

≥ Ongoing Needs Assessment Activities

The Maternal, Child and Adolescent Health Program (MCAH) conducts ongoing needs assessment activities to monitor and assess the health of the state's MCAH populations. Ongoing data collection and analysis related to our priority needs inform state level programs and policies. Dissemination of findings to local health jurisdictions (LHJs) and stakeholders supports their efforts to effectively address these priorities as well. Annual Scope of Work (SOW) revisions also provide an opportunity for local programs to address emerging health issues through their local MCAH programs.

In Fall 2012, MCAH, in partnership with the Family Health Outcomes Project (FHOP) at the University of California at San Francisco (UCSF), developed a form based on the literature to effectively and feasibly capture and quantify local collaborative efforts.

MCAH's 2016-2020 needs assessment planning is also underway. In February 2013, MCAH convened an internal steering committee that has been meeting weekly to develop needs assessment guidelines for its implementation at 61 LHJs. With the changing political, economic, demographic and social environments MCAH will mandate all LHJs to reassess what is most important and make judicious choices that will yield the greatest health gains for the MCAH population they serve. The goal is to facilitate evidence-based decision making in defining local priorities and mobilize their stakeholders to use surveillance data in policy decision support and the development of a five-year local action plan. To support this effort, MCAH is developing an epidemiologic profile from a composite of select health indicators and measures for each LHJ. An action plan template that aligns with the MCAH LHJ SOW is being developed to assist LHJs with linking their needs assessment findings to local program planning and evaluation. Together with FHOP, MCAH is preparing local training and technical assistance to build capacity and support local needs assessment efforts. These capacity building efforts include compiling a series of problem analysis and best/ promising practices literature for

MCAH selected priority health issues; analyzing and making available local trend data and sub-population group comparisons of select local health indicators. Local data is being made available to assist LHJs to guide them in identifying priority problems and target populations for intervention. LHJs will be required to submit a local needs assessment report by May 2014 and five-year action plan by May 2015. As part of the planning process, six local MCAH directors were invited to provide their input in the planning process. Needs assessment activities will also include a series of brief online surveys which address MCAH areas of interest including CSHCN, Native American populations and ACA implementation.

To enhance program communications, MCAH and SCD which is referred to as CMS in previous annual reports, have initiated monthly face to face meetings starting in April 2013. Update on state needs assessment plans have been discussed regularly at these meetings.

III. State Overview

A. Overview

>Geography

California is the most populous state and, in terms of total land area, the third largest state in the nation. Covering over 156,000 square miles California is home to numerous mountain ranges, valleys and deserts. [1] It is bordered by Oregon to the north, Mexico to the south, Nevada and Arizona to the east, and the Pacific Ocean to the west. Depending on how urban and rural areas might be classified, as much as fifteen percent of California could be designated as rural. [2] There are 58 counties in the state with a land area ranging from 47 square miles in San Francisco to 20,053 square miles in San Bernardino. Most counties cover an area greater than 1,000 square miles. The regions with the largest land area include Inyo, Kern, and Riverside Counties. Each of these counties covers an area greater than 7,000 square miles. The smallest regions -- those with less than 600 square miles of land area -- include Santa Cruz, San Mateo, San Francisco, and Amador Counties. [1]

>Population

In 2010, an estimated 39.1 million people resided in California, an increase from 34.1 million in 2000. [3] California's population growth is expected to continue over the next 10 years to reach 44.1 million by 2020. [3] Currently, in 2010, an estimated 42% of the population is White, 37% Hispanic, 12% Asian, 6% African American, 2% multi-race, 0.6% American Indian, and 0.4% Native Hawaiian/Pacific Islander. Trends in the racial/ethnic composition of California's population through 2020 predict a continuing decline in the White population proportion and an increase in the Hispanic population, which will become the largest racial/ethnic group in California. The proportions of other racial and ethnic groups in California will remain relatively stable through 2020.

California's diversity is shaped by the multitude of racial and ethnic sub-groups across the state. For example, California's Asian population, the largest in the nation, demonstrates substantial diversity. The largest Asian sub-groups in California are Chinese, Filipino and Vietnamese. Within each Asian group is variation in language and culture. While the largest numbers of Asians reside in the large population centers of Southern California in Los Angeles (L.A.), Orange, and San Bernardino counties, counties with the largest percentage of Asian residents are in the San Francisco Bay Area. [3] Hispanic groups in California are predominantly Mexican (83%), followed by other Hispanic or Latino groups from Central and South America (15%). Less than 2% are Puerto Rican or Cuban. Due to shifts in immigration patterns, an increasing number of indigenous Mexicans have settled in California. [4] [While Southern California has the largest numbers of Hispanic residents, at 77%, Imperial County has by far the largest proportion of Hispanic residents in California. In addition, more than 50% of the population in the agricultural counties of Central California is Hispanic.[5] /2012/In 2009, 28.1% or 147,766 of 526,774 births were to foreign-born Hispanic women and 23.2 % or 122,187 of 526, 774 births were to US-born Hispanic women.//2012//

//2013/ > **Economy**

For 2012-13, the State faces a \$15.7 billion budget deficit. To restore fiscal balance, more cuts to state programs and the state workforce were proposed. //2013//

>**Age Distribution**

In 2010, an estimated 49.4% of the child population 0-18 years of age was Hispanic, followed by White (30.5%), Asian (9.9%), and African American (5.7%). Children identified in multiple race categories were 3.6%. American Indian (AI; 0.5%) and Pacific Islanders (0.4%) made up a small proportion of the overall child population. By 2020, over 52% of children are expected to be Hispanic. The number and percent of Asian children will increase, though not as substantially as Hispanic children. The number and proportion of the White and African American children are expected to decline. Other groups are expected to remain stable. Young children 0-5 years of age are in a particularly sensitive developmental period, and experiences during this time have great influence over subsequent life course health trajectories. The population of children 0-5 years of age has increased from 3 million in 2000 to 3.3 million in 2010, and is projected to reach 3.8 million by 2020. The 2010 racial/ethnic distribution of the young child population was similar to children overall. As with the overall population, proportion of children ages 0-5 who are Hispanic are expected to continue to increase through 2020, while the proportion that is White are expected to continue to decline. Other racial/ethnic groups are projected to remain fairly stable through 2020. [3] In 2010, there were 8.1 million women of reproductive age (ages 15-44) in California. The largest group was Hispanic women (41%), followed by White (37%), Asian (13%) and African American (6%). The percentage of Hispanic women is expected to continue to increase among this age group through 2020 to 47%, and the percentage of White women are expected to decline to 32%. Other groups are expected to remain somewhat stable. Of particular interest are the youngest women of reproductive age, who demonstrate increased risks and poorer birth outcomes compared to their older counterparts. [6], [7] In 2010, there were an estimated 1.5 million females ages 15-19 and 875,000 females ages 15-17 in California. Hispanic females were the largest racial/ethnic group among the 15-19 year olds (47%), followed by White (33%), Asian (10%), and African American (7%). Racial/ethnic distribution was similar among females ages 15-17. //2012/ In 2011, the population of children and reproductive age women increased. Among children and reproductive age women, the Hispanic population proportion increased to 49.8% and 41.9%, respectively, the White population proportion decreased to 30.0% and 36.0%, respectively, and small or no changes were observed in other racial/ethnic groups. [3] //2012//

>**Immigration**

California is home to 9.9 million immigrants, the largest number and percentage of foreign born residents in the United States. [8] International immigration has accounted for 40% of California's population growth since 2000. Further, since 44.5% of California births are to women born outside the U.S., [9] the well-being of this population has a strong influence on overall MCAH status in California. Most of California's immigrants

are from Latin America (56%) or Asia (34%). The leading countries of origin for immigrants are Mexico (4.4 million), the Philippines (750,000) and China (659,000). [9] Immigration status is related to poverty among children in California, which in turn is a strong predictor of health outcomes. Overall, 48% of California's children have immigrant parents; 34% have at least one legal immigrant parent and an estimated 14% have at least one undocumented immigrant parent. Among these children, 24% of children with legal immigrant parents are poor and 38% of children with undocumented immigrant parents are poor. [10] California has the largest number and proportion of undocumented immigrants of any state. [11] Many undocumented immigrants in California experience difficulty in meeting basic needs and accessing services, while facing additional health risks related to low wage jobs that lack protections and benefits. In 2008, approximately 2.7 million undocumented immigrants lived in California, an increase from 1.5 million in 1990.[11] In 2004, approximately 41% of California's undocumented immigrants resided in L.A. County. [10]

>Languages Spoken

Limited English proficiency (being able to speak English less than 'very well') poses challenges for educational achievement, employment, and accessing services, and results in lower quality care for immigrant communities--each of which influences MCAH outcomes. Among California's population over 5 years of age, 14.3 million speak a language other than English at home and 6.7 million have limited English proficiency. [8] California's linguistic diversity requires the MCAH system to develop linguistic competence in multiple languages. Among youth in California's public schools, one in four is an English Language Learner (ELL) who is not proficient in English. These 1.5 million students speak 56 different languages, but over 1.2 million of ELL students are Spanish speakers. Other common languages are Vietnamese, Filipino, Cantonese, and Hmong. ELL students reside in every county in California, and in 14 counties in California's Southern, Central Valley, and San Francisco Bay areas, ELL students make up over 25% of the student population. [12]

>Education

In California, one in five individuals over the age of 25 has not completed high school and nearly 10% has not completed 9th grade. Further, measures of educational attainment show that while graduation rates have declined only slightly from 69.6% in 2000 to 68.5% in 2008, drop-out rates have risen sharply from 10.8% in 2000 to 18.9% in 2008. [13] Educational attainment varies greatly by race/ethnicity and gender. The 2007-08 dropout rate was higher than the state average for African Americans (32.9%), AI /Alaska Natives (AN; 24.1%), Hispanics (23.8%), and Pacific Islanders (21.3%), and was lower than the state average for Whites (11.7%), Filipinos (8.6%) and Asians (7.9%). [14] California's high school graduation rate for African Americans (59.4%) and Hispanics (60.3%) was substantially lower than for Whites (79.7%) and Asians (91.7%). The graduation rate for females (75.8%) is higher than for males (67.3%) overall, and for each racial/ethnic group.[15] /2012 In 2009, the graduation rate increased to 70%. [13]

>Income

According to the most recent census data, over 4.6 million Californians, 13% of the population, have incomes at or below 100 percent of the federal poverty level (FPL). The 100 percent FPL in 2008 was \$21, 200 for a family of four. African Americans, Hispanics, and AI have the highest rates of poverty in California. [16] Among children under age 18 the rate is higher: 16% of the population is in poverty, or approximately 1.6 million children. [17] Projections of child poverty rates through 2012 anticipate that child poverty in California will increase as a result of the recession, peaking at 27% in 2010 before declining slightly to 24% in 2012. In L.A. County, home to 25% of California's children, one in three children is projected to be in poverty in 2010. California child poverty varies tremendously by region. Counties with the highest child poverty rates are in the Central Valley, Northern Mountain, or border regions of California: Tulare (31%), Lake (28%), Fresno (28%), Del Norte (28%), and Imperial (27%). Counties with the lowest rates of child poverty (below 10%) are in the San Francisco Bay Area, Wine Country, and the Lake Tahoe/mountain recreational area. [17] Only examining the federal poverty level obscures the struggles faced by many families in California because of the high cost of living in this state. An alternate measure of poverty is the self-sufficiency standard, a measure of the income required to meet basic needs (housing, child care, transportation, health care, food, applicable taxes and tax credits and other miscellaneous expenses) that accounts for family composition and regional differences in the cost of living. While 1.4 million (11.3%) of California households are below the FPL, an additional 1.5 million households in California lack adequate income to meet basic needs. [16] [18] Income insufficiency is highest among households with children. Among households with children, 36% of married couple households, 47% of single father households, and 64% of single mother households have insufficient income to meet basic needs. Households headed by single mothers in some racial/ethnic groups have even higher rates of income insufficiency. Nearly 8 out of 10 Hispanic single mother households and fully 7 out of 10 African American single mother households experience income insufficiency. The major financial stressors for households with children are housing and child care; many of these families struggle to meet the most basic needs, cannot afford quality child care, and have limited financial resources to address crises. [18] It is also worthwhile to note that rates of poverty and low income are higher during pregnancy than when measured among children. This means that many more infants are born into financial hardship than statistics on children indicate. [19] /2012/ Poverty among children under age 18 rose to 19.9% in 2009. Another poverty indicator, the percent of public school students eligible for free or reduced price school lunch, increased from 51.0% in 2006 to 55.9% in 2010. [20] While employment grew in 2010, the unemployment rate also increased to 12.4%, the third highest rate in the U.S. [21] Economic recovery has been uneven with some LHJs experiencing continued job losses in 2010. The construction and retail industries experienced continued employment decline in 2010 by more than 10%. [22] //2012//

>Housing

California's high housing costs create a burden for families, resulting in less income available for other resources needed to maintain health. [23] Lack of affordable housing

also forces families to live in conditions that negatively impact MCAH outcomes: overcrowded or substandard housing or living in close proximity to industrial areas increases exposure to toxins such as mold and lead, as well as increased stress, violence, and respiratory infections. [23] It also exposes families to urban deserts, i.e., neighborhoods lacking sidewalks, grocery stores and parks. Even for working families, the high cost of fair market rent is out of reach. In 2010, the fair market rent in California ranged from \$672 in Tulare County to \$1,760 in San Francisco Bay Area counties. [24] In California, on average, one wage earner working at minimum wage would have to work 120 hours per week, 52 weeks per year in order to afford a two-bedroom apartment at fair market rent. The current foreclosure crisis has greatly impacted California homeowner families. In 2008 and 2009 combined, there were over 425,000 residential foreclosures in California. [25] Foreclosure can force families into lower quality homes and neighborhoods, lead to great financial and emotional stress, and disrupt social relationships and educational continuity. Inability to access affordable housing leads to homelessness for some families. More than 292,000 children are homeless each year in California, which is ranked 48th in the percent of child homelessness in the United States, with only Texas and Louisiana having worse rates among children. [26] Homelessness in children has been linked to behavioral health problems, [23] and negatively impacts educational progress. [26] //2012/ Concerns have increased about the effect of foreclosure on renters and community members continuing to live in neighborhoods impacted by high rates of foreclosure. In 2010, there were about 170,000 foreclosures. [25] //2012// /2013/ In December 2011, California had the second highest rate of foreclosures in the country. [27] //2013//

>Public Health System

CDPH is the lead state entity in California providing core public health functions and essential services. The Department has five centers to provide detection, treatment, prevention and surveillance of public health and environmental issues. The MCAH Program, the lead entity that manages the Title V Block Grant is housed under the Center for Family Health (CFH). CFH also oversees provision of supplemental food to women, infants and children, family planning services, prenatal and newborn screening (NBS) and programs directed at addressing teen pregnancy, maternal and child health and genetic disease detection. The other Centers within CDPH include the Center for Chronic Disease Prevention and Health Promotion (CCDHP) which provides surveillance, early detection and prevention education related to cancer, cardiovascular diseases, diabetes, tobacco cessation, injury and obesity; the Center for Environmental Health which is responsible for identifying and preventing food borne illnesses and regulates the generation, handling and disposal of medical waste; the Center for Health Care Quality which licenses and inspects healthcare facilities to ensure quality of care, inspects laboratory facilities and licenses personnel; and the Center for Infectious Diseases which provides surveillance, health education, prevention and control of communicable diseases. To facilitate health planning and coordination and delivery of public health services in the community, California is divided into 61 LHJs, including 58 counties and three incorporated cities. These cities are Berkeley, Long Beach, and Pasadena. In addition to providing the basic framework to protect the health of the community through

prevention programs, LHJs provide health care for the uninsured, which may include mental health and substance abuse treatment services. Given the diversity of these LHJs in size, demographics, income and culture, tremendous diversity also exists in how LHJs organize, fund and administer health programs. MCAH allocates Title V funds to LHJs to enable them to perform the core public health functions to improve the health of their MCAH populations. All LHJs must have an MCAH Director to oversee the local program. LHJs must also conduct a community needs assessment and identify local priorities every five years. LHJs address one or more local priorities in their annual MCAH Scope of Work. LHJs must also operate a toll-free telephone number and conduct other outreach activities to link the MCAH population to needed care and services with emphasis on children and mothers eligible for Medi-Cal. Other LHJ activities include assessment of health status indicators for the MCAH population, and community health education and promotion programs. Specific MCAH categorical programs administered by LHJs include the Adolescent Family Life Program (AFLP), the Black Infant Health Program (BIH), the California Perinatal Services Program (CPSP), the Sudden Infant Death Syndrome (SIDS) education and support services, and Fetal and Infant Mortality Review (FIMR). /2012/ CCS addresses the health service needs of CSHCN in the state. These services include diagnostics and treatment, case management, and physical/occupational therapy for children under age 21 with CCS-eligible medical conditions. Larger counties operate their own CCS programs and smaller counties share the operation of their programs with the state CCS regional offices: Sacramento, San Francisco and L.A.//2012//

/2013/The Office of Family Planning (OFP) was moved from CDPH to the Department of Health Care Services (DHCS) effective July 2012. The Teen Pregnancy Prevention Programs under OFP, including the I&E Program and the California Personal Responsibility Education Program (CA PREP) will move to MCAH. Currently, MCAH is actively implementing CA PREP. Additionally, the Governor's budget proposes the development of the Office of Health Equity under CDPH, which will consolidate multiple organizational entities in multiple Human and Health Service agencies.//2013//

/2014/ The Office of Health Equity will play a key leadership role to reduce health and mental health disparities to vulnerable communities through the building of cross-sectoral partnerships.//2014//

/2013/The Governor established the Get Healthy California Task Force in May 2012 to improve the health of Californians.

> **Access to Health Care**

In California, 19 percent of the population did not have health insurance in 2009/10, and highest among Hispanics. [13]

> **Healthcare Reform**

The Patient Protection and Affordable Care Act of 2010 (ACA) created a new mechanism for purchasing health insurance coverage called a Health Benefit Exchange (HBEX). California was the first state to pass legislation to create a quasi-

governmental body that follows the “active purchaser” model of benefits exchanges. [28] //2013// /2014/ **Starting October 2013, “Covered California, the state-run health insurance market, will qualify low-income individuals and families for free health insurance through Medi-Cal and moderate-income families to premium subsidies to make private health coverage affordable.”/2014//**

Major State Initiatives

The process used by MCAH to prioritize and address current and emerging issues impacting the health of the MCAH population through its major initiatives is multifaceted. This process includes monitoring the MCAH population health status, consultation with our stakeholders, collaboration with local MCAH directors, partnering with programs within CDPH and with staff from other departments such as the California Department of Education (CDE), the California Department of Social Services (DSS), the DHCS and Alcohol and Drug Programs (ADP) and with a variety of public health educators, clinicians and organizations concerned with the well-being of the State's Title V populations. The process also includes support of ongoing MCAH priorities and priority needs identified through the needs assessment process. The process includes consideration of public input, alignment with CDPH's strategic plan and priorities, availability of resources and the political will to address these factors. /2012/ A more in-depth discussion of the major state initiatives is included as an attachment to this section.//2012// Given this multifaceted approach, California's Title V major state initiatives include the following:

>1115 Waiver, Promoting Organized Systems of Care for Children with Special Health Care Needs (CSCHN)

California's Medicaid Section 1115 waiver for hospital financing and uninsured care expired on August 2010 and provides an opportunity to transform the delivery of health care to children enrolled in CCS in a more efficient manner that improves coordination and quality of care through integration of delivery systems, uses and supports medical homes and provides incentives for specialty and non-specialty care with a new waiver application.

Pursuant to (Assembly Bill (AB) x4 6, August 2009), DHCS submitted a new and comprehensive Section 1115 Medicaid waiver. This legislation sought to advance two policy objectives in restructuring the organization and delivery of services to be more responsive to the health care needs of enrollees to improve their health care outcomes and slowing the long-term rate of Medi-Cal program expenditures.

A Stakeholder Advisory Committee consists of individuals representing the populations for whom the delivery of care would be restructured through the waiver design. Reporting to the Stakeholder Advisory Group are technical workgroups (TWG) constructed to discuss each of the populations and make recommendations to DHCS on what could be included in the 1115 Waiver that would improve the delivery of care for CSCHN. The CCS TWG workgroup has assisted in specifically recommending several

delivery models to pilot test in order to determine if any one of them can be used to more effectively provide care for CCS clients. The CCS TWG has advised retention of the successful parts of the CCS program including quality standards and the network of providers.

Members of the CCS TWG represent families, provider organizations (American Academy of Pediatrics[AAP-CA], Children's Specialty Care Coalition, California Association of Medical Product Suppliers, and California Children's Hospital Association); County CCS programs and County Health Administrators; foundations and MCMC health plans. The activities of the CCS TWG have been supported by the Lucile Packard Foundation for Children's Health. Specific information on the CCS TWG can be found at: <http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupCCS.aspx>.

//2012/The "Bridge to Reform" Section 1115 Waiver was approved in November 2010. In April 2011 the Request for Proposal to implement the CCS portion of the Waiver was released seeking applications from qualified entities to develop and administer Demonstration Projects for a group of CCS clients. //2012// //2013/Five projects were selected with 4 different models of care through which CCS children will have all their health care needs met through a single coordinated health system. Projects have phased-in start dates from June 2012 to 2013 and an evaluation program is under development.//2013// **//2014/MCMC, the 1115 Waiver Model, began April 2013 in San Mateo County while the Accountable Care Organization model will begin later in 2013.//2014//**

>Child Health Insurance Coverage

State legislation AB 1422, along with funding from the First Five Commission and program savings enacted by the Managed Risk Medical Insurance Board (MRMIB) will allow the Healthy Families Program, (HF), California's low cost insurance for children and teens who do not qualify for Medi-Cal, to continue providing health care coverage to current enrollees.

From July 2003 through December 2009, over 4 million children receiving assessments were pre-enrolled for up to two months of no cost, full-scope Medi-Cal benefits. The number of families utilizing the CHDP via this process appears to gradually increase due to the number of families losing private health insurance due to the economy. //2012/ From July 2003 through 2010, over 4.4 million children were pre-enrolled.//2012// //2013/From July 2003 through 2011, over 5.8 million children were pre-enrolled.//2013// **//2014/ The combined HF and Medi-Cal enrollment for fiscal year (FY) 2010 was 6,188,788. , The California Health and Human Services Agency (CHHSA), MRMIB and DHCS develop a transition plan for HF enrollees to Medi-Cal. Medi-Cal established the Targeted Low Income Children's Program which expands child eligibility to 250% of FPL. The transition, implemented in phases, began on January 2013, HF will continue to serve families until they are transitioned to Medi-Cal, including AIM-linked infants. In addition, children continue to be pre-enrolled into Medi-Cal through the CHDP Gateway.//2014//**

> Obesity

See National Performance Measure 14 and State Performance Measure 6.//2013//

>Breastfeeding

Due to state budget cuts in August 2009, funds were reduced for the Birth and Beyond California (BBC) a hospital-based breastfeeding continuous quality improvement (QI) project which promotes model hospital policies to improve in-hospital exclusive breastfeeding rates. Funding continues for RPPC in L.A. to develop a report on BBC pilot project findings and provide TA for all other RPPC regions for 2 years. To date, 20 hospitals participated and 2 RPPC regions obtained other funds to continue the BBC work. BBC curricula and tools will be posted on the MCAH breastfeeding website.

/2012/ In addition to the original 23 hospitals that participated in the BBC project, 13 more hospitals have successfully completed this program without the support of CDPH funding. BBC generated national interest and was highlighted at the first California Hospital Breastfeeding Summit held in January 2011. //2012//

/2013/MCAH released the “BBC: A Hospital Breastfeeding Quality Improvement and Staff Training Demonstration Project Report”. Curricula, trainer notes, evaluation tools, and other materials for hospitals are posted at <http://cdph.ca.gov/BBCProject.//2013//>

MCAH is in the process of releasing 2008 in-hospital exclusive breastfeeding data and be made available online with links to resources to help hospitals improve their exclusive breastfeeding rate.

In December 2009, MCAH and the Women, Infants and Children (WIC) Supplemental Nutrition Program, in collaboration with the California Breastfeeding Coalition, and the California WIC Association began the California Breastfeeding Roundtable. The Roundtable met for the second time in June 2010 and has drafted a strategic plan that will be used by the CDPH Nutrition, Physical Activity and Obesity Prevention Program (PAOPP) grant funded by the Centers for Disease Control and Prevention (CDC). MCAH is represented in the US Breastfeeding Committee and be involved in its national promotion of workplace lactation support. MCAH has been advocating for a new CDPH lactation policy and piloting a bring-your-infant to work lactation supportive policy.

CCS is partnering with the California Perinatal Quality Care Collaborative (CPQCC) in a breast milk nutrition QI collaborative for 2010 involving 11 community and regional Neonatal Intensive Care Units (NICUs) with a goal of collaboratively improving by 25% any breast milk at discharge for <1500 gm. infants. The baseline period is 10/1/08 through 9/30/09 and the intervention timeframe is 10/1/09 through 9/30/10. Each NICU has its own goal statement and is also collecting data on process and balancing metrics. In addition to monthly calls and exchanges via e-mail, there are three face-to-face learning sessions in 2010. /2012/This Collaborative ended October 2011. The goal of improving by 25% any breastfeeding at discharge for <1500gm infants was met.//2012//

/2013/ WIC and MCAH finalized a web-based hospital breastfeeding policy curriculum for hospital administrators. In 2011, the Infant Feeding Act was passed requiring that all

maternity hospitals have an infant feeding policy that supports breastfeeding by 2014.
//2013//

/2014/ MCAH collaborated with the Office of Emergency Preparedness to develop an infant feeding plan and with Chronic Disease Division to develop breastfeeding-supportive clinics. //2014//

>Comprehensive Black Infant Health (BIH) Program assessment

MCAH places a high priority on addressing the persistent poor birth outcomes that disproportionately impact the African American community. MCAH has focused efforts to address social disparities to close the gap--BIH is central in these efforts.

The report recommended the development and implementation of a single core model for all local BIH program sites to enhance the impact on African American infant and maternal health. MCAH convened groups of key stakeholders including local BIH and MCAH staff, state MCAH staff, and UCSF Center on Social Disparities in Health staff to develop various aspects of the revised model and comprehensive evaluation plan. The revised model integrates the most current scientific findings, /2013/lessons learned from our previous model, staff and partner expertise//2013// and state and national best practices. The revised model is strength-based, ensures linkages to prenatal care and empowers women to make better health choices for themselves and their families and improve their ability to manage stress related to the social, cultural, and economic issues that are known to influence health, and encourages broader community engagement to address the problem of poor birth outcomes. Services are provided in a culturally competent manner.

The program starts an assessment of clients' needs and strengths. There is primarily case management based on each client's needs. Central to this model is the 20 session group intervention (10 prenatal and 10 postpartum) that encourages and supports behaviors to help African American women become strong individuals and effective parents. The evaluation and data collection process has been revised to assess the program's effectiveness and has program standards and quality assurance measures to ensure the revised model's fidelity. In June 2010, a panel of national experts that was convened endorsed the concept; felt the model was scientifically supported and made recommendations for refinement.

Training on the new model and pilot implementation was conducted at approximately half of the BIH sites in summer of 2010.

/2012/ In November 2010, eight of the 15 BIH sites implemented the revised model. Initial qualitative reports indicate that clients are well engaged and find the group intervention positive and empowering. An early assessment finds that sites have found two major issues: (1) state and local administrative and logistical challenges delayed implementation and transition between the former model and revised model, resulting in loss of recruitment sources, and (2) local sites have not changed their recruitment messages to reflect the revised model. MCAH, working collaboratively with UCSF Center for Social Disparities in Health, and local sites are addressing client recruitment.

BIH sites will be required to complete a client recruitment plan. MCAH will be transitioning the remaining sites through TA and training, to begin implementation in November 2011.//2012//

/2013/ The revised model was implemented in November 2011. In March 2012, MCAH published the report entitled: Black Infant Health Program Pilot Implementation (Phase I) Preliminary Assessment Report. In 2012, MCAH will conduct site profiles of each LHJ and launch an upgraded management information system//2013// **/2014/ (MIS). All profiles were completed and all sites have been trained to use the MIS. Data will be analyzed to generate information for program improvement and evaluation.**
//2014//

>Preconception Health

While the main goal of preconception care is to provide health promotion, and screening and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies, Implicit in its Preconception Health and Health Care Initiative (PHHI) MCAH employs a life course perspective that promotes health for women and girls across the lifespan, regardless of the choice to reproduce, and recognizes the impact of social and environmental factors on maternal and infant outcomes. MCAH partners with organizations and stakeholders across the state to provide direction for the integration of preconception care into public health and clinical practice, develop policy strategies to support preconception care and promote preconception health messaging for women of reproductive age.

/2012/ The Preconception Health Council of California//2012// (PHCC), established in 2006 through a partnership between MCAH and MOD, remains at the center of preconception health activities in the state. In May 2009, the PHCC launched a comprehensive preconception health website--Every Woman California. The website features information about health considerations for women of childbearing age -- including low-literacy PDFs on 21 preconception health topics -- as well as resources, tools and best practices for providers. The website has a partner registration feature to encourage networking and resource sharing among those interested in preconception health and health care and features interactive event calendars and discussion forums: <http://www.everywomancalifornia.org>. /2012/ /2013/ It was updated in 2012 and features reproductive life planning (RLP) and new preconception health clinical resources and statewide initiatives. //2013//

MCAH worked to incorporate preconception health messaging by including interconception curriculum content in BIH and the trainer module for California Diabetes and Pregnancy Program (CDAPP).//2012//

Other preconception health activities include a folic acid awareness campaign implemented in early 2009 designed to address Latinas and women of lower education attainment. It featured Spanish language radio Public Service Announcements (PSAs); outreach to the community through health promoter training; and vitamin distribution and

education through local public health programs. The campaign resulted in a 1200% increase in calls to referral line and 45,000 bottles of vitamins distributed.

MCAH received the First Time Motherhood grant funds from Health Resources and Services Administration (HRSA)/MCHB to implement a preconception health social marketing campaign. /2012/ Data indicated that the lowest prevalence of daily folic acid use was among Latinas, and the lowest prevalence of healthy weight and smoking abstinence were among African Americans.//2012// The project will test "preconception health" and RLP messages in a life course context and message delivery mechanisms, including web- and mobile-based strategies, with different populations, especially African-American women, Latinas and youth of color. The campaign will also address broader societal influences on health. MCAH will be working on this campaign through early 2011. /2013/ PHHI collaborated with AFLP PYD to develop the RLP guiding framework and tool for the client-centered goal setting teen pregnancy prevention program. //2013//

MCAH staff continues to participate in a number of national preconception health-related workgroups including the national preconception health indicators workgroup/2013/, the national expert panel on life course metrics //2013// and the CDC's preconception health consumer workgroup /2014/**Show Your Love campaign**//2014//.

PHCC is the coordinating hub for preconception health activities across the state such as the Interconception Care Project of California (ICPC), an American Congress of Obstetrics and Gynecologists (ACOG), District IX project funded by MOD that is charged with developing postpartum care visit guidelines for obstetric providers. The project aims to provide physicians with tools to address issues at the postpartum visit that could affect a subsequent pregnancy and counsel the patient about /2012/ways to improve their health status and //2012// plans for future children. /2013/ ICPC guidelines were completed and include English and Spanish provider algorithms and patient handouts on 21 common postpartum conditions//2013// /2014/, **with diabetes offered in Vietnamese.**//2014// /2013/Providers were informed of its availability and guideline trainings were offered. //2013//

MCAH LHJs have also undertaken activities related to preconception health. The L.A. Collaborative to Promote Preconception/Interconception Care produced a curriculum for public health providers; published a data brief on preconception health in LA County; established a website; held a second preconception health summit for providers in the county; and developed an evaluation framework for the collaborative. It also oversees local preconception health projects that have had promising results such as the California Family Health Council's (CFHC) effort to develop and introduce a pre/interconception care curriculum into nearly 80 Title X clinics and the Public Health Foundation Enterprises WIC's WOW project (WIC Offers Wellness) which extended its integration of interconception health into WIC from one center to 61 centers throughout L.A. and Orange County. /2013/PHHI developed preconception health scope of work objectives and provided technical assistance to MCAH LHJs. State and local MCAH are partnering to implement the federal Office of Minority Health Peer Preconception Health Program

in community colleges and universities //2013// // **2014/ Together with local partners, MCAH trained about 200 Preconception Peer Educators (PPE) in the San Joaquin Valley and developed statewide training and outreach resources online.**

>High-Risk Infants

The High Risk Infant Follow-up Program (HRIF) screens babies who might develop CCS-eligible conditions after discharge from a NICU and assure access to quality specialty diagnostic care services. All CCS-approved NICUs are required to have a HRIF Program or a written agreement for services by another CCS-approved HRIF Program.

In 2006, CCS redesigned HRIF and started the Quality of Care Initiative (QCI) with CPQCC. The QCI developed a web-based reporting system to collect HRIF data to be used in quality improvement activities. As of March 2010, 60 of the 74 CCS-approved HRIF Programs are reporting on-line, with a reporting of over 2,000 HRIF Program referrals and 1500 HRIF Program visits. /2012/As of March 2011, 62 of the 65 CCS-approved HRIF Programs are reporting on-line, with over 10,860 HRIF Program Referrals/Registrations and 7,181 HRIF Program Standard Core Visits.//2012// /2013/As of February 2012, 65 of 66 CCS-approved HRIF programs are reporting online, with 19,055 HRIF Program Referrals/Registrations and 17,079 HRIF Program Standard Core Visits. The HRIF Executive Committee established a QI workgroup in February 2012. //2013// **/2014/ As of February 2013, 67 of 69 HRIF programs are reporting online with 5170 HRIF Program Referrals/Registrations and 1550 HRIF Program Standard Core Visits for 2012. HRIF summary reports provide information on the follow-up status of enrollees, demographic/social risk information, status of medical and special service needs, neurological examination outcome and developmental outcome. Feedback and report from HRIF Program staff are obtained in the annual quality audit report conducted. //2014//**

>Neonatal Quality Improvement Initiative

CMS and the California Children's Hospital Association (CCHA) sponsored a statewide QI Collaborative, partnering with CPQCC, to decrease Central Line Associated Blood Stream Infections (CLABSIs) in NICUs using the Institute for Healthcare Improvement (IHI) model for QI. Thirteen regional NICUs participated in 2006-07, reducing CLABSIs by 25 percent for all weight groups. In the second year, all 22 Regional NICUs participated, aided by a Blue Shield Foundation grant. The CLABSI rate in 2008 was 2.33 per 1000 line days and 3.22 in 2007, but some of this reduction was due to a CDC definitional change for CLABSIs beginning Jan. 2008. After the grant extension ended in June 2009, 14 regional NICUs continued the CLABSI prevention collaborative and for 2010 they are adding bloodstream infection (BSI) prevention. For 2009 the CLABSI rate for the 14 NICUs was 2.05 for all weights, and competing priorities have been the greatest barrier to infection prevention. /2012/For 2010, the CLABSI rate for all weights had decreased to 0.97, which is a 77% decrease since the inception of the Collaborative in 2006. The Collaborative is continuing in 2011 and will be inviting more Regional NICUs to join.//2012//

/2013/ By mid-2011, CLABSI rate decreased another 70% from 2009; for all birth weights combined it has declined to 0.65 infections / 1000 central line-days. Participating NICUs are implementing practice policies. To comply with Section 2701 of the ACA, elements of the NICU CLABSI collaborative will be brought to all CCS approved NICUs and PICUs beginning July 2012.//2013// **/2014/ The collaborative ends mid-2013. It has sustained gains with an overall CLABSI rate of 0.65/1000 central line-days.**

CCS began a new NICU CLABSI prevention collaborative that integrates QI routinely. This new collaborative funded by the American Hospital Association is linked to a NICU CLABSI prevention collaborative in 14 other states, Of the 180 CCS collaborative, that joined, 68 are CA NICUs. The goal is to enroll all 132 CA NICUs. //2014//.

>Pediatric Critical Care

CMS has structured a system of 21 CCS-approved pediatric intensive care units (PICUs) to assure that infants, children and adolescents have access to appropriate quality specialty consultation and intensive care services throughout the state. CCS sets standards for all CCS-approved PICUs and periodically conducts PICU site visits to help ensure standards are followed. Included in the standards is a requirement to submit annual morbidity/mortality data to CCS. /2012/There are 22 PICUs; Pediatric Risk of Mortality III data are collected.//2012//

CMS and the University of California, Davis conducted a survey of PICU medical directors to assess the infrastructure for Pediatric Critical Care quality care and the need for statewide benchmarking standards to direct QI efforts. CMS will focus on collaboration with PICU leadership in developing a statewide data collection and reporting system for QI purposes. /2012/Work is progressing on the comprehensive severity-adjusted PICU database and finalizing standards for Community Level PICUs.//2012//

/2013/ In February 2012, there were 23 CCS-approved PICUs. Annual PICU reports are stratified by PRISM III scores or data is through the Virtual PICU Performance System (VPS) which exports data into the Pediatric Intensive Care Unit Evaluation (PICUEs)-PRISM III program. An Institutional and Comparative Report is submitted by PICUs. A second level PICU, designated as “Community PICU” has been. A PICU Regional Cooperative Agreement (RCA is under development.//2013// **/2014// In 2013, two CCS Community PICUs were approved, while the RCA is being developed. The VPS California PICU database was developed to be the standard for all PICU’s in California. This dataset will be representative of nearly all CSHCN in California.//2014//**

>Pediatric Palliative Care

CMS submitted a 1915(c) waiver to the Centers for Medicare and Medicaid Services which was approved December 2008. Many stakeholders across California and in other

states participated in the development of the waiver program. The program, which began to enroll children in January 2010, allows Medi-Cal clients to receive hospice-like services at home while concurrently receiving curative treatments. The program partners with hospice and home health agencies to provide a range of services to improve the quality of life for eligible children and their families including care coordination, family training, expressive therapies, respite care and bereavement counseling for caregivers. The initial three year program started in five counties: Alameda, Monterey, Santa Cruz, Santa Clara, and San Diego, and will expand to 13 counties by the third year. /2012/A request for amendment was submitted to CMS and approved to add the service: 'pain and symptom management' (by hospice providers) in October 2010. Year 2 has started in Marin, Orange, SF, and Sonoma counties and is projected to expand to Fresno and LA counties this fall; these (including the first 5) are the targeted 11 counties.//2012//

/2013/The waiver was originally approved April 2009 through March 2012 for 11 of the original 13 counties participating. Medical eligibility criteria were expanded in August 2011 to include any child with a life-threatening or life-limiting CCS-eligible condition with anticipation of 30 inpatient days in the next year, who would benefit from the supportive palliative services offered by PFC. The five year waiver renewal application has been submitted.//2013// **/2014/ The Pediatric Palliative Care Waiver was renewed effective through March 2017 with UCLA conducting the program evaluation Preliminary results show high levels of program satisfaction and significant program savings. As of December, 2012, there were 84 children enrolled in the program in 9 counties, served by one of 10 participating agencies.//2014//**

>Maternal Health

Maternal mortality doubled in California since 1998 to 16.9 deaths per 100,000 live births in 2006, well above the Healthy People 2010 benchmark. African-American women were roughly four times more likely to die from pregnancy-related causes with 46.1 deaths per 100,000 live births compared to 12.9 for Hispanic women, 12.4 for White women and 9.3 for Asian women. /2012/ In 2008, maternal mortality dropped slightly. However, the disparity ratio for African –American mothers continued to rise.//2012// Subsequently, MCAH has supported diverse efforts to identify and address factors that appear to be contributing to increasing rates of maternal morbidity and mortality in California under the “Safe Motherhood” initiative.

First, MCAH gathers and manages statewide and local data needed to analyze factors related to poor birth outcomes and perinatal morbidity and mortality. MCAH conducts the PAMR which is the first statewide fatality review of maternal deaths. Pregnancy-related deaths from 2002 and 2003 have been reviewed and a report on findings is in development. /2012/ The California Pregnancy-Associated Mortality Review: Report on cases reviewed from 2002-2003 was released in April 2011 which describes the methods, the key findings and recommendations from the Committee. Findings have informed MCAH strategies for addressing the rise in maternal mortality. //2012// The Maternal Quality Indicator Work Group (MQI) trends maternal morbidity data and tests methods for monitoring national obstetric quality measures in California. /2012/ MQI has found significant change in maternal morbidity with increased rates of diabetes, maternal

hypertension and asthma.//2012/ **//2014/MQI created a composite indicator and compared ways to track elective delivery.//2014//**

Secondly, MCAH promotes creation of regionalized collaborative networks of care and ensure that patients access care appropriate to their level of risk. RPPC is a statewide regional network that provides consultation to all delivery hospitals and uses current statewide and hospital-specific outcomes data to implement strategies to improve risk-appropriate care for mothers and their babies and collaborates with perinatologists for high-risk mothers and their infants. /2012/ RPPC work with obstetric hospitals to incorporate two obstetric care toolkits; “Improving the Health Response to Obstetrical Hemorrhage” and “Elimination of Non-Medically Indicated Deliveries prior to 39 Weeks Gestation.”//2012// The California Perinatal Transport System (CPeTS) facilitates transport of mothers with high-risk conditions and critically ill infants to regional intensive care units and collects transport data for regional planning and outcome analysis. MCAH also provide support for local programs to improve maternal health through maternity care improvement projects (Local Assistance for Maternal Health). Currently, San Bernardino County is providing leadership to reduce non-medically indicated labor induction with anticipated health benefits to mother and infant. L.A. County is leading a collaborative effort to improve hospital response to obstetrical hemorrhage, a leading cause of maternal morbidity and mortality. /2012/ The projects in San Bernardino and L.A. county will close at the end of June 2011 and two more counties have been selected to lead county wide efforts in a maternity care quality improvement project.//2012// /2013/Several LHJs are promoting preconception health.//2013// **//2014/Due to funding cuts, the Local Assistance to Maternal Health (LAMH) project was reduced to providing technical assistance through the RPPC program.//2014//**

Thirdly, MCAH has developed a Maternal Health Framework (MHF) to guide program development, including improvements for current programs and opportunities to create new programs. The MHF considers social and ecological contributing factors to maternal health in 3 phases of the life course: prior to, during and following pregnancy to restore a mother to health should a health complication arise during pregnancy./2012/ The MHF is being shared with all MCAH LHJs and external stakeholders as an example of an application of life course theory to real world public health policy and program planning. //2012//

For Phase I, the Preconception Health programs (described elsewhere) are focusing on maximizing health of women and girls of reproductive age before they get pregnant. Some programs target pregnant women with the goal of maximizing health during pregnancy.

For Phase II, the BIH program addresses health disparities for African-American mothers and children by facilitating access to prenatal care and providing health education and social support services to mothers. CPSP provides enhanced prenatal services to meet nutrition, psychosocial and health education needs of clients. AFLP provides case management and education to pregnant and parenting adolescents to promote healthy

pregnancy outcomes, effective parenting and socioeconomic independence. OFP provides comprehensive education, family planning services, contraception and reproductive health services with the goal of reducing unintended pregnancies and optimizing maternal health prior to pregnancy.

Finally, in Phase III, MCAH provides programs and services to address common complications of pregnancy. CDAPP recruits, educates and provides consultation and technical assistance to providers who deliver comprehensive health services for high-risk pregnant women with pre-existing diabetes or women who develop diabetes while pregnant. CMQCC has developed two QI toolkits: one to reduce morbidity of obstetrical hemorrhage, a common complication of pregnancy and one to reduce elective inductions of labor prior to 39 weeks gestation which appears to be associated with higher rates of cesarean delivery. //2013/ The toolkit //2013// **//2014/ “Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age” //2014//** //2013/ to reduce elective inductions prior to 39 weeks gestation was licensed to the MOD for national dissemination. It will be translated into Spanish and distributed throughout Mexico based on an agreement with a Mexican national perinatal treatment center and the California Office of Binational Border Health.//2013// **//2014/ It includes elimination of elective inductions and elective C-sections before 39 weeks gestation and was relicensed in 2013. The Spanish translation of the OB Hemorrhage Toolkit has been delayed.//2014//** //2013/A third toolkit to improve the quality of care for preeclampsia is now in development. //2013// **//2014/ The toolkit to Improve the Health Care Response to Preeclampsia was released in April 2013.//2014//**

WIC contributes to optimizing health outcomes throughout all three phases by linking families to local community and public health services and by providing lactation support, nutrition education and nutritious food to low income pregnant women, new mothers and children.

>Data and Surveillance

In 2010, MCAH began collaborating with WIC on public health research projects. The goal of the first project is to create data linkages between WIC program data, the Birth Statistical Master File and MCAH program data in order to identify areas in California where there is a need for WIC services and opportunities to better target WIC services to MCAH populations, and to evaluate outcomes associated with the receipt of WIC services. Geographic information systems (GIS) and 21 hotspot maps will be used to examine results at local levels. //2012/Analyses were completed for linked 2008 data during the past year. Choropleth maps and hot-spot analyses were completed for specific counties and used by WIC to target resources in a funding announcement. Choropleth maps were then generated and disseminated to other WIC program areas for local planning and outreach. . Data for 2009 were linked and will get analyzed in 2011 for similar resource allocation and planning purposes. MCAH also provided training and TA to State WIC staff as well as local WIC providers and agencies on how to interpret and use choropleth maps;. //2012// //2013/ In 2012, WIC program data were linked to the 2010 birth file. MCAH has begun to develop maps using the 2010 data, and a detailed

report on WIC participation around the time of pregnancy. //2013// **/2014/ A detailed report was provided to WIC on 2010 WIC participation around the time of pregnancy. In 2013, WIC program data were linked to the 2011 birth file. MCAH has also started to examine the impact of WIC on a variety of MCAH outcomes, such as pre-term birth. //2014//**

Second, California's Maternal and Infant Health Assessment (MIHA) Survey was expanded in 2010. /2012/ MIHA achieved a high response rate with the 2010 expanded sample, assuring adequate sample size for the proposed state and select county-level analyses of income-eligible women who are not enrolled in WIC. In 2010, women were asked their reasons for not being on WIC. These preliminary results were shared with WIC. The final 2010 data set will be available in July 2011 and MCAH and WIC are working to identify priority analyses and applied uses of these data. //2012// /2013/ County-level data tables and charts were published. //2013// **/2014/ Updated tables, maps, charts and reports using 2011 data will be posted online. The sample design has been revised to allow county-level estimates for the 35 counties with the most births. //2014//**

Over the past year, MCAH collaborated with CDC to develop seven proposed Healthy People 2020 measures, which will combine data from the Pregnancy Risk Assessment Monitoring System (PRAMS) and MIHA. The combined estimates will allow tracking of key MCAH indicators, including infant sleep position, substance use and weight gain during pregnancy, postpartum smoking, and preconception/interconception care, many of which are otherwise unavailable from other data sources, and will represent approximately 85% of all births in the United States.

/2012/ Six PRAMS-MIHA Healthy People 2020 (HP 2020) measures have been accepted as part of the Maternal, Infant, and Child Health topic area to provide baseline data for each HP 2020 objective. Additionally, MCAH collaborated with researchers at UCSF and CDC to submit an abstract to the 3rd National Preconception Health Conference in June 2011, highlighting the new HP 2020 objectives related to preconception/ interconception health, current baseline estimates and targets for 2020, and ways that states can use PRAMS-MIHA data to monitor and inform efforts to achieve HP 2020 targets. //2012//

/2014/In 2013, Morbidity and Mortality Weekly Reports estimated how many women were eligible, but not enrolled in WIC during pregnancy, described their characteristics, and identified variation by state using a combined MIHA-PRAMS analysis.//2014//

/2014/ MCAH will publish data on the 2011 teen birth rate (TBR) and racial/ethnic and geographic disparities. //2014//

/2012/ Since 2004, the Office of Vital Records and MCAH have collaborated to plan Birth Data Quality Workshops across California annually. Joint meetings target area

hospitals with missing data and RPPC assist with presentations to birth clerks who collect birth data to better understand the items on the birth certificate, definitions of medical terms listed, and how the data helps to improve care for women and their infants. Local and state birth registrars, county MCAH Directors, local hospital administration, perinatal nursing staff, medical records and birth data collection staff are brought together, and hospitals are recognized for improvement and high achievement. In 2010, more than 530 participants attended a workshop. /2013/ 2012 is the 8th year for these workshops to improve birth data quality.//2013// **/2014/ Eight workshops to improve birth data quality are scheduled for 2013. //2014//**

MCAH is making a concerted effort to increase surveillance capacity with GIS through use of enhanced address standardization and geocoding techniques; complex spatial analyses; automated map development with use of the Python coding language; and map building and sharing through interactive online maps. Thematic maps, spider diagrams, and statistically based hot-spot analyses of data from multiple sources (MCAH, WIC, Vital Statistics, the American Community Survey and others) have been used to locate regions at the state, county and local level in need of enhanced public health services. Hot-spot analyses were conducted to locate clusters of women in need of WIC services, or could benefit from home visiting program services.

Specialized spider diagram maps were developed to analyze geospatial associations between place of residence of mothers with very low birth weight (VLBW) infants, their delivery hospital and nearest NICU have illustrated the role that distance can play in access to appropriate care for VLBW infants.

MCAH LHI data books, used for local surveillance and needs assessment activities, are being revised by the Family Health Outcomes Project (FHOP) to enhance local surveillance. New indicators will be added to align with the new state priorities, State Performance Measures, and social determinants of health. Data books will be updated each year to support regular community-level monitoring, as is required by the new LHI scopes of work.

/2014/With the support of RPPC, //2014// MCAH disseminates breastfeeding initiation rates annually to all maternity hospitals and provides them with TA to implement evidence-based policies and practices that support breastfeeding. The California WIC Association (CWA) has used these data to publish an annual report that ranks hospitals based on breastfeeding rates generating media attention. California breastfeeding data are available at: <http://cdph.ca.gov/breastfeedingdata>.

/2013/ MCAH continues to post hospital breastfeeding initiation data. These data were used by the CWA to publish their reports.

CCS performance measure data is reported annually by counties. For the Medical Home performance measure, 83% of CCS clients have medical homes, based on county reports of clients with Medical home, which range from 42% to 99%.

>California's Primary and Secondary Teen Pregnancy Prevention Initiatives

Incorporation of teen pregnancy prevention programs into MCAH affords an opportunity for coordinated service delivery across primary and secondary teen pregnancy prevention efforts.//2013//. **/2014/ Two, cross-cutting areas of focus include positive youth development and healthy relationships.//2014//**

>AFLP PYD

In September 2010, MCAH received notification of a Support for Pregnant and Parenting Teens at High Schools and Community Service Centers award from the U.S. Department of Health and Human Services (HHS), Office of Adolescent Health. MCAH received \$2 million per year for 3 years, beginning 2010- 2011. MCAH seeks to improve and increase capacity of the pregnant and parenting services currently offered to eligible youth served through its Adolescent Family Life Program and the California School-age Families Education Program (Cal-SAFE) . The intent is to maximize use of limited resources through the AFLP provision of case management and support services and the Cal-SAFE provision of child and developmental services to support AFLP client school completion. /2013/ MCAH awarded 11 local sites for piloting the new positive youth development case management intervention with integrated life planning to promote reproductive life planning and build youth resiliency. **/2014/MCAH re-applied for the U.S. Department of Health and Human Services (HHS), Office of Adolescent Health funding of the Pregnancy Assistance Fund Program for 4 years, beginning 2013- 2014. //2014//**

>California Personal Responsibility Education Program (CA PREP)

PREP educates adolescents on abstinence and contraception to prevent pregnancy and sexually transmitted infections (STIs), through evidence-based program models and adulthood preparation subjects.

>Information and Education (I&E)

I&E provides adolescents with pregnancy and STI prevention information and linkages to health care. Funded through state general funds and matching Title XIX funds, the most recent RFA for this program was released in 2010, and made funding available from Summer 2012 to Fall 2016.//2013//

> Home Visiting Program

The Maternal, Infant and Early Childhood Home Visiting Program was established on March 23, 2010 by the ACA of 2010, which amended Title V of the Social Security Act by adding Section 511. MCAH is designated as the single State entity to oversee and administer home visiting funds on behalf of California. To receive funding from HRSA and ACF, MCAH began working in partnership with DSS, ADP, the California Head Start State Collaboration Office (CHSSCO) of CDE, and local stakeholders from each of California's 61 LHJs in order to develop California's Home Visiting Program application

(submission, July 9, 2010), Needs Assessment (submission September 20, 2010), and Updated State Plan (submission June 9, 2011). /2013/MCAH was awarded the Home Visiting Expansion Grant to increase the number of communities served. This effort targets particularly high risk and difficult to enroll populations and evaluates individual, program and community factors affecting enrollment and retention. MCAH anticipates implementation of home visiting programs by mid-year 2012. **/2014/Client enrollment began in 2012./2014//**

Two evidence-based models, Nurse-Family Partnership (NFP) and Healthy Families America, were selected to meet the needs of the 21 funded communities identified as “at-risk” through a formal Needs Assessment, a geospatial hot-spot analysis using quantitative data, and qualitative information from local MCAH Directors.

>Health Communications and Public Health Successes

MCAH continues its strong partnership with key partners including local MCAH programs. MCAH helped develop news releases on teen births and infant mortality. MCAH developed fact sheets on multiple MCAH-related health issues.//2013// **/2014/ Since April 2014, MCAH and CMS have been meeting monthly to improve information exchange between the programs./2014//**

>Strategic Map

/2013/CDPH developed, and will implement the Strategic Map, a graphic representation of CDPH’s strategy. MCAH provided input in its development and will participate in CDPH strategic priorities and objectives.//2013// **/2014/ In Winter 2013, the Office of Quality Performance and Accreditation was created to provide leadership and coordinate department initiatives that seek to improve the quality and performance of programs and processes within CDPH, including public health accreditation. //2014//**

B. Agency Capacity

California has a statewide system of programs and services that provides comprehensive, community-based, coordinated, culturally competent, family-centered care. For example, Special Care Centers (SCCs) and hospitals that apply to become CCS-approved must meet specific criteria for family-centered care (FCC). FCC is assessed by the CMS Branch as part of the ongoing review process of CCS-approved SCCs and hospitals. Local CCS programs facilitate FCC by assisting families to access authorized services, such as pediatric specialty and subspecialty care, and by providing reimbursement for travel expenses, meals, and motel rooms during extended hospital stays.

/2014/Reference to Children’s Medical Services and/or CMS Branch is gradually being phased out and replaced by Systems of Care Division (SCD)./2014//

MCAH and CMS programs provide direct services, enabling services, population-based services and/or infrastructure-building services. A table is attached as a guide to identify the lead agencies with which these programs are affiliated, the primary population these programs target; pregnant women; mothers and infants; children, adolescents, and CSCHN) and the availability of the program at the local or community level. These programs were created or permitted by statute and include the following:

>Adolescent Family Life Program (AFLP)

AFLP aims to promote healthy development of adolescents and their children, healthy lifestyle decisions, including immunization and pregnancy prevention and continuation of adolescents' education. It uses a case management model to address the social, medical, educational, and economic consequences of adolescent pregnancy, repeat pregnancy and parenting on the adolescent, her child, family, and society. It also links clients to mental health, drug and alcohol treatment, foster youth, family planning and dental care services and direct services available through Medi-Cal and Temporary Assistance for Needy Families (TANF) or Cal Works as it is known in California. AFLP targets services to pregnant and parenting teens and is providing services to approximately 6000 adolescents in 38 /2014/33//2014//programs throughout the State. In many counties, AFLP is the only case management program available for pregnant and parenting teens. /2012/ The caseload for 2010 was 8,902 clients in 37 programs./2012// /2013/ MCAH awarded 11 local agencies to increase program capacity and professional development in the area of positive youth development. //2013//

>Black Infant Health (BIH)

BIH which has the goal of reducing African American infant mortality in California uses case management and group interventions to support African American women in their pregnancies and improve birth outcomes. The BIH program is currently serving approximately 3000 women in 16 /2014/15//2014// programs in the State. /2012/BIH revised services to include a client-centered, strength-based group intervention with case management. //2012//

>California Birth Defects Monitoring Program (CBDMP)

CBDMP collects and analyzes data to identify opportunities for preventing birth defects and improving the health of babies. The 2006 /2014/2009//2014//birth year information was recently linked to vital statistics live birth and fetal death information, creating a database of more than 129,000 /2014/135,323//2014// pregnancies affected with birth defects from a base population of 6.25 million births. Birth year 2007 /2014/2010//2014// linkage will be completed soon. /2013/Birth year information is linked to vital statistics data for 8 counties. The CBDMP Registry has data for more than 140,000 /2014/144,650//2014//babies with birth defects since 1983. //2013//

>California Children's Services (CCS) Program

CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical

conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae.

The program authorizes medical and dental services for CCS-eligible conditions, establishes standards for providers, hospitals, and SCCs for the delivery of care, and provides physical and occupational therapy and medical case conference services at selected public school sites for children with specific medically eligible conditions. Thirty-one "independent" counties fully administer their own CCS programs, and 27 "dependent" counties share administrative and case management activities with CMS Branch Regional Offices. Social Security Income (SSI) beneficiaries with a CCS medically-eligible diagnosis are served by the CCS program. /2012/The CCS caseload for FFY 2009 is 179,306 of which 76.1% are in Medi-Cal; 14.3% in HF, and 9.6% in state only CCS.//2012// /2013/ There were 246,301 clients in the CCS Program in SFY 10-11, based on the CMS Net system.//2013//

CCS has a regional affiliation system with 114 CCS-approved NICUs. NICUs providing basic level intensive care services are required to enter in to a Regional Cooperation Agreement (RCA) with NICUs that provide more extensive services, to facilitate consultation and patient transfers as needed. CCS approves the designated level of patient care (Intermediate, Community and Regional) provided in each NICU, and verifies that the RCA is in place. Starting with 2004 data, all CCS NICUs are required to submit their CCS data through CPQCC.

>California Diabetes and Pregnancy Program (CDAPP)

CDAPP promotes optimal management of diabetes in at-risk women, before, during and after pregnancy. Regional teams of dietitians, nurses, behavioral specialists and diabetic educators provide training and technical assistance to promote quality care provided by local Sweet Success providers and to recruit and train new Sweet Success providers in areas of need. /2013/ CDAPP funding for regional services was eliminated; however, a resource and training Center will be maintained//2013// **/2014/ to provide webinar trainings and resources to CDAPP Sweet Success Affiliates. //2014//**

>California Early Childhood Comprehensive Systems (ECCS)

ECCS promotes universal and standardized social, emotional and developmental screening. ECCS collaborative efforts provide CHDP with guidance on validated and standardized developmental/social-emotional health screening tools for earlier identification of children with developmental delays. The revised guidelines were an important collaboration between CHDP and the MCAH led team of the national Assuring Better Child Health and Development (ABCD) Screening Academy Project. The work to enhance California's capacity to promote and deliver effective and well-coordinated health, developmental and early mental health screenings for young children, ages 0-5, continues through the Statewide Screening Collaborative (SSC), which served as the stakeholders in the ABCD project.

//2014/Plans were developed to implement Help Me Grow whose core components complement the developmental screening activities of the California Home Visiting Program and California's Race-to-the-Top Early Learning Challenge.//2014//

ECCS is partnering with Alameda County to develop early childhood programs of care for children 0 to 8 years of age California Project Launch. /2012/ Project Launch's goal is to show the feasibility and impact of recommended policy changes to establish and maintain a developmental continuum that prepares children to learn. //2012//

//2014/Systems change resulted in introducing evidence-based practices;; improved social-emotional services; new partnerships; a shift toward a more comprehensive early childhood view (ages 0-8); promoting improved screening tools, curricula, and referral protocols; and working toward a common framework for providing child and family services.//2014//

/2013/California Home Visiting Program staff has recently convened the State Interagency Team (SIT) Workgroup, whose stakeholder members include ECCS and California Project LAUNCH (CPL). SIT will work to improve the quality, efficiency and effectiveness of home visiting through interagency collaboration.//2013//

>Child Health and Disability Prevention (CHDP) Program

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

CHDP provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutrition assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment.

>Comprehensive Perinatal Services Program (CPSP)

CPSP provides comprehensive perinatal care including obstetrical, nutrition, health education, and psychosocial services from qualified providers to Medi-Cal eligible women. There are 1566 active CPSP providers in California /2012/(1592 for 2010)//2012//. MCAH develops standards and policies; provides TA and consultation to the local perinatal services coordinators; and maintains an ongoing program of training for all CPSP practitioners throughout the state. Local MCAH staff /2012/ monitor service delivery, recruit new providers and//2012//offer technical assistance (TA) and consultation to potential and approved providers in the implementation of CPSP program standards.

>Fetal Infant Mortality Review Program (FIMR)

Sixteen local LHJs have FIMR Programs that enable them to identify and address contributing factors to fetal and infant mortality. A Case Review Team examines selected fetal and infant death cases, /2013/ conducts maternal interviews, //2013// identifies factors associated with these deaths, and determines if these factors represent systems problems. /2014/ **A Case Review Team examines fetal and infant death cases, and identifies factors, including systems issues associated with these deaths.** //2014// Recommendations from the Case Review Team are presented to a Community Action Team that develops and implements interventions that lead to positive changes. /2013/ MCAH is building an aggregated database with data reporting from all 16 jurisdictions//2013//.

>Genetically Handicapped Persons Program (GHPP)

GHPP provides case management and funding for medically necessary services to people with certain genetic conditions. Most GHPP clients are adults, but 4.6 percent are children under 21 years. The GHPP serves eligible children of higher family incomes who are ineligible for the CCS program.

GHPP client enrollment is stable, with 1750 clients for 2008-2009. /2013/GHPP client enrollment for 2010-2011 was 1537.//2013//

>Hearing Conservation Program (HCP)

HCP helps to identify hearing loss in preschoolers to 21 years of age in Public Schools. All school districts are required to submit to CMS an annual report of hearing testing. /2013/ For 2009/10, 780 school districts reported their hearing screening results and 1.9 million students were screened.//2013//

>Health Care Program for Children in Foster Care (HCPCFC)

HCPCFC is a public health nursing program /2013/ administered by the local CHDP Program, is //2013// located in county child welfare service agencies and probation departments to provide public health nurse expertise in meeting the medical, dental, mental and developmental needs of children and youth in foster care. . /2014/**As of May 2012, the foster care children caseload was 57,459.**//2014//

>High Risk Infant Follow-up (HRIF)

Infants discharged from CCS-approved NICUs are followed in NICU HRIF clinics. Three multidisciplinary outpatient visits are authorized by CCS up to age three to identify problems, provide and complete referrals, and monitor outcomes.

The HRIF program continues to provide three multidisciplinary outpatient visits /2014/ , **and additional visits as determined medically necessary,** //2014// to identify problems, institute referrals, and monitor outcomes. The QCI developed a web based reporting system to collect HRIF data for quality improvement activities. Statewide trainings were provided to all NICU and HRIF Program staff before implementation and a follow-up training was held in February 2010.

//2014/Statewide data trainings were held . By March 2013, 67 of 69 HRIF programs are reporting online.//2014//

/2012/ >California Home Visiting Program (CHVP)

CHVP aims to improve service coordination for at-risk communities to promote improvements in maternal and infant health, school readiness, reduction of child maltreatment, improved community referral systems, and reductions in crime and domestic violence. //2012// /2013/The focus will be on the implementation of two evidence-based home visiting models: Nurse Family Partnership (NFP) and HF America.//2013//

>Human Stem Cell Research Program (HSCR)

HSCR develops comprehensive guidelines to address the ethical, legal, and social aspects of stem cell research and ensure the systematic monitoring and reporting of HSCR activity that is not fully funded by Proposition 71 money granted through the California Institute for Regenerative Medicine. A diverse group of 13 national and international specialists serve on a HSCR Advisory Committee to advise CDPH on statewide guidelines for HSCR.

/2014/ >Information & Education (I&E) Program

The I&E Program funds local agencies to implement sexual and reproductive health education programs that equip teens at high risk for pregnancy with the knowledge, and skills in partner communication, sexual negotiation and refusal skills to make responsible decisions regarding risky sexual behaviors and to access reproductive health services.//2014//

>Local Health Jurisdiction (LHJ) Maternal Child and Adolescent Health Programs (LHDMP)

61 LHJs receive Title V allocations that support local infrastructure, including staff, to conduct culturally sensitive collaborative and outreach activities to improve services for women and children, refer them to needed care, and address state and local priorities for improving the health of the MCAH population.

>MCAH Toll-free Hotline

MCAH staff responds to calls and refer callers to local MCAH programs. LHJs also have local toll-free numbers that provide information and referrals to clients. Local MCAH contact information is made available online.

>Medical Therapy Program (MTP)

MTP provides physical and occupational therapy services to children with CCS MTP eligible conditions. There is no financial eligibility requirement. MTP conducts multidisciplinary team conferences to support case management and care coordination. The number of clients enrolled in the MTP has shown a slight declining trend over the past 5 years of 7% and is currently 24,777 /2012/in 2010 and 24,433 for 2011.//2012//
/2014/ Client enrollment are below 1999 levels.//2014//

>Newborn Hearing Screening Program (NHSP)

NHSP helps identify hearing loss in infants and guide families to the appropriate services needed to develop communication skills. In California, 243 hospitals are certified to participate in the NHSP as of December 2009. /2013/Five hospitals were pending certification and 253 hospitals certified as Inpatient Infant Hearing Screening Providers.//2013// **/2014/All hospitals with licensed perinatal services are certified and participating in the NHSP.//2014//**

>Pediatric Palliative Care Waiver Program

This program allows for the provision of expanded hospice type services and curative care concurrently. This program is designed to improve the quality of life for children with life limiting or life threatening conditions, and their family members. It is anticipated that cost neutrality will be achieved by reduced hospital stays, medical transports and emergency room visits in addition to other costs avoided while the child is enrolled in the program. /2013/As of March 2012, there were 9 active hospice or home health agency providers.//2013//

/2014/ >California Personal Responsibility Education Program (CA PREP)

CA PREP educates high-risk adolescents on both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, through replication of evidence-based programs to delay sexual activity, increase contraceptive use or reduce pregnancy. CA PREP also implements activities to prepare young people for adulthood and are also referred to family planning related health care services.//2014//

>Regional Perinatal Programs of California (RPPC)

RPPC promote access to risk-appropriate perinatal care to pregnant women and their infants through regional QI activities. RPPC facilitate local perinatal advisory councils to provide regional planning, coordination, and recommendations to assure appropriate levels of care. In addition the local perinatal advisory councils perform hospital surveys and perinatal assessments of regional and statewide significance; develop communication networks locally; disseminate educational materials and produce a statewide newsletter; provide resource directories, referral services, and hospital linkages to the Northern and Southern CPeTS; and assist hospitals with QI activities, data collection protocols, and quality assurance policies and procedures. /2013/ Production of a newsletter was terminated.//2013// **/2014/ A mid-year report including updates to steps toward reduction of early elective deliveries <39 weeks by hospitals was implemented.//2014//**

CPeTS maintains a web-based bed availability list, locate beds for high-risk mothers and infants and provide transport assistance, transport data reports, and perinatal transport QI activities, including emergency triage and transport in the event of a disaster. Maternity hospitals can obtain information 24 hours a day, 7 days a week to facilitate transfers. **/2014/ All CCS-approved NICUs are included. QI activities are focused on in-transit operational and therapeutic management issues.//2014//**

>Sudden Infant Death Syndrome (SIDS) Program

SIDS is funded in all 61 LHJs to provide support to families that experience a SIDS death, conduct prevention activities, and enable staff to attend annual training. The SIDS Program provides statewide technical assistance and support to healthcare and public safety personnel and parents including education about SIDS, grief counseling, and information on prevention to reduce the risk of SIDS.

Technical Assistance

MCAH places high priority on providing stakeholders and partners with quality assistance where necessary to improve MCAH program performance. The following programs were created to address the developmental assistance needs in the state:

>Breastfeeding Technical Assistance Program

This program promotes and supports efforts to make breastfeeding the infant feeding norm. Its website (<http://www.cdph.ca.gov/programs/breastfeeding/Pages/default.aspx>) contains targeted breastfeeding information for families and providers. It has piloted BBC to assist hospitals to improve their exclusive breastfeeding rates and collaborated with Medi-Cal, WIC and the CA Breastfeeding Coalition to improve hospital support for breastfeeding.

/2013/ > Nutrition and Physical Activity Technical Assistance Initiative

This integrates healthy eating and physical activity promotion within MCAH and its local programs. Strategies include providing technical assistance, development of healthcare policies, training and guidelines; supporting partners in coalition building; and using epidemiological information to design, implement, and evaluate nutrition and physical activity initiatives.//2013//

>Oral Health Technical Assistance Program

Oral Health Program provides local technical assistance and state level coordination and collaboration to address the oral health needs of pregnant women, mothers, children and adolescents, especially within low-income families, by expanding access to dental care and preventive services, and by encouraging local MCAH Programs to work in collaboration with new and existing dental and health-related programs. This year, 18 local MCAH programs have chosen oral health as a priority objective. Another 25 //2012/ 21 //2012//local MCAH programs collaborate on various community tasks forces involving oral health issues. Further, direction has been provided by updating oral health educational components in the CPSP “Steps to Take” Guidelines, BIH prenatal and postpartum curriculums, AFLP “Infant Feeding” Guidelines and CDAPP’s Sweet Success Guidelines. /2012/MCAH is disseminating perinatal clinical oral health guidelines to assist providers deliver oral health services.//2012//

>Preconception Health and Healthcare

MCAH is partnering with organizations and stakeholders across the state to provide direction for the integration of preconception care into public health practice, develop policy strategies to support preconception care, and promote preconception health messages to women of reproductive age. /2012/Reproductive life planning concepts and

tools are being integrated into BIH and AFLP programs.//2012//2013/MCAH provides preconception health training and technical assistance.//2013// **2014/MCAH partnered with the Office of Minority Health to train and support preconception peer educators in colleges and universities.//2014//**

Major Collaboratives

MCAH and CMS value the input provided by its stakeholders across communities and has actively fostered collaboratives, task forces and advisory/work groups to address MCAH and CSCHN health issues. These collaboratives, task forces and advisory/work groups also serve to coordinate preventive and health care delivery with other services at the community level as well as with the health components of community-based systems. These include the following:

> Adolescent Sexual Health Work Group (ASHWG)

ASHWG is a collaborative of 23 organizations from CDPH, CDE and non-governmental organizations who address sexual and reproductive health needs of youth. Its vision is to create a coordinated, collaborative, and integrated system among government and non-government organizations to promote and protect the sexual and reproductive health of youth in California. Current activities focus on core competencies for providers and educators, integrated data tables (available at: http://www.californiateenhealth.org/download/ASHWG_Integrated_Data_Tables.pdf) and **2014/ positive youth development.//2014//**

>California Perinatal Quality Care Collaborative (CPQCC)

CPQCC is a cooperative effort of public and private obstetric and neonatal providers, insurers, public health professionals and business groups. It develops perinatal and neonatal quality improvement infrastructure at state, regional, and hospital levels. For 2010, CPQCC membership is at 128 NICUs, with all of the 114 CCS-approved NICUs as members.//2012//; for 2011, there were 129 NICUs, with 115 CCS-approved NICUs as members.//2012//. //2013/CPQCC includes hospitals representing over 90% of all neonates cared for in NICUs,//2013//

The Perinatal Quality Improvement Panel (PQIP), is a standing subcommittee of CPQCC, that provides oversight for all quality functions of CPQCC by creating, initiating and conducting statewide quality projects and/or prospective trials; publishing and disseminating new and updated QI toolkits; analyzing the CPQCC database and designing supplemental data collection tools; and initiating and implementing research projects focused on QI. //2012/PQIP revised its charter and re-designed its structure, developing 4 sub-committees.//2012// //2013/The goal is to support benchmarking and performance improvement activities http://www.cpqcc.org/quality_improvement/collaborative_3_delivery_room_management_qi_collaborative_and_nicu_qi. //2013// **2014/ PQIP defines indicators and benchmarks, recommends QI objectives, provides models for performance improvement, and assists providers in a multi-step transformation of data into improved patient care.//2014//**

> California Maternal Quality Care Collaborative (CMQCC)

CMQCC is the statewide umbrella organization for assessing the current state of knowledge of maternal illness and complications and transforming this knowledge into targeted, evidence-based, data-driven clinical quality improvement interventions and public health strategies statewide and at the local level. CMQCC's mission is to end preventable maternal morbidity and mortality by improving the quality of care women receive during pregnancy, childbirth, and postpartum. CMQCC maintains an informative website of resources and policies for both public and private use (www.cmqcc.org) and provides educational outreach to health professionals. /2012/ CMQCC convenes the Pregnancy-Associated Mortality Review (PAMR) Committee and provides TA to local maternity care quality improvement projects. CMQCC also developed and disseminated two toolkits for obstetric care providers: "Improving the Health Response to Obstetric Hemorrhage" and "Eliminating Non-Medically Indicated Deliveries Before 39 Weeks of Gestational Age". //2012// /2013/ CMQCC is preparing a third toolkit to improve identification and effective therapy for preeclampsia/eclampsia and is developing a maternal data center to track maternity care quality improvement efforts.//2013// **/2014/The Preeclampsia Prevention Toolkit was released and a multi-hospital collaborative was initiated. MCAH participates in an advisory committee to develop risk appropriate maternal levels of care and the California Maternal Data Center.//2014//**

>Family Voices of California (FVCA)

FVCA helps CSCHN families through a coordinated network of regional, family-run FVCA Council Member agencies. FVCA continues to provide information to families and professionals on issues relating to a Medical Home, including organizing healthcare information and navigating health systems, /2014/ **changes in Medi-Cal, the difference between occupational therapy (OT) and physical therapy (PT) and medically related OT and PT; autism; and insurance.//2014//**

FVCA collaborated with DHCS and other partners on various committees, taskforces, senate hearings, and stakeholder groups related to 1115 Waiver, CCS redesign, and the Title V Needs Assessment. FVCA has ensured that parents and community members are involved in these processes, has provided financial support to families to enable their involvement, and has facilitated providing parent and community member input through key informant interviews and focus groups. **/2014/FVCA will evaluate CSHCN's timely access to appropriate care providers during the HF client transition into Medi-Cal.//2014//**

/2012/ >Maternal Quality Indicator (MQI) workgroup

The MQI workgroup conducts trend analysis of maternal morbidity rates, chronic conditions that compromise maternal health /2013/analyzes composite healthcare costs of maternal morbidities. //2013// and suggests strategies for monitoring quality benchmarks for obstetric hospitals.//2012//

>Prenatal Substance Use Prevention

MCAH's efforts related to perinatal substance use prevention are conducted through partnerships and collaboration. MCAH representatives participate in the California Fetal

Alcohol Spectrum Disorders (FASD) Task Force, an independent, public-private partnership of parents and professionals from various disciplines committed to improving the lives of Californians affected by FASD and eliminating alcohol use during pregnancy. MCAH also participates in the State Interagency Team FASD workgroup, composed of members from the MCAH, (DSS, Department of Mental Health (DMH), CDE, Department of Developmental Services (DDS) and ADP acting as lead. The goal of the workgroup is to identify interagency and systems issues that provides potential opportunities for prevention/intervention of FASD. /2013/The FASD Workgroup gave its recommendations in May 2010.//2013//

MCAH LHJs have identified perinatal substance use prevention as a priority. They have engaged in community mobilization and capacity building, and implemented screening, assessment, and referral to treatment programs that address their particular needs.

>Preconception Health Council of CA

One of the key ways that MCAH partners with other entities is through PHCC which was established in 2006 by MCAH and MOD, California Chapter. In May 2009 the PHCC launched its official website: www.everywomancalifornia.org, which is supported by Title V funds. The website contains information for both consumers and providers and includes an interactive section for health professionals featuring discussion forums, opportunities for networking and resource-sharing, and an event calendar. MCAH also received a First Time Motherhood grant from HRSA/MCHB to develop a preconception health social marketing campaign reaching women at increased risk for poor pregnancy outcomes. /2013/ The Interconception Care Project of California and the California Guidelines for Preconception Care were developed through the PHCC. //2013//

>Transition Workgroup

CMS recognizes the importance of transitioning health care for CSHCN from pediatric to adult services. During site reviews of new SCCs and CCS programs, the issue of health care transition planning and age and developmentally appropriate care for CSHCN is reviewed and discussed.

CMS formed a statewide Transition Workgroup comprised of healthcare professionals, experts in transition care, former CCS clients and family representatives who worked together on the Branch's Transition Health Care Planning Guidelines for CCS programs. The Guidelines were released in 2009, as a CCS Information Notice.

CMS collaborates with the California Health Incentives Improvement Project (CHIIP) and funded by the Medicaid Infrastructure Grant from the Centers for Medicare and Medicaid Services. As staffing allows, CMS will participate on the CHIIP Youth Transition Advisory Committee. /2014/ **The Youth Transition Advisory Committee was defunded and terminated.**//2014//

Business Partners

To further enhance current capacity to provide community based preventive and health care services, expertise in health related services through provision of technical assistance

is improved via contractual relationships with clinical and academic health experts. These include:

>2012/ > Advanced Practice Nurse Program (APN)

APN maintains accredited advanced practice nursing programs. The program goals are to (increase the availability of quality reproductive health care services for childbearing women in underserved areas by preparing nurses in a program that meets state and national guidelines and recruit and enroll students.//2012// /2013/APN was eliminated effective July 2012.//2013//

>Branagh Information Group

MCAH contracted with the Branagh Information Group to develop, maintain and provide technical assistance for LodeStar, a comprehensive software package for AFLP agencies conducting case management for pregnant and parenting teens and their children. Branagh Information Group also was contracted to develop and maintain BIH Management Information Services (MIS), a software package for BIH agencies conducting case management. /2013/Branagh Information Group provide Help Desk support and training for the BIH MCAH MIS, a new database for BIH.//2013//

>The California Adolescent Health Collaborative (CAHC)

MCAH has a contract with CAHC to provide adolescent health expertise, address current adolescent health concerns through technical assistance to the local MCAH programs and other partners. CAHC also supports core activities of ASHWG. /2012/ Through Internet Sexuality Information Service, CAHC reaches adolescents using digital media. //2012//

>California State University, Sacramento (CSUS)

CSUS provides /2012/ and coordinates //2012// CPSP Provider /2012/ Overview and Steps To Take //2012// Training, is developing on-line provider training, and supports statewide /2012/CPSP//2012// meetings.

>Childhood Injury Prevention Program

To reduce injury-related mortality and morbidity among children and adolescents, MCAH contracts with the Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University. CIPPP provides technical support for local MCAH programs and their partner agencies via face to face meetings, teleconferences, e-mail, a list serve, and literature reviews of the latest injury prevention research **/2014/from journals and reports from more than 30 professional disciplines //2014//**

>Family Health Outcomes Project (FHOP) at the University of California, San Francisco

FHOP provides technical assistance and training, analyzes data for LHJs, provides a current web listing of useful resources, assists in establishing guidelines, and prepares

special state reports for MCAH and CMS./2012/FHOP is working with CMS on developing and implementing a family survey for use over the next 5 years./2012//

>Health Information Solutions

With direction from MCAH, Health Information Solutions developed and maintains the Improved Perinatal Outcomes Data Reports (IPODR) website. IPODR allows users to view and download the most recent demographic and hospital data about California mothers and infants. The data are available in tables for the most recent year available, in maps aggregating the past three years, and in graphs displaying a 15-year /2014/20-year//2014//trend. Information is available at the state, county, and zip code levels.

>Perinatal Profiles at the School of Public Health, University of California at Berkeley

This project produces an annual report that provides information on sentinel indicators of perinatal quality care for all the maternity hospitals and regions in California that may reveal where efforts are needed for the purpose of continuous quality improvement.

/2014/The reports provide information about birth certificate data completeness and quality./2014//

/2012/ >Public Health Institute (PHI)

Together with MCAH, PHI conducts medical record abstraction and assists in the data analysis for -PAMR./2012//

>Maternal and Infant Health Assessment (MIHA) with the Center on Social Disparities in Health, University of California in San Francisco

MIHA is an annual survey that collects population-based information about maternal health status, health behavior, knowledge, and experiences before, during and shortly after pregnancy. Findings are disseminated through conference presentations, reports and posting of survey results through the MCAH website.

/2014/ Center for Health Policy at University of California, Los Angeles (UCLA)

The Center for Health Policy was contracted to develop cost savings estimates of early management of preeclampsia, eclampsia and obstetric hemorrhage./2014//

Select Statewide Programs Serving the MCAH Population

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

As of January 2010, there were 878,005 children enrolled in HF, an approximately 1.6% decrease from the previous year. Of those children, approximately 2.9% (25,878) are being served by CCS for their special health care needs.

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

State law requires MRMIB to enroll infants of AIM mothers into HF. AIM infants above 250% will be able to continue in HF up to 2 years of age before having to meet current eligibility. As of January 2010, CCS serves 418 AIM children. /2012/ As of February 2011, 865,480 children were enrolled in HF. Of these, 2.6% (22,130) are served by CCS.//2012//

/2014/ State law required the transition of children enrolled in HF to Medi-Cal. HF continues to serve children that have not yet transitioned to Medi-Cal, including AIM-linked infants.//2014//

>Rehabilitation services

Services such as physical therapy for SSI beneficiaries under the age of 16 with a CCS medically-eligible diagnosis are served by MTP. Children with mental or developmental conditions receiving SSI are served by the DMH, DDS and CDE. In FY 2009-2010, CCS received 86 referrals. Of these, five were not medically eligible for CCS and two could not be verified. CCS will continue to work with the Disability Evaluation Division to train local staff to conduct CCS medical eligibility evaluations which should result in fewer referrals to CCS.

>Family-centered, community-based coordinated care (FCC) for CSHCN

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

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

In 2009 the Children's Regional Integrated Service System (CRISS) annual FCC conference focused on mental health services for children and youth with special health care needs. The conference was co-sponsored with the University Center on Excellence in Developmental Disabilities (UCEDD), FVCA, and CMS. /2012/In 2010 CRISS FCC conference was "Working Together in Challenging Times: CCS, Families and the Community".//2012

The CRISS NICHQ project to promote medical homes for children with epilepsy in a Sonoma County Federally Qualified Health Center (FQHC) was completed in 2009. CRISS worked with the Sonoma County CCS program to take on responsibility for continuing to convene the project's local oversight committee, and FQHC is continuing activities to support medical homes for children with epilepsy.

Additionally, CRISS makes the parent health notebook and other medical home materials available on its website www.criiss-ca.org. /2013/ /CCS is partnering with CRISS to provide local medical home projects. The Alameda Medical Home Project is implemented through provider training in medical home concepts, resources, and referral pathways with pediatric practices and clinics.//2013//

L.A. Partnership for Special Needs Children (LAPSNC), which promotes parent involvement in meetings and on committees, cosponsored an all-day conference entitled "Weathering Difficult Times: Resources for Children with Special Needs and their Families". Parents served on the planning committee for this meeting and 130 providers and parents were in attendance. /2012/LAPSNC is planning a conference in 2011 focusing on the impact of the 1115 waiver on CSHCN.//2012//

FVCA continues its active role as a significant resource for families and professionals on issues relating to a medical home, including organizing healthcare information and navigating health systems.

In 2009, FVCA created a youth council, Kids As Self Advocates (KASA), that meets once a month via conference call and face to face every other month. CCS has attended some of the KASA meetings, and KASA youth have provided input to CCS on transition issues. KASA youth have received leadership training, and FVCA provides staff time for a youth group coordinator and provides youth with stipends for participation at meetings and travel.

In addition to youth leadership training, FVCA is developing the FVCA Parent Leadership Training Curriculum to prepare families to partner in decision-making and has piloted trainings at the annual Family Resource Supports Institute.

In 2009, FVCA was a collaborative member of "Partners in Policymaking" and worked to provide leadership training to 35 self-advocates and parents of children with developmental disabilities in L.A. County. The 2010 training will be in San Bernardino County.

Over the last eight years, FVCA in collaboration with advocates across the state convened annual statewide Health Summits that have brought together families, professionals, agency representatives, advocates, insurers, health policy experts and legislators to discuss access to affordable and appropriate health care for CSHCN and to develop strategies to address the challenges families face. FVCA funds this conference through its federal MCHB grant and private sponsors, thus providing families with travel scholarships and stipends to be able to attend.

Other FVCA 2009 activities have included: Council's monthly meetings to address parent and community involvement; hosting 9 statewide webinars for families and professionals on topics such as the Family Opportunity Act, health care transition, nutrition for CSHCN, and impacting legislators; and participation in the Prematurity Coalition's Summit, providing and organizing a panel on Home Based Community Care to address parent and community involvement during and after hospital stays for families with babies born prematurely.

In 2009 and 2010, FVCA collaborated with DHCS and other partners on various committees, taskforces, senate hearings, and stakeholder groups related to 1115 Waiver, CCS redesign, and the Title V Needs Assessment, ensuring that parents and community members are involved in these processes. FVCA has provided financial support to families to enable their involvement, and has facilitated parent and community member input for interviews, focus groups, and surveys. /2013/FVCA and CCS hold monthly webinars with families of CSHCN./2013// **/2014/ CCS leadership presents program updates at the annual FVCA summit. //2014//**

Approaches to Culturally Competent Service Delivery

Because California is a cultural melting pot, it is paramount that both MCAH and CMS interact and provide services in a culturally, linguistically and developmentally competent manner with people of diverse backgrounds. Both MCAH and CMS value and respect the diversity of clients our programs serve. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures. Both MCAH and CMS have mechanisms to promote culturally and linguistically competent approaches to service delivery such as:

- > BIH delivers culturally competent services to address the problem of disproportionate African American maternal and infant mortality.

/2013/>CDAPP Resource and Training Center has brochures, teaching aids and a food guide in various languages./2013//

- > MCAH and CMS collect and analyze data according to race, ethnicity, age, etc. to identify disparities.

- > MCAH and CMS program materials are mostly published in English and Spanish, and translated to other languages as needed.

- > FIMR has posted a guide and tool on the MCAH website for assessing cultural and linguistic competence among their funded agencies.

C. Organizational Structure

Arnold Schwarzenegger is the Governor of California, a position he has held since November 2003. S. Kimberly Belshé is the Secretary for CHHSA, which is a cabinet-level position that reports directly to the Governor. Mark B. Horton, MD, MSPH is the Director of the CDPH, which is one of thirteen departments in CHHSA together with the DHCS. David Maxwell-Jolly, Ph.D. is the Director of DHCS.

/2012/ In November 2011, Edmund “Jerry” G. Brown, Jr. was elected to replace Arnold Schwarzenegger as the Governor of California. Shortly thereafter, Diana Dooley was appointed to replace S. Kimberly Belshé as the Secretary for CHHSA. In March 2011, Howard Backer, MD, MPH replaced Mark B. Horton, MD, MPH as the Interim Director of the CDPH. Toby Douglas replaced David Maxwell-Jolly, Ph.D. as the Director of DHCS. //2012//

/2013/ On June 13, 2011, Ron Chapman, MD, MPH, was sworn in as director of CDPH by CHHSA Secretary Diana S. Dooley. //2013//

The State of California designates CDPH to administer the MCAH Program.[29, 30] MCAH has the primary responsibility for carrying out Title V functions, the MCAH program, and other similar programs that include the HSCR and Cord Blood Banking Program and CBDMP. MCAH reports directly to CDPH’s CFH, which is one of five centers responsible for carrying out CDPH’s core activities.[31] Catherine Camacho is the Deputy Director of CFH, a position she’s held since CDPH was established in July 2007.[32] Vickie Orlich is the Assistant Deputy Director for CFH. **/2014/ As of February 2013, Dan Kim is acting Deputy Director for CFH. As of July 2012, Christine Nelson is serving as the Assistant Deputy Director for CFH. //2014//**

/2012/ In response to the United States’ Patient Protection and ACA of 2010, which President Obama signed into law in March 2010, the MCAH Program created the Home Visiting Program (HVP), which manages the ACA’s Maternal, Infant, and Early Childhood Home Visiting Program. //2012//

MCAH coordinates with DHCS’ CMS Branch to handle Title V activities related to CSHCN. **/2014/ Reference to CMS Branch is gradually being phased out and replaced by Systems of Care Division (SCD). //2014//**

Information about MCAH is provided in the sub-sections below. Information about CMS Branch is available in Section III D. For updated organizational charts for MCAH and CMS Branch, see the attachments to Sections III C and III D, respectively.

>Maternal Child and Adolescent Health Program (MCAH)

Shabbir Ahmad, PhD, has acted as Chief of MCAH since June 2007. Les Newman is the Assistant Chief, a position he has held since February 2001. MCAH includes professionals from various clinical, public health, and scientific disciplines.

MCAH consists of six branches:

- Epidemiology, Assessment and Program Development
- Fiscal Management and Contract Operations
- Program Allocations, Integrity and Support
- Program Standards
- Policy Development
- California Birth Defects Monitoring Program

/2013/ As of January 2012, Christine Nelson, replaced Les Newman as the Assistant Chief. //2013// **/2014/ Addie Aguirre is Assistant Division Chief for MCAH. MCAH now consists of seven branches with the addition of the California Home Visiting Program. MCAH is also awaiting upcoming changes to some of its branch names: Fiscal Management and Contract Operations will change to Federal Monitoring and Compliance; and Program Allocations, Integrity and Support will change to Title V Integrity and Support. //2014//**

> Epidemiology, Assessment and Program Development (EAPD) Branch

EAPD Branch analyzes and assesses program and population-based data and information that allow MCAH to monitor program implementation, evaluate program effectiveness, develop policies, and allocate appropriate resources. EAPD Branch also oversees the compilation of all federal Title V reporting requirements for the annual block grant application/report and statewide five-year needs assessment.

Mike Curtis, Ph.D., is the Acting Chief of EAPD Branch, a position he held since June 2007. EAPD Branch consists of two sections with a total of 19 staff positions:

- Epidemiology, Evaluation and Data Operations
- Surveillance, Assessment and Program Development

/2014/Mark Damesyn, Ph.D. joined EAPD as chief of the Epidemiology, Evaluation, and Data Operations Section in April 2012. //2014//

EAPD Branch also houses the Human Stem Cell Research and Cord Blood (HSCRCB) Program, which is responsible for implementing legislation mandating the monitoring of stem cell research in California.[33]

> Fiscal Management and Contract Operations (FMCO) Branch

FMCO Branch assumes the contract monitoring functions for MCAH, including fiscal forecasting, budget-related work, management of over 400 contracts, and working with Department of Finance and other control agencies. Jo Miglas is the Chief of the FMCO Branch, a position she's held since 2007.

FMCO Branch consists of three units with a total of 23 staff positions:

- Accounting and Business Operations
- Maternal, Child and Adolescent Health Contracts and Grants.
- Office of Family Planning Allocation and Matched Funding

//2014/ FMCO Branch consists of a total of 16 staff positions. MCAH is awaiting upcoming name change for the FMCO Branch, which is to be called the Federal Monitoring and Compliance Branch: the Accounting and Business Operations Section would be called Federal Monitoring and Reporting Section; the Maternal, Child and Adolescent Health Contracts and Grants Section would be called the Technical Assistance and Compliance Section; and the Office of Family Planning Allocation and Matched Funding Section would be absorbed by the Technical Assistance and Compliance Section.//2014//

> Program Allocation, Integrity and Support (PAIS) Branch

PAIS Branch undertakes activities associated with allocation and matched funding of MCAH programs; program integrity; special projects and administrative activities associated with more than fifteen MCAH programs, including bill analysis and regulation development; policies and procedure development; administrative activities related to management analysis, personnel, training, and procurement; and information technology management, including website maintenance, local area network support, and management of servers, hardware, software, and inventory. Fred Chow is the Chief of the PAIS Branch, a position he has held since 2007.

PAIS Branch consists of three units with a total of 18 positions:

- Allocation and Matched Funding
- Special Projects and Administrative Support Unit
- Information Technology Unit

//2014/ MCAH is awaiting upcoming name change for the PAIS, which is to be called the Title V Integrity and Support Branch: the Allocation and Matched Funding Section would be called the Title V Fiscal and Program Oversight Section; the Special Projects and Administrative Support Unit would be called Program Services Section; and the Information Technology Unit would be absorbed by CDPH Information Technology Services Division, which will continue to serve MCAH.

Title V Integrity and Support Branch consists of a total of 19 staff positions.//2014//

> Program Standards Branch (PS)

The Program Standards Branch coordinates the implementation of standards of care for pregnant women, children, and infants in the AFLP, Advanced Practice Nursing program, BIH, CPSP, and local MCAH programs. PS program consultants provide consultation and technical assistance to LHJs and other organizations. Anita Mitchell, MD is the Chief of PS Branch, a position she has held since July 2005. Dr. Mitchell is board certified in Pediatrics. The PS Branch consists of a total of 11 staff positions.

//2012/ In August 2010, Karen Ramstrom, DO, MSPH, replaced Anita Mitchell, MD as the Chief of the PS Branch. //2012// /2014/ PS Branch consists of a total of 24 staff positions. In January, 2013, I&E and CA PREP were moved under the administration of the PS Branch. Advanced Practice Nursing program was eliminated in July 2012.//2014//

> Policy Development (PD) Branch

PD Branch develops policies and procedures in support of all MCAH programs and collaborates on Federal, State, and local levels, providing expertise on multiple health priorities including nutrition, obesity, breastfeeding, physical activity, oral health, ECCS, preconception health, FIMR, SIDS, RPPC, CPeTS, CDAPP, CMQCC, CPQCC and BIH program development. PD Branch identifies relevant data points for annual reporting to ensure that LHJs address state priorities and program requirements.

Karen Ramstrom, DO, MSPH, is the Chief of PD Branch, a position she has held since May 2006. Dr. Ramstrom is board-certified in Preventive Medicine and Family Medicine. PD Branch consists of eleven staff positions.

//2012/ In August 2010, Connie Mitchell, MD, MPH, replaced Karen Ramstrom, DO, MSPH as the Chief of the PD Branch. //2012// **/2014/ As of July 2012, Sandra Bahn is the acting Branch Chief for PD.**

> California Birth Defects Monitoring Program (CBDMP)

CBDMP is legislatively mandated to provide surveillance of birth defects and maintains a birth defect registry. CBDMP joined MCAH in January 2007. [29] Marcia Ehinger, MD, board-certified in pediatrics and clinical genetics, is the Chief of CBDMP, a position she has held since July 2007. **/2014/ As of August 2012, Barbara Warmerdam is the Section Chief over CBDMP.**

>California Home Visiting Program (CHVP)

CHVP was created as a result of the Patient Protection and Affordable Care Act of 2010. The home visiting program focus is to provide comprehensive, coordinated in-home services to support positive parenting, and to improve outcomes for families residing in identified at-risk communities. Christopher Krawczyk, Ph.D., is the Branch Chief of CHVP, a position he has held since March 2012. CHVP Branch consists of a total of 26 staff positions. //2014//

D. Other MCAH Capacity

Information about the MCAH Program is provided in Section III C (Organizational Structure) above. Information about the CMS Branch is provided below. **//2014/The CMS Branch was reorganized in 2007. Reference to Children's Medical Services (CMS) and/or CMS Branch is gradually being phased out and replaced by Systems of Care Division (SCD).//2014//**

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

Louis Rico, Chief, Systems of Care Division is Acting Chief for the CMS Branch until a replacement can be recruited for the position. The CMS Branch was reorganized in 2005. The Branch is composed of the following five sections: Program Development, Regional Operations, Statewide Programs, Program Support, and Information Technology. **//2012/Louis Rico, is no longer Acting Chief for the CMS program, but continues as Chief of the Systems of Care Division with its oversight of the CMS program. On November 1, 2010, Dr. Robert Dimand, under a new organizational structure, became the Chief Medical Officer for CMS with responsibilities for medical oversight and direction including policy development and revision. Dr. Dimand comes to CMS from his previous position as Professor and Chair of the Dept. of Pediatrics at UCSF Fresno and Chief of Pediatrics at Children's Hospital of Central California. He is fellowship trained in Pediatric Critical Care Medicine and Pediatric Gastroenterology.**

There are currently seven sections: Program Development, Dependent County Operations, Independent County Operations, Statewide Programs, Program Support, Information Technology, and Waiver and Research.

On November 1, 2010, under a new organizational structure, Stephen Halley became the Chief Operations Officer for CMS with responsibilities for operational oversight and direction as well as operations and administrative policy. Mr. Halley joined CMS in July 2010 as Assistant Branch Chief replacing Harvey Fry who held the position from January 2005 through 2008. Mr. Halley had been in private consulting and had worked with a number of state departments. He was also a former hospital administrator. **//2012//**
//2014/The Chief Operations Officer position is currently vacant.//2014//

//2013/ In the new organizational structure, the Chief Medical Officer oversees the Statewide Medical Services Branch, which is comprised of 7 medical consultants, 3 nurses, and the Medical Policy and Consultation Section. Dr. Joseph Schulman, MD, a

nationally recognized leader in Neonatal Medicine and Quality Outcomes, and the lead author on a manuscript describing the optimal approach to CLABSI in New York has joined CCS. He is coordinating the multidisciplinary efforts around CLABSI, Health Care Associated Complications and “never events” in the NICU. //2013// **/2014/ Dr. Marcia Ehinger, a board certified geneticist and pediatrician, joined SCD in 2012. //2014//**

> Program Development Section (PDS)

PDS is responsible for the development and implementation of program policy, regulations, and procedures for the programs administered by the Branch and for provision of statewide consultation in a variety of professional health disciplines. Jill M Abramson MD, MPH is the Chief of the Program Development Section. She is a board certified pediatrician and is board eligible in Preventive Medicine. PDS has 15 positions. /2012/PDS has 13 positions. //2012// /2013/The section was renamed Medical Policy and Consultation Section (MPAC) and now has 8 positions. The new section is responsible for program policy, statewide consultation and medical consultation. //2013// **/2014/ to CCS county programs and providers. //2014//**

The PDS Section consists of three units: the Program Policy and Analysis Unit, the Research Unit and the State Consultation Unit. The Program Policy and Analysis Unit is responsible for development and implementation of program policy, regulations, and procedures for all programs administered by the Branch. Unit staff develop provider standards for CCS; develop policies and procedures to assist in the implementation of HRIF and Pediatric Palliative Care programs; review and approve/deny all requests for organ transplants for children covered by CCS and Medi-Cal; and provide pediatric consultation to Medi-Cal and other DHCS programs. The unit is also responsible for research and program analysis functions and development and implementation of a pharmaceutical rebate program for CCS and GHPP, and implementation of a new delivery system that enhanced access to medical foods and improved clinical management for metabolic patients. /2012/The unit facilitates negotiations and claims processing for out-of-state providers when a child enrolled in CCS is treated in another state either emergently or electively. //2012//

The Research Unit consists of three research staff responsible for program data retrieval, aggregation and analysis for the CCS and CHDP programs. /2012/ In 2010, a new Research and Waiver Section was created. The Research Unit which was under the Program Development Section was transferred and merged with the Waiver unit to form the Research and Waiver Section. //2012//

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

neonatal and pediatric intensive care units, and medical therapy units for compliance with established program standards, policies, and procedures.

/2012/>Waiver and Research Section

Don Fields is Chief of the Waiver and Research Section. The Section is comprised of two units the Waiver Unit and the Research Unit.

The Waiver Unit, with 14 positions, has the responsibility for implementing the CCS portion of the Federal 1115 Waiver. The Waiver Unit will implement the CCS pilot programs that will redesign the CCS Program in certain geographic areas to provide the full-range of health care benefits to children with CCS eligible medical conditions, including primary and preventative services. The new system of care will maintain CCS provider standards and require the delivery of services to eligible children by facilities and individual providers who meet these standards. The implementation will include contract development, a readiness review, enrollment and contract management of the pilots. **/2014/Reference to the Waiver Unit is appropriately referenced as the Waiver and Research Section. The California 1115 Waiver is also known as the “Bridge to Reform Waiver”.** //2014//

The Research Unit consists of six research staff responsible for program data retrieval, aggregation and analysis for the CCS and CHDP programs. The research staff will also design and implement the enrollment process for the CCS pilots. //2012// **/2014/The Research Unit staff are responsible for program data retrieval, aggregation, and analysis for CCS, CHDP, and other SCD programs.** //2014//

/2013/ The Waiver and Research Section is also responsible for two Disease Management Programs for Seniors and Persons with Disabilities (SPDs) with chronic conditions or major medical conditions. These programs provide coordinated care to SPDs in designated counties. //2013// **/2014/The Waiver and Research Section is comprised of 13 positions.** //2014//

> Regional Operations Section (ROS)

ROS is composed of three CMS regional offices located in Sacramento, San Francisco, and L.A. The section provides case management services for CCS-eligible clients residing in dependent counties (those with populations of less than 200,000). Case management services include, but are not limited to, determination of medical eligibility and authorizations for services, including review and approval of EPSDT Supplemental Services requests, resolution of financial appeals, determination of eligibility for MTU services, and program consultation/TA. **/2014/The SCD maintains a statewide presence with offices located in Sacramento, the San Francisco Bay Area, and in Los Angeles. The CCS Program provides administrative case management services as noted in previous narrative.** //2014//

Regional office professional staff also have oversight responsibilities for local CCS and CHDP programs, including evaluating and monitoring county CCS and local CHDP

programs for compliance with federal and State regulations and local policies and procedures. Oversight responsibilities include, but are not limited to, program development, review and approval of annual budgets and work plans, and provision of TA and program consultation. **//2014/Reference to “regional office” refers to Systems of Care Division.//2014//**

Staff in the regional offices are responsible for coordinating and facilitating on-site reviews of hospitals, special care centers, neonatal and pediatric intensive care units, and medical therapy units for compliance with established program standards, policies, and procedures and for certifying outpatient rehabilitation centers located within CCS medical therapy units. **//2014/ Staff in all geographical locations are involved in CCS program operations. //2014//**

V. David Banda is the ROS Section Chief, a position he has held since December 2008. He was manager of the CMS Hearing & Audiology Services Unit/NHSP for 10 years and has more than 30 years of experience in the Department. In 2009, the Governor's budget eliminated 12 positions. ROS now has 40 positions. **//2012/ROS is currently identified as Dependent County Operations Section and Independent County Operations Section. //2014/ V. David Banda now serves as a program consultant to the Chief, SCD, and is responsible for handling the most complex and sensitive programmatic issues as directed by the Division Chief. David is well versed in children's related programs, including the CCS program, and has held a number of mid-level manager positions in SCD. //2014//**

James Delgado is the Acting Section Chief for the Dependent County Operations and has held that position since November 1, 2010. Prior to this position, Mr. Delgado was a manager in the DHCS Medical Case Management Program for approximately 10 years. There are 44 positions in this Section.**//2012//**

//2013/ As of June 2, 2011, James Delgado was appointed as the Section Chief for the Dependent County Operations Section (DCOS) formerly known as the Sacramento Regional Operations Section. Mr. Delgado has 25 years of state service. Of the 44 positions within DCOS, 34 positions are in Sacramento and 10 positions in L.A. //2013//

//2012/ The Section Chief for the Independent County Operations is currently vacant. V. David Banda is the Section Chief for Independent County Operations. There are 41 positions in this Section.//2012// //2013/ The Section Chief for the Independent County Operations is Janis Fong. There are 38 positions in this Section.//2013//

> Statewide Programs Section (SPS)

The Statewide Programs Section is responsible for administration of specialty programs with statewide responsibilities. Joleen Heider-Freeman is the Section Chief of SPS as of May 2005. The SPS currently has 24 filled positions. The SPS vacant positions have been cut due to the Governor's Balanced Budget Reduction Act. **//2012/The SPS currently has 27 filled positions and 1 vacant position. Joleen Heider-Freeman retired as of April 8, 2011. V. David Banda is the Section Chief of SPS since April 11, 2011.//2012/**

/2013/The SPS currently has 14 filled positions and six vacant positions//2013//
/2014/The SPS is comprised of 20 positions.//2014//

There are three units within the section: Specialty Programs, Hearing and Audiology Services, and GHPP. The Specialty Programs Unit is responsible for the monitoring of the HCPFC, identifying CHDP administrative needs and priorities and initiates efforts to accomplish CHDP objectives, and offers TA with the Transition Planning Statewide Guidelines. /2013/SPS is offering TA with CCS Transition Planning.//2013//
/2014//SPS does not provide transition planning TA.//2014//

The Hearing and Audiology Services Unit is responsible for the maintenance and monitoring of NHSP and for providing consultation/TA to providers and local programs regarding program benefits. The Unit is also responsible for the development and implementation of the NHSP Data Management Service (DMS). Staff in the unit monitor contracts with NHSP Hearing Coordination Centers (HCCs) providing follow-up testing and treatment services to infants with suspected hearing loss; evaluate and certify school audiometrists; and provide TA for the CHDP providers on the audiometric testing of hearing for children in the school setting.

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

GHPP provides all medical and administrative case management services for approximately 1750 clients statewide with serious, often life threatening, genetic conditions (e.g., hemophilia, cystic fibrosis, sickle cell anemia). /2012/GHPP has 1800 clients.//2012// /2013/GHPP has 1540 clients//2013// **/2014/ For GHPP enrollment data, see Agency Capacity.//2014//**

> Program Support Section (PSS)

PSS is composed of three units and has responsibility for a variety of activities in support of Branch operations. The Section Chief is Erin M. Whitsell. She has held the position since 2003. There are currently 17 positions in PSS. /2012/Since Fall 2010, PSS is composed of two units: Administrative and PSU.//2012// /2013/Effective November 2011, Joseph De La Torre became the Section Chief of PSS.//2013// **/2014/ PSS supports Division operations. //2014//**

The Administration Unit is responsible for fiscal, personnel, contracting, purchasing and business services for CMS. Staff in the unit review, approve, and process CCS county and CHDP county/city invoices; resolve invoicing/payment issues; develop and implement administrative and fiscal procedures for new programs administered by the Branch; develop and manage contracts and interagency agreements; process contract and county expenditure invoices; and maintain personnel and business services transactions for all CMS Branch staff. /2012/These activities are for all Systems of Care Division (SCD) staff.//2012

The Provider Services Unit (PSU) is responsible for enrolling providers for the CCS, CHDP, and GHPP programs and acts as a liaison between CMS Branch programs, their providers, the Medi-Cal Payment Systems Division, and the State fiscal intermediary. Staff in PSU also process hospital approval updates and all special care center directory updates and works with Information Technology staff in posting updates to various sites. Staff also develop and conduct provider training to individual and group health care providers, hospitals, special care centers, clinics, etc. in statewide formal training seminars. **/2014/ PSU acts as a liaison between all Division programs, their providers, the Medi-Cal Payment Systems Division, and the State fiscal intermediary.//2014//**

The Clerical Support Unit provides general clerical support to the CMS Branch management and staff. The unit is responsible for completion of complex typing assignments; assisting in organizing and filing all program documents; respond to telephone calls, faxes, and e-mails; disseminates program information to State staff, local agencies, the general public, and various other organizations; coordinates meetings; and, makes travel arrangements for staff. **/2012/ Clerical Support Unit has merged with PSU. PSU also provides general clerical support to the SCD management and staff. The clerical support staff assist in organizing and filing all program documents; respond to telephone calls, faxes, and e-mails; and disseminate program information to State staff, local agencies, the general public, and various other organizations.//2012 /2014/ SCD no longer has a separate clerical unit.//2014//**

> Information Technology Section (ITS)

ITS is responsible for all aspects of information technology support for the CMS Branch and CMS Net, the Branch's automated case management system. This includes CMS Branch office products, CMS Net network support, CMS Net operations, and CMS Net Help Desk operation. The section provides consultation to the CHHSA's Data Center regarding county LAN/WAN connectivity and is responsible for corrections and modifications to CMS Net application. **/2012/This is hosted at the Office of Technology Services' (OTech) Data Center.//2012// Brian Kentera was appointed Chief in February 2008. The CMS Net system is used by the county and State Regional CCS offices to manage the health care of approximately 170,000 children. /2012/The CMS Net system is used for managing the cases of 185,000 CCS and 1800 GHPP clients.//2012// /2013/The CMS Net system is used for managing the cases of 177,000 CCS and 1500 GHPP clients.//2013// /2014/ Reference to Children's Medical Services (CMS) Branch is gradually being phased out and replaced by Systems of Care Division (SCD). Brian Kentera serves as the ITS Chief. The CMS Net system is used by all State CCS offices. The CMS Net system is used to manage 180,200 active CCS cases and 1,630 active GHPP cases.//2014//**

The section is divided into two units: Information Systems and Information Technology. This section provides consultation to OTech, a division within the Office of the State Chief Information Officer, formerly the California Department of Technology Services. ITS currently consists of 11 State staff and 9 contractors. **/2014/ITS has 12 staff. The**

Office of the State Chief Information Officer was re-named California Technology Agency.//2014//

E. State Agency Coordination

MCAH and CMS are the primary entities in California that provide core public health and essential health care services for mothers, infants, children and CSCHN through its Title V programs. This requires involvement at the community, local and state level and seeking out of community based organizations (CBOs), building intra and inter-agency collaboration, partnering with universities, health foundations, hospitals and health professional organizations and working with individuals we serve. Both MCAH and CMS provide leadership in working with these various stakeholders to identify and focus our priorities, establish a process and create a plan to address these priorities and demonstrate progress in meeting these priorities.

Both MCAH and CMS actively foster statewide collaboratives and partnerships. A detailed discussion of our major collaboratives and partnerships was included in Section III-B, Agency Capacity.

> Department of Education (CDE)

MCAH collaborates with CDE on the ECCS grant to coordinate early childhood health programs for California's children.

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

The CCS MTP provides physical therapy and occupational therapy services to program eligible children in the public school setting. The local education agency provides the space and equipment for the MTU, and the county CCS program provides the administrative and clinical staff. /2013/The State Interagency Cooperative Agreement between the CDE and DHCS, CMS, CCS MTP, was revised last year by CCS. //2013//

The CMS Liaison to CDE participates on the Improving Special Education Services Stakeholders Group to achieve objectives of the State Improvement Grant.

MCAH is a part of the ASHWG collaborative comprised of representatives from CDPH, CDE and non-governmental organizations to address sexual and reproductive health issues of California adolescents.

MCAH collaborates with CDE on the ECCS grant to coordinate early childhood health programs for California's children. In addition, The ECCS Coordinator is working with CDE on two early childhood grants: 1) to train early childhood child care and educators on evidence-based practices for identifying and working with autistic children in their environments, and 2) to train the trainers at pilot sites to work with early childhood care and education staff on how to promote the social emotional wellness of young children. The goal is to create a statewide, sustainable system that is based on a common approach developed by Vanderbilt University Center on the Social Emotional Foundations for Early

Learning. /2014/This collaboration ended. //2014//

> Department of Developmental Services (DDS)

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

CMS executed a Data Use Agreement with DDS to obtain outcome data on Early Start program enrollment of infants identified with hearing loss through the Newborn Hearing Screening Program.

MCAH collaborates with the Early Start program at DDS on planning and implementation activities of the ECCS grant. The ECCS coordinator has been appointed by Dr. Mark Horton, to represent CDPH on the DDS Early Start Interagency Coordinating Council, as mandated by the Individuals with Disabilities Education Act. CDPH also participates on the Data Committee.

DDS has expressed interest in the potential for prevention through MCAH preconception health activities and invited to participate on the PHCC. /2014/ **DDS is participating on the PHCC//2014//**

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

HCPCFC is a collaboration between DSS and CMS to improve oversight of health care for children in foster care. CMS initiated a performance measure to evaluate the effectiveness of the HCPCFC administrative case management. A data collection system is being developed. /2013/Revised performance measures will be implemented on July 1, 2013.//2013//

With the passage of AB X4 4 in July of 2009, the HCPCFC became a mandated program statewide. The role of the Public Health Nurse (PHN) remains that of administrative case manager working collaboratively with the Social Worker and/or Probation Officer.

Five regional committees as well as a statewide subcommittee of the CHDP Program Executive Committee meet on a quarterly basis. /2013/Four regional committees as well as a statewide subcommittee of the CHDP Program Executive Committee meet on a quarterly basis. //2013//

AFLP continues to collaborate with the DSS/Cal-Learn as part of case management oversight for pregnant and parenting teens.

Under the ECCS grant, the Statewide Screening Collaborative (SSC) continues to provide technical assistance to DSS to implement developmental screening at the county level for foster children as part of the federal law, Child Abuse Prevention and Treatment Act, which requires that any child under the age of 2 with substantiated abuse or neglect be referred to early intervention services. /2014/The SSC has developed the Help Me

Grow model as a way to develop local systems of early identification and referral. The Help Me Grow Learning Community comprises 18 counties who are implementing Help Me Grow//2014//

/2012/Assembly Bill 12 (AB 12), California's Fostering Connections Act was signed into law on September 30, 2010 bringing numerous changes to the Foster Care system, most notable the extension of foster care benefits to age 21. //2012// /2013/CMS continues to collaborate with DSS and local program PHNs in the development of AB 12 related policies and procedures.//2013//

> Managed Risk Medical Insurance Board (MRMIB)

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

Under ECCS grant, the SCC is working with MRMIB to identify ways to incentivize the use of standardized developmental screening tools in their plans. A survey was conducted in 2009 that showed only 1.26% of their children under the age of 5 were being screened with a validated tool.

> Childhood Lead Poisoning Prevention Branch (CLPP)

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

The Health Assessment Guidelines section on management of elevated blood lead levels has been revised as recommended in the November 2007 Morbidity and Mortality Weekly Report.

CHDP and CLPP released a joint letter in December 2008 outlining the updated CDC recommendations on childhood lead poisoning prevention. /2012/CHDP and CLPP are reviewing blood lead referral and screening rates to ensure that blood lead testing is done at the appropriate intervals of 12 and 24 months.//2012//

MCAH and CMS participate in the statewide planning process led by CLPP to eliminate childhood lead poisoning and meet the HP 2010 goal. A federal interagency strategy and objectives have been developed. /2012/MCAH is no longer involved in this project.//2012//

> Immunization Branch (IZB)

The CMS and IZ Branches collaborate with the Vaccines for Children (VFC) program by providing vaccination coverage and modifications through the CHDP program, including: tetanus, diphtheria and acellular pertussis vaccine; FluMist; meningococcal conjugate; measles, mumps, rubella, and varicella; hepatitis A, hepatitis B, Haemophilus influenzae type B vaccine, rotavirus, influenza, human papillomavirus and meningitis

vaccines./2013/Pneumococcal vaccine (PCV13 and Pneumovax23 when appropriate) are provided by the CHDP program.//2013//

CMS and IZ Branches, Medi-Cal, and MCMC meet three times per year to discuss results of the Advisory Committee on Immunization Practices (ACIP)-VFC National Meetings. CMS and IZ branches work together on adding new vaccines and modifying existing vaccine benefits in concordance with the ACIP recommendations.

MCAH has partnered with the IZ Branch to provide immunization updates to the MCAH Perinatal Services coordinators, review immunization brochures on immunization during pregnancy, development of educational materials on H1N1 in pregnancy and the importance of influenza vaccination. /2012/MCAH worked closely with the IZ Branch to provide information on pertussis to MCAH providers.//2012// **/2014/MCAH coordinated with the IZ branch to partner with Text4Baby to remind mothers to immunize their babies and educate parents about the new requirement, that all students entering, advancing or transferring into 7th grade will need proof of an adolescent whooping cough booster immunization .//2014//**

> California Nutrition, Physical Activity and Obesity Prevention Program/ Champions for Change

MCAH and CMS collaborate with the California Nutrition, Physical Activity and Obesity Prevention Program and the Champions for Change to promote healthy lifestyles to reduce the prevalence of obesity. MCAH and CMS participated on the 2009 Childhood Obesity Conference committee, which showcased evidence-based prevention interventions and community efforts. MCAH featured their BBC project, working with hospitals to integrate Quality Improvement efforts within the maternity care setting to ensure policies and practices are supportive of breastfeeding, as well as the work they are doing to promote healthy weight before, during and after pregnancy, and “Tracking Childhood Obesity Trends Using Geographic Information System (GIS) Mapping, California: 1996-2006.” MCAH was also on the planning committee for the 2009 Weight of the Nation, a national forum to highlight progress in the prevention and control of obesity through policy and environmental strategies. MCAH was instrumental in including a life course perspective and a presentation on BBC.

/2012/MCAH is working on the next Childhood Obesity Conference scheduled for 2011 in San Diego, partnering with CDE, UC Berkeley’s Atkins Center for Weight and Health, CA Endowment and Kaiser Permanente. **/2014 /MCAH is working with the same partners on the 2013 Childhood Obesity Conference in the Long Beach Convention Center.**

MCAH is providing expert consultation for the California Obesity Prevention Program to 15 clinics to become “Breast Feeding Friendly. //2014//

MCAH participated in a multi-agency workgroup to develop the Health in All Policies Task Force report which has specific nutrition and physical activity recommended policies, programs, and strategies that State agencies can implement to advance health. /2014/MCAH has been an active partner in developing and implementing the strategies in the Coordinated Chronic Disease Plan.//2014//

PHCC Interconception Care Project of CA, in coordination with ACOG District IX and funded by MOD, is finishing provider guidelines for the post-partum visit, which include management of women who developed gestational diabetes during their prior pregnancy.//2012//

> **Medi-Cal Managed Care Division (MCMC)**

California WIC Association, WIC, and MCAH meet monthly with MCMC Division to clarify and simplify access to breastfeeding supportive benefits.

> **Safe and Active Communities Branch (SAC)**

The Safe and Active Communities (SAC) Branch is the lead agency within CDPH responsible for coordinating statewide injury and violence prevention efforts. This includes the prevention of intentional and unintentional injuries as well as surveillance and epidemiology. Current intervention efforts focus on child passenger safety (CPS), violence prevention (ranging from child maltreatment, violence against women, including sexual assaults, homicide and suicide), elder maltreatment, fall prevention, pedestrian safety and creating safe and active communities conducive to walking and bicycling. SAC's injury surveillance and epidemiology program includes the California Injury Data Online, a web-based do-it-yourself injury surveillance table builder (www.dhs.ca.gov/EPICenter).

MCAH collaborates with SAC on injury prevention activities, including local training programs, SIDS and the Child Death Review Team (CDRT), SAFE-KIDS California Advisory Committee and the Strategic Coalition on Traffic Safety. MCAH Title V support data collection and prevention work of the local CDRTs. MCAH and SAC are also working together to address Electronic Death Recording System data issues related to Shaken Baby Syndrome and SIDS. /2013/MCAH and SAC will also be collaborating to analyze trauma related maternal deaths.//2013//

> **Office of Audits and Investigations**

MCAH works closely with DHCS Audits and Investigations to ensure the integrity of MCAH programs.

> **Genetic Disease Screening Program (GDSP)**

CMS and GDSP work together to address issues as they arise and update policies and reporting /forms as needed in an effort to ensure that babies who screen positive receive expedited care at a CCS approved Special Care Center. Although CCS makes a special effort to expedite these cases some slight delays may occur due to the CCS staffing cuts.

CCS provides services for conditions identified on (NBS) tests, develops standards, and approves Metabolic, Endocrine, and Sickle Cell Special Care Centers (SCCs) for treatment.

/2012/MCAH collaborated with GDSP to revise “Your Future Together,” a preconception and prenatal health information booklet for women obtaining marriage licenses.//2012// /2013/Newborns screening now also includes screening for Severe Combined Immunodeficiency. //2013//

> Women, Infants & Children (WIC) Supplemental Nutrition Division

MCAH and CMS collaborate with WIC in a variety of areas, including improvement of prenatal care, linkages between MCAH and WIC data files, obesity prevention, oral health, childhood injury prevention, and breastfeeding. In 2010, MCAH began collaborating with WIC on several applied, public health research projects (as described in Section III-A). /2014/ **WIC and MCAH are in discussions regarding how they could collaborate to increase enrollment in WIC, especially among high risk and hard to reach eligible women, infants and children.**//2014//

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

WIC, MCAH, California WIC Association, and the Nutrition, Physical Activity and Obesity Prevention Program developed a California Breastfeeding Roundtable to develop and implement a breastfeeding strategic plan.

CMS collaborates with WIC regarding CHDP provider relations, relevant health assessment guidelines and communications. For example, WIC's food package changes and the new pediatric referral form were communicated to CHDP providers via Provider Information Notices. CHDP Health Assessment Guidelines promote the use of WIC nutrition education materials for providers to use for anticipatory guidance. Additionally, CMS assists WIC with using the Pediatric Nutrition Surveillance System (PedNSS) prevalence data for local program nutrition education plans.

CMS also coordinates with WIC regarding the provision of specialty enteral nutrition products for the Special Needs Population in WIC and CCS.

CMS, WIC and MCAH meet quarterly for program updates /2012/ coordinate projects and develop relevant policies/guidelines.

MCAH coordinated with WIC, CA WIC Association, the CA Obesity Grant and the CA Breastfeeding Coalition to coordinate National Breastfeeding Week activities, and hosted

the 2011 Hospital Breastfeeding Summit. MCAH also partnered with WIC to develop and disseminate a teen cookbook.//2012// /2013/This collaboration continued for the 2012 2nd Annual Breastfeeding Summit.//2013// **/2014/This collaboration continued in the third Annual Breastfeeding Summit, including PAC-LAC.**

Both WIC and MCAH are leading the development of a policy for supporting lactating mothers and their infants in an emergency. MCAH and WIC are sending a letter to hospital executives to provide direction for implementation of the Infant Feeding Act that requires hospital to have an infant feeding policy by 2014.

MCAH produced prenatal weight gain grids for pregnant women with twins. The grids were developed with input from WIC and continue to be based on the 2009 Institute of Medicine's Weight Gain During Pregnancy: Reexamining the Guidelines. WIC is linking to the new grids from their website.//2014//

>CDPH Center for Health Care Quality

Collaboration between CDPH and CMS: CLABSI reporting. CDPH issued its first public report on hospital CLABSI in 2012. CMS and CDPH have begun to collaborate to help ensure benchmarking data accuracy because neonatal reporting entails data elements unique to this age group and evaluation of inconsistent/anomalous values requires specialized knowledge of NICU care processes.//2013//

> Universities

MCAH and CMS work closely with the University of California and other universities in the state. Partnerships include the National Adolescent Health Information Center and the Bixby Center for Reproductive Health Research & Policy at UCSF, Stanford University (on CMQCC and CPQCC issues), and the Center for Injury Prevention Policy and Practice at San Diego State University (SDSU). UCSF FHOP provides consultation and training to local MCAH jurisdictions in monitoring and updating local 5-year plans, data collection, identification of data sources, data analysis and survey development. FHOP also provides consultation, data analysis, stakeholder meetings and interviews for the Title V Needs Assessment. **/2014/ MCAH worked with UCSF FHOP to develop an introductory webinar on addressing the built environment and its influence on nutrition and physical activity.//2014//**

UCLA's Center for Healthy Children, Families and Communities participates in the Statewide Screening Collaborative as well as collaborate with the maternal QI project. /2012/ UCLA was contracted to conduct an analysis of maternal morbidity and improve data collection at hospitals that is needed to report on Joint Commission obstetrical measures for quality improvement.//2012// /2013/Additionally, the UCLA Center for Health Policy Research has been contracted to provide the 1115 Bridge to Reform Evaluation, as well as the evaluation of the Pediatric Palliative Care Waiver Program.//2013//

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

In collaboration with MCAH, UCSF Center on Social Disparities in Health conducts, analyzes, and reports on MIHA. MCAH contracted with the UCSF Center on Social Disparities in Health to assess BIH program services. UCSF's recommendations have served as a foundation to develop a standardized intervention and evaluation plan. /2012/UCSF partners with MCAH in the development and implementation of the evaluation of BIH.//2012//

Through a contract with SDSU Institute of Public Health and CCHA the Catheter Associated Bloodstream Infection Prevention Neonatal Quality Improvement Initiative (NQI) using the IHI model was initiated in 2007 with 13 regional NICUs. CLABSIs were reduced by 29% in all weight groups. The collaborative expanded in 2008 to include all 22 CCS-approved regional NICUs. And in July 2009, the collaborative has continued on with 14 regional NICUs and expansion to all hospital associated bloodstream infections. /2012/The bloodstream infection (BSI) prevention Collaborative is continuing through 2012.//2012//

> California District of the American Academy of Pediatrics (AAP-CA)

Under the leadership of MCAH ECCS, the SSC is working with the AAP-CA. AAP-CA has designated Dr. Renee Wachtel, a developmental pediatrician, to represent the AAP-CA on the SSC. She has been leading a subcommittee for the Collaborative to work with Medi-Cal Fee-For-Service on identifying issues with developmental screening reimbursement. Recommendations to be provided to Medi-Cal in spring 2010.

/2013/ Conference calls between the AAP-CA Chapter Champions, the state NHSP staff, and the HCC directors occur every other month. An article on the NHSP was published in the District magazine. A podcast is being developed to educate pediatricians about the NHSP and their role in coordinating care during and after the identification process. Two of the Chapter Champions will be attending the national Early Hearing Detection and Intervention meeting in 2012. No Chapter Champion from Chapter 3 has been designated//2013//

The CMS Branch collaborates with AAP-CA on many initiatives such as the 1115 Waiver, the CCS Needs Assessment, and the Palliative care Initiative.

/2012/> American Congress of Obstetricians & Gynecologists California (ACOG) District IX

ACOG supported the toolkit to eliminate non-medically indicated deliveries prior to 39 weeks gestation and developed a Speaker's Bureau for the statewide effort. ACOG has representation at PHCC and CMQCC Executive Committee. /2014/ **ACOG works closely with MCAH and MOD on promoting the use of the toolkit to eliminate non-medically indicated deliveries <39 weeks gestation.**//2014//

>March of Dimes (MOD)

MCAH partners with MOD in the PHCC. MOD and ACOG, with input from the Preconception Council, is developing an Interconception Health Care Toolkit for use in

California. MCAH provided a toolkit to eliminate non-medically indicated deliveries before 39 weeks gestation to the MOD for national dissemination. MOD funds 8 California obstetrical hospitals in a national collaborative to reduce elective early term deliveries. MOD provided CPeTS with a grant to develop regionalized, risk appropriate maternal care. MCAH previously collaborated with MOD on the Preterm Labor Assessment Toolkit and a Folic Acid Promotion Campaign. //2012// /2013/ MCAH will be collaborating with MOD as well as the Association of State and Territorial Health Officers to meet their national challenge to reduce preterm births by 8% from 2009 levels by 2014.//2013//**2014/ In partnership with the CDC Preconception Health Initiative and PPE, MCAH and PHCC implemented the *Show Your Love* public awareness campaign.//2014//**

> **California Association of Neonatologists (CAN) and Stanford University**

CMS and MCAH work with these groups on a perinatal and neonatal morbidity and mortality reporting system that provides information on quality of care, and serves as a basis for quality improvement in participating hospitals. CMS participates in CAN/District IX Board Meetings and annual conferences and in 2009-10 has provided progress reports on the Federal 1115 Waiver Renewal and the CCS Technical Workgroup which will be making recommendations for CCS redesign <http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx>. Collaboration with Stanford and CPQCC continues with NICU and HRIF data collection and the breast milk nutrition QI **/2014/ Length of Stay//2014//** Collaborative. CMS has worked with the Packard Foundation as they assess a service system for Children and Youth with Special Health Care Needs (CYSHCN) in CA. /2012/ CMS is working with CAN on NICU Z code conversions to national codes and looking at NICU models of provider reimbursement.//2012//

> **Children's Specialty Care Coalition (CSCC)**

CSCC is an organization of pediatric specialty and subspecialty providers practicing at CCS-approved tertiary hospitals and Special Care Centers. CSCC has participated in the Title V Needs Assessment process and is also an active participant in the 1115 Waiver Redesign process. /2012/CSCC is working with CCS and Medi-Cal on Z code conversions to national codes for NICUs and PICUs.//2012//

> **California Conference of Local Health Officers (CCLHO)**

CMS works with CCLHO on issues related to county program operations for CSHCN, preventive health services for children, and the CMS Net Data system.

> **California Children's Hospital Association (CCHA)**

The Children's Hospitals are vital providers of services to children in the CCS program. CMS works closely with hospitals in the Title V Strategic Planning Process; develops quality improvement initiatives; and advocates for children's services.

In collaboration with CCHA, CMS is sponsoring a Neonatal Quality Improvement Initiative. CMS collaborates with CCHA in the NQI Initiative, which includes all 22 Regional NICUs. /2012/This collaboration ended in 2009./2012//

> Other Professional Organizations

CMS collaborates with the California Dental Association, the California Association of Orthodontists, the Oral Health Access Council, the California Orthopedic Surgeons Association, the California Association of Home Health Agencies, California Association of Ophthalmologists, California Association of Medical Products Suppliers and the Hemophilia Council and Foundations to improve working relationships, recruit providers, and address barriers to access to services. CMS works with Medi-Cal to improve reimburse processes for providers.

A number of professional organizations are actively involved in the Title V Needs Assessment process and participating in the 1115 Waiver Redesign process.

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

The Palliative Care Waiver was approved by Federal Centers for Medicare and Medicaid Services with a start date of July 1, 2009. /2012/Start date was April1, 2009./2012//

ECCS partners with many others through the SSC, including First 5, the California Academy of Family Physicians, the California Association of Health Plans, the Advancement Project /2014/**and Children Now.**/2014//

MCAH contracts with the CAHC to support LHJs' efforts on adolescent health.

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

MCAH and CMS are involved in strategic planning for California's CDC-five year funded Nutrition, Physical Activity and Obesity Prevention Program. CMS conducted statewide webinars with local CHDP program staff to identify health care strategies for the health care sector of the Obesity Prevention Plan.

CMS coordinated with MCMC Health Plans: Kaiser, Cal Optima, Anthem Blue Cross and Health Plan of San Joaquin to provide training workshops, "Pediatric Obesity: Provider Skill Sets for Improved Care" to accelerate provider practice changes regarding childhood obesity. CMS is collaborating with Head Start on childhood obesity

intervention since the majority of Head Start children receive health assessments through CHDP.

/2012/MCAH collaborates with the ARC of CA in the Fetal Alcohol Spectrum Disorders Task Force, an independent, public-private partnership of parents and professionals from various disciplines committed to improving the lives affected by FASD and eliminating alcohol use during pregnancy.

MCAH has representation on the US Breastfeeding Promotion Committee and on the MCH Nutrition Council of the Association of State and Territorial Public Health Nutrition Directors (ASTPHND). The Council addresses policy, programs and services including promoting nutrition wellbeing across the lifespan for women including breastfeeding. The MCAH Nutrition and Physical Activity Coordinator served as Chair of the ASTHPND MCH Nutrition Council. The Council's goal is to achieve optimal health through healthy eating and active living and provide members with networking, educational and advocacy opportunities.

CMS is coordinating with MCAH to present at the 6th Biennial Childhood Obesity Conference during the Healthcare Prevention Strategies Track. The workshop will address the efforts made by the CHDP program related to pediatric obesity. Also, CMS is collaborating with MCAH and WIC to develop strategies to implement the new WHO Growth Charts. The CHDP Nutrition Subcommittee has been charged with the task of developing CHDP provider trainings on the use of the new WHO Growth Charts.

>Multiple Collaborations through Home Visiting Program

MCAH joined with DSS, ADP, and CA Head Start State Collaboration Office of CDE to develop the state's Home Visiting Program application and Needs Assessment.

/2014/This collaboration is continuing in the Interagency Home Visiting Workgroup. Additional collaborating agencies include DDS and Race to the Top in the CDE./2014//

Additional input was obtained from the CA Emergency Management Agency; the Safe and Active Communities Branch of the CDPH; the STOP Violence Against Women regional coordinator for CA; CA Partnership to End Domestic Violence; and the Domestic Violence Assistance Program and local MCAH directors /2012//

F. Health Systems Capacity Indicators (HSCI)

Introduction

Social, demographic and economic factors have been identified to explain the disparities in health. Some argue that health disparities may reflect the variation in health system characteristics such as the adequacy of public health services and the availability and quality of health care services received.

This section covers a discussion of select health indicators, a comparison of health disparities with programs targeting the economically disadvantaged populations and public health activities that aim to close the disparity gap. Please note that in California, the Medicaid Program is called Medi-Cal; SCHIP is called HF; EPSDT is called the CHDP Program.

Health Systems Capacity Indicator 01

The rate of children hospitalized for asthma (International Classification of Diseases (ICD)-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	22.0	22.9	22.3	21.9	21.9
Numerator	5993	6290	6187	5511	
Denominator	2723382	2745856	2771815	2514468	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	Provisional

Field Level Notes

Section Number: Form17_Health Systems Capacity Indicator #01

Field Name: HSC01

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form17_Health Systems Capacity Indicator #01

Field Name: HSC01

Row Name:

Column Name:

Year: 2011

Field Note:

Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPPD-PDD), January 1-December 31, 2011. Primary diagnoses of each discharge abstract were tabulated, secondary diagnoses were not included.

Denominator:

State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2011 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010 using these updated population projections was 24.5.

Health Systems Capacity Indicator 02

The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	83.4	90.1	88.5	83	83
Numerator	552084	589521	567757	510,203	
Denominator	661753	653829	630326	617,510	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

Section Number: Form17_Health Systems Capacity Indicator #02

Field Name: HSC02

Row Name:

Column Name:

Year: 2012

Field Note:

Manual indicator for 2012 is based on 2011.

Numerator is the number of children less than one year of age enrolled in Medi-Cal who received at least one CHDP service in State Fiscal Year (FY) 2011/12. Denominator is the unduplicated number of children less than one year of age enrolled in Medi-Cal in FY 2011/12.

Section Number: Form17_Health Systems Capacity Indicator #02

Field Name: HSC02

Row Name:

Column Name:

Year: 2011

Field Note:

Manual indicator for 2011 is based on 2010.

Narrative:

Health Systems Capacity Indicator 02 (HSCI-02) is the percent of Medi-Cal enrolled children less than one year of age who received at least one CHDP health assessment in the reporting year. In FY 2008-09, HSCI 02 was 83.4 percent, an increase of .9 % from FY 2006-07/2012/; in FY 2009-10, HSCI 02 was 90.1 percent, an increase of 8% from the prior year. The denominator--unduplicated Medi-Cal enrolled children less than one year of age (661,753 for FY 2008-09)--has decreased by 5.99% since 2006-07. The continued increase in this indicator is most likely to CHDP Gateway pre-enrollment and infant deeming. The unduplicated Medi-Cal enrolled children less than one year of age (557,757 for FY 2009-2010) decreased by 15.8% since 2008-2009. The unduplicated

Medi-Cal enrolled children less than one year of age (539,085 for FY 2010-2011) decreased by 3.35% since 2009-2010. The unduplicated Medi-Cal enrolled children less than one year of age (510,203 for FY 2011-2012) has decreased by 5.35% since 2010-2011.

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

Quarterly meetings between CHDP programs and MCMC plans are occurring in some counties and less frequently in other counties. SCD continues to collaborate with MCMC plans on statewide operational problems that occur with the carve-out of CCS services in Medi-Cal and HF managed care plans.

Local CHDP programs continue to provide education, training and outreach to CHDP provider office staff and the community in order to assist the number of eligible children into health care. The CHDP Gateway pre-enrollment process and infant deeming appear to be having the greatest effect on this performance measure.

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

SCD continues to collaborate with MCMCD management staff on statewide operational issues that affect local CHDP programs, including provider office site visits and sharing of information between program site reviewers in MCMC and CHDP.

Health Systems Capacity Indicator 03

The percent State Children’s Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator					
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?	Provisional	Provisional	Provisional	Provisional	

Field Level Notes

Section Number: Form17_Health Systems Capacity Indicator #03

Field Name: HSC03

Row Name:

Column Name:

Year: 2012

Field Note:

Specific data for HSCI 3 is not available

Section Number: Form17_Health Systems Capacity Indicator #03

Field Name: HSC03

Row Name:

Column Name:

Year: 2011

Field Note:

Specific data for HSCI 3 is not available

Narrative:

Health Systems Capacity Indicator 03 (HSCI-3) is the percent of HF enrollees under one year of age who received at least one CHDP health assessment. HF plans do not conduct CHDP health assessments, but instead perform preventive examinations based on the AAP guidelines. The HF Program relies on the Health Plan Employer Data and Information Set (HEDIS) to evaluate the performance of the health plans. While HEDIS data is available on the MRMIB website, the specific data for HSCI-3 is not collected by MRMIB.

Pursuant to Assembly Bill 1494, the 2012-13 State Budget required the transition of children enrolled in HF to the Medi-Cal Program. The transition began January 1, 2013, and is expected to be completed in four phases no sooner than September 2013. With the transition, there are no new enrollments of children into HF except for babies enrolled in Access for Infants and Mothers (AIM) program. HF will remain open for those families that have not yet transitioned to Medi-Cal, including AIM-linked infants who will be transitioned to Medi-Cal in a later phase. In addition to the HF transition to Medi-Cal, children will continue to be pre-enrolled into Medi-Cal through the CHDP Gateway.

Many of the children being transitioned from HF to Medi-Cal will be able to retain the same health plan and doctors, while others will have to choose a different plan and find new providers. Phase 1 of the transition involved transitioning 409,000 children enrolled in HF that is also a Medi-Cal managed care plan in the same county. Phase 2 involves approximately 259,000 children enrolled in HF that is a subcontractor to a Medi-Cal managed care plan in the same county. Phase 3 will affect approximately 151,000 children enrolled in an HF plan that is neither a Medi-Cal managed care plan nor a subcontractor to one in the child's county. Phase 4 will affect approximately 42,000 children residing in a county where Medi-Cal completes a successful expansion of managed care to rural counties.

Health Systems Capacity Indicator 04

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	79.0	79.7	79.6	79.8	79.8
Numerator	416314	403578	390717	386,668	
Denominator	527150	506582	490856	484,470	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	Provisional

Field Level Notes

Section Number: Form17_Health Systems Capacity Indicator #04

Field Name: HSC04

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form17_Health Systems Capacity Indicator #04

Field Name: HSC04

Row Name:

Column Name:

Year: 2011

Field Note:

Source: State of California, Department of Public Health, Center for Health Statistics, 2011 Birth Statistical Master File.

Tabulations (by place of residence) were done by the MCAH Program. Birth records with missing information in prenatal care initiation or visits fields were excluded from analysis.

Section Number: Form17_Health Systems Capacity Indicator #04

Field Name: HSC04

Row Name:

Column Name:

Year: 2009

Field Note:

Source: State of California, Department of Public Health, Center for Health Statistics, 2009 Birth Statistical Master File.

Tabulations (by place of residence) were done by the MCAH Program. Birth records with missing information in prenatal care initiation or visits fields were excluded from analysis.

Health Systems Capacity Indicator 05a

Percent of low birth weight (< 2,500 grams)

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NONMEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2011	payment source from birth certificate	6.7	6.8	6.8
Infant deaths per 1,000 live births	2009	matching data files	5.5	4.2	5.0

Field Level Notes

Section Number: Form18_Indicator 05

Field Name: LowBirthWeight

Row Name: Percent of low birth weight (<2,500 grams)

Column Name:

Year: 2011

Field Note:

Source: State of California, Department of Public Health, Center for Health Statistics, 2011 Birth Statistical Master File.

Expected payer source for delivery was used. Births with unknown birth weight or births weighing <227g or >8165g were excluded when calculating percentages. Births with missing payer source are included in the Total. Tabulations (by place of residence) were done by the MCAH Program.

Health Systems Capacity Indicator 05b

Infant deaths per 1,000 live births

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NONMEDICAID	ALL
Infant deaths per 1,000 live births	2009	matching data files	5.5	4.2	5.0

Section Number: Form18_Indicator 05

Field Name: InfantDeath

Row Name: Infant deaths per 1,000 live births

Column Name:

Year: 2012

Field Note:

Source: State of California, Department of Public Health, Center for Health Statistics, 2009 Birth Cohort file.

Expected payer source for delivery was used to compute rates. Cases with missing payer source included in Total. Tabulations (by place of residence) were done by the MCAH Program.

Health Systems Capacity Indicator 05c

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NONMEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2011	payment source from birth certificate	77.9	88.5	83.5

Field Level Notes

Section Number: Form18_Indicator 05

Field Name: CareFirstTrimester

Row Name: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

Column Name:

Year: 2013

Field Note:

Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File.

Payer source for prenatal care was used. Infant birth records with missing prenatal care initiation were excluded from analysis. Infant birth records with missing payer source included in Total. Tabulations (by place of residence) were done by the MCAH Program.

Health Systems Capacity Indicator 05d

Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NONMEDICAID	ALL
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2011	payment source from birth certificate	76.9	82.4	79.8

Field Level Notes

Section Number: Form18_Indicator 05

Field Name: AdequateCare

Row Name: Percent of pregnant women with adequate prenatal care

Column Name:

Year: 2013

Field Note:

Source: State of California, Department of Public Health, Center for Health Statistics, 2011 Birth Statistical Master File.

Payer source for prenatal care was used. Birth records with missing information in prenatal care initiation or visits fields were excluded from analysis. Table reflects adequacy of prenatal care reported for women between the ages of 15 and 44 who gave birth to a live infant. Birth records with missing payer source included in Total. Tabulations (by place of residence) were done by the MCAH Program.

Health Systems Capacity Indicator 06a

The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. -Infants (0 to 1)

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL MEDICAID
Infants (0 to 1)	2011	200
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, SCHIP and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2011	250

Field Level Notes

Section Number: Form18_Indicator 06 - Medicaid

Field Name: Med_Infant

Row Name: Infants

Column Name:

Year: 2013

Field Note:

Source: ~~2010~~ 2011 Medicaid data supplied by California Department of Health Care Services, Medi-Cal (California's Medicaid) Eligibility Branch based on an All County Welfare Directors Letter No. 11-16e. specifying the 2011 Federal Poverty Levels (FPLs) for various programs. <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c11-16E.pdf>. The California Department of Health Care Services stated that the Federal Poverty Level did not change between 2010 and 2011.

Section Number: Form18_Indicator 06 - SCHIP

Field Name: SCHIP_Infant

Row Name: Infants

Column Name:

Year: 2013

Field Note:

Source: ~~2010~~ 2011 State Children's Health Insurance Program (SCHIP) Eligibility Levels supplied by Managed Risk Medical Insurance Board (MRMIB), Eligibility, Enrollment & Marketing Division based on Eligibility Levels for the ACCESS To Mothers and Infants (AIM) Program. The 250% of poverty levels reported by MRMIB represent the upper range level. For infants 0-1 years of age, the range is 200%-250%.

Narrative:

Medi-Cal is in the midst of major transformation as it shifts most enrollees to managed

care and prepares for a major expansion due to ACA. Child enrollment will surge as children transition to Medi-Cal from HF. It is projected that Medi-Cal will see an increase of a million or more enrollees due to ACA, including 680,000 in 2014, the first year of Medi-Cal expansion under health care reform. Starting January 1, 2014, Medi-Cal eligibility will be set at 139% of the FPL.

As of January 1, 2013, HF no longer enrolled children other than babies enrolled in AIM. HF-enrolled children were transitioned to the Medi-Cal for Families Program. Medi-Cal has established the Targeted Low Income Children’s Program which will expand eligibility for Medi-Cal for children to 250 percent FPL for 2013. This will provide Medi-Cal coverage to children who were previously HF- eligible.

Health Systems Capacity Indicator 06b

The percent of poverty level for eligibility in the State’s Medicaid and SCHIP programs. -Medicaid Children

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
b) Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range __ to __)	2011	133 100
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
b) SCHIP Children (Age range 1 to 5) (Age range 6 to 18) (Age range __ to __)	2011	250 250

Field Level Notes

Section Number: Form18_Indicator 06 - Medicaid

Field Name: Med_Children

Row Name: Medicaid Children

Column Name:

Year: ~~2012~~ 2013

Field Note:

Source 2011 Medicaid data supplied by California Department of Health Care Services, Medi-Cal (California’s Medicaid) Eligibility Branch based on an All County Welfare Directors Letter No. 11-16e. specifying the 2011 Federal Poverty Levels (FPLs) for various programs. <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c11-16E.pdf>. The California Department of Health Care Services stated that the Federal Poverty Level did not change Between 2010 and 2011.

Section Number: Form18_Indicator 06 - SCHIP

Field Name: SCHIP_Children

Row Name: SCHIP Children

Column Name:**Year:**-2013**Field Note:**

Source: 2011 State Children’s Health Insurance Program (SCHIP) Eligibility Levels supplied by Managed Risk Medical Insurance Board (MRMIB), Eligibility, Enrollment & Marketing Division . The 250% of poverty levels reported by MRMIB represent the upper range levels for each population group. Children 1 through 5 years of age have eligibility levels ranging from 133%-250% of FPL; children 6-18 years of age have eligibility levels ranging from 100%-250%.

Narrative:

See HSCI 6A.

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

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2011	200
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2011	300

Field Notes:**Section Number:** Form18_Indicator 06 - Medicaid**Field Name:** Med_Women**Row Name:** Pregnant Women**Column Name:****Year:** 2013**Field Note:**

Source: 2011 Medicaid data supplied by California Department of Health Care Services, Medi-Cal (California’s Medicaid) Eligibility Branch based on an All County Welfare Directors Letter No. 11-16e. specifying the 2011 Federal Poverty Levels (FPLs) for various programs. <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/cl1-16E.pdf>. The California Department of Health Care Services stated that the Federal Poverty Level did not change Between 2010 and 2011.

Section Number: Form18_Indicator 06 - SCHIP**Field Name:** SCHIP_Women**Row Name:** Pregnant Women**Column Name:****Year:** -2013**Field Note:**

Source:-2011 State Children’s Health Insurance Program (SCHIP) Eligibility Levels supplied by Managed Risk Medical Insurance Board (MRMIB), Eligibility, Enrollment & Marketing Division based on Eligibility Levels for the ACCESS To Mothers and Infants (AIM) Program. The 300% of poverty level reported by MRMIB represents the upper range. Eligibility levels for pregnant women range from 200-300% of FPL. The California Department of Health Care Services stated that it did not produce a Federal Poverty Levels Letter for 2010 and that the Federal Poverty Level did not change from 2009

Health Systems Capacity Indicator 07a

Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	94.8	93.8	93.4	93.7	93.7
Numerator	3,364,542	3974016	3718767	3879778	
Denominator	3,549,664	4235016	3979767	4140778	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?		Final	Final	Provisional	

Field Level Notes

1. Section Number: Form17_Health Systems Capacity Indicator #07A

Field Name: HSC07A

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator for 2012 was reported based on 2011 results.

2. Section Number: Form17_Health Systems Capacity Indicator #07A

Field Name: HSC07A

Row Name:

Column Name:

Year: 2011

Field Note:

Numerator: All persons 1 to 21 years of age who received a service paid by the Medi-Cal program during the Federal fiscal year: October 2009-September 2010 (this is an unduplicated count), including both Fee-for-Service and Managed Care beneficiaries, as well as certified and uncertified beneficiaries (i.e., those who shared a cost for their care). Source: Fiscal Forecasting and Data Management Branch, California Department of Health Care Services.

Denominator: Consists of the sum of two indicators: (1) An estimate of uninsured children (1-21 years old) eligible for Medi-Cal. Source: 2009 California Health Interview Survey; (2) All persons 1 to 21 years of age who received a service paid by the Medi-Cal program during the Federal fiscal year: October 2010-September 2011 (this is an unduplicated count), including both Fee-for-Service and Managed Care beneficiaries, as well as certified and uncertified beneficiaries (i.e., those who shared a cost for their care). Source: Fiscal Forecasting and Data Management Branch, California Department of Health Care Services.

Data reported starting 2009 should not be compared to prior years' data because of a methodological change in estimating the denominator beginning 2009. Rate for prior years' using the revised denominator estimates: 2008=93.7

Narrative:

Health Systems Capacity Indicator 07a (HSCI-7a) is the percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program. For 2011, it

is estimated that 93.7% of Medicaid eligible children received a service paid for by the Medicaid Program.

The CHDP Health Assessment Guidelines for CHDP providers are under revision to include methods to provide family-centered and culturally competent care. The CHDP Health Assessment Guidelines Review subcommittee described major causes of childhood injury and provides updated anticipatory guidance for injury prevention in children and youth ages 0-21. Information and resources for anticipatory guidance are provided in the areas of SIDS, motor vehicle safety, non-motorized vehicle safety, water safety, poison control, and burns.

In 2012, CHDP Health Assessment Guidelines for CHDP providers included revised recommendations for quadrivalent HPV vaccine CHDP coding. The recommendation is for administration of a single supplement dose of PCV13 to children who have received a full series of PCV7 due to pneumococcus pneumonia which remains a leading cause of serious bacterial illness in children and adults; recommended ages for MCV4 (meningococcal conjugate vaccine) booster dose; CHDP Health Assessment Guidelines include revision for injury prevention and anticipatory guidance recommendations and legislation surrounding car seat safety for infants and children; and the revised CHDP facility review tool and medical record review tool which will be utilized by the local CHDP program staff to perform on-site review of an applicant or enrolled provider’s service site(s) to assure that a minimum standard is maintained in the delivery of the quality of care.

Health Systems Capacity Indicator 07b

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	49.4	50	47.6	47.6	
Numerator	413,704	440,212	423316		
Denominator	836,967	880,094	889036		
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied					
Is the Data Provisional or Final?			Final	Provisional	

Field Level Notes

Section Number: Form17_Health Systems Capacity Indicator #07B

Field Name: HSC07B

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator for 2011 is based on 2010. 2011 data will be available in June 2013.

Section Number: Form17_Health Systems Capacity Indicator #07B

Field Name: HSC07B

Row Name:

Column Name:

Year: 2011

Field Note:

This measure is the percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year. Source is the revised HC DFA-416 Form, element number 1 and 12a. Numerator is from the revised HCFA-416 Form element number 12a for FY 2011-12. Denominator is from the revised HCFA-416 Form element number 1 for FY 2011-12.

Historical Information:

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

Narrative:

Health Systems Capacity Indicator 07b (HSCI-7b) is the percent of EPSDT eligible children (CHDP in California) aged 6 through 9 years who received any dental services during the year. The goal of this indicator is to increase dental health services to Medi-Cal eligible children at an important stage of dental development.

The CHDP Gateway covers dental services for pre-enrolled children up to 60 days after a CHDP health assessment and has increased access to dental services. CHDP Gateway offers the opportunity to apply for permanent enrollment in Medi-Cal or HF which includes dental benefits.

A Power Point dental training has been developed and released on the State CHDP website for CHDP providers and local program staff which includes resources and oral health topics specific to screening and referring children to a dentist by age one. The main purpose of the training is to encourage appropriate dental referrals using a four category classification system. A condensed dental training has also been developed and will be placed on the CHDP website shortly. Fluoride varnish applications, 3 per year, became a benefit of the Medi-Cal program for children age 0 to 6. There will soon be a power point fluoride varnish training for CHDP providers to be placed on the CHDP website.

Brochures entitled, "Fluoride Varnish-- Helping Smiles Stay Strong" and "Every Child Needs a Dental Home" have been released to local CHDP programs and is available online. A resource guide which includes online links for brochures including most oral

health topics for children ages 0 to 5 and 6 through 20 has been developed and distributed to local programs

The Growing Up Healthy brochures with age specific dental information have been completed in 4 languages and are on the SCD and MCAH website. Another brochure, “Prevent Tooth Decay in Babies and Toddlers” has just been revised. As soon as this revised brochure can be translated into five other languages, the revised brochures will be placed on the CHDP and MCAH websites. Two resource guides have been developed and distributed to local programs. They include online links for brochures including most oral health topics for children ages birth through age 5, and ages 6 through 20.

The State Dental Hygienist Consultant in conjunction with the Oral Health Subcommittee of the CHDP Executive Committee continues dental updates to providers, local program staff, and families.

Health Systems Capacity Indicator 08

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	28.2	30.1	31.4	32.7	32.7
Numerator	25554	28,253	30123	32,788	32,788
Denominator	90464	93899	95788	100,271	100,271
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	Final

Field Level Notes

Section Number: Form17_Health Systems Capacity Indicator #08

Field Name: HSC08

Row Name:

Column Name:

Year: 2012

Field Note:

The numerator is the no. of disabled children under 16 years of age with SSI enrolled in CCS for fiscal year 2011-12.

(aid codes of 20 and 60). Numerator data source is CMS Net;

The denominator is the no. of children under 16 years of age receiving SSI in 2011. The denominator data source is from the publication: Social Security Administration Office of Policy, Children receiving SSI.

Section Number: Form17_Health Systems Capacity Indicator #08

Field Name: HSC08

Row Name:

Column Name:

Year: 2011

Field Note:

The numerator is the no. of disabled children under 16 years of age with SSI enrolled in CCS for FY 2010-11 (aid codes of 20 and 60). Numerator data source is CMS Net;

The denominator is the no. of children under 16 years of age receiving SSI in 2011. The denominator data source is from the publication: Social Security Administration Office of Policy, Children receiving SSI.

Health Systems Capacity Indicator 09a

The ability of the State to assure MCH Program access to policy and program relevant information

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

*Where:
1 = No, the MCH agency does not have this ability.
2 = Yes, the MCH agency sometimes has this ability, but not on a consistent basis.
3 = Yes, the MCH agency always has this ability.

FIELD LEVEL NOTES

Section Number: Form19_Indicator 09A

Field Name: BAN

Row Name: Annual linkage of birth certificates and newborn screening files

Column Name:

Year: 2014

Field Note:

Linked birth certificate and newborn screening files is only available to MCAH upon request.

Health Systems Capacity Indicator 09b

The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Products in the Past Month

DATA SOURCES	Does your State participate in the YRBS survey? (Enter 1-3)*	Does your MCH program have direct access to the State YRBS database for analysis? (Enter Y/N)
Youth Risk Behavior System (YRBS)	2	Yes
Other: California Student Survey	3	Yes
California Health Interview Survey	3	Yes
California Healthy Kids Survey	3	Yes
*Where: 1 = No. 2 = Yes, the State participates but the sample size is <u>not</u> large enough for valid statewide estimates for this age group. 3 = Yes, the State participates and the sample size is large enough for valid statewide estimates for this age group.		

FORM NOTES FOR FORM 19

None.

Field Level Notes

Section Number: Form19_Indicator 09B

Field Name: YRBSS_09B

Row Name: Youth Risk Behavior Survey (YRBS)

Column Name:

Year: 2014

Field Note:

The California Youth Risk Behavior Survey (YRBS) is funded by the U.S Centers for Disease Control and Prevention. The 2009 and 2011 survey failed to yield a response rate of at least 60%, precluding weighting of the data to make it representative of the student population. California is working closely with state, county, and local school health programs to improve the YRBS response rate. Surveys are conducted in schools using a sample of 9th through 12th graders. The YRBS was developed to monitor priority health risk behaviors that contribute the leading causes of mortality, morbidity and social problems among adolescents. The survey is part of a surveillance effort conducted by the California Department of Public Health, the California Department of Education and the Public Health Institute in cooperation with the Centers for Disease Control and Prevention. The biennial sample size for this survey is approximately 1,500 surveys.

Section Number: Form19_Indicator 09B

Field Name: Other1_09B

Row Name: Other

Column Name:

Year: 2014

Field Note:

The California Student Survey (CSS) utilizes data from a voluntary, representative, randomly-selected biennial sample of schools and classrooms (seventh, ninth graders, and 11th graders). The CSS collects information on adolescent alcohol and other drug use patterns, including data on tobacco use (smoking), marijuana, and inhalants, along with physical activity, nutrition and eating habits, depression, and external and internal resilience enhancing assets. The CSS allows for trend data analyses, and provides data on a range of health related behaviors comparable with the Youth Risk Behavior Survey.

The California Health Interview Survey (CHIS) is a telephone survey of adults, adolescents, and children from all parts of the state. The survey is conducted every two years. CHIS is the largest state health survey and one of the largest health surveys in the United States and is able to provide statewide and local level estimates on a number of health related issues, including adolescent tobacco use.

The California Healthy Kids Survey (CHKS) is a voluntary, representative, biennial sample of California students, grades 7, 9, 11, and enrolled in non-traditional schools (community day schools or continuation schools). CHKS is a comprehensive youth health risk and resilience survey that includes data on tobacco use, alcohol, and other drugs. An optional tobacco module is available for use by school districts, and contains additional items related to perceived social norms about tobacco. CHKS provides trend data and provides data on current tobacco use by grade, gender, race and county through an online query system.

IV. State Priorities

A. Background and Overview

California's Title V performance reporting will include a total of twenty five to twenty eight measures: eighteen national performance measures (NPM) mandated by HRSA and seven to ten additional measures chosen by the state. /2012/ Sensible performance measures help our partners and stakeholders understand what is important, establish expectations in measurable terms, collect data on progress, make decisions with the collected information and adjust course when necessary. //2012// The three SPM in this report include the following:

SPM 01: The percent of children birth to 21 years enrolled in the CCS program who have a designated medical home; /2013/ This was revised to: The percent of children birth to 21 years enrolled in the CCS program who have all their health care provided by and coordinated by one health care system.//2013//

SPM 02: The percent of primary care physicians, approved to participate in the CCS program, who are receiving authorizations for care; /2013/ This was inactivated and replaced by a newly created SPM 10.//2013//

SPM 03: The percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey;

The seven other state performance measures under consideration may include some of the measures reported in the 2006-2010 Five Year Needs Assessment. /2012/ The additional SPMs in this report include:

SPM 04: The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy

SPM 05: The percent of cesarean births among low risk women giving birth for the first time.

SPM 06: The percent of women of reproductive age who are obese.

SPM 07: The percent of women whose live birth occurred less than 24 months after a prior birth.

SPM 08: The percent of adolescents reporting a high level of school connectedness.

/2013/SPM 09: Low-income infant mortality rate.

SPM 10: The percent of CCS clients who have a designated primary care physician and/or a specialist physician who provides a medical home.//2013//

Careful consideration of incorporating the life course approach was used in selecting the MCAH-specific SPMs. Beyond measuring disease risk or conditions, these new SPMs include protective factors, cut across critical periods of development over the life course and may influence the capacity of the population to reach its full developmental potential. The detail sheets (Form 16) further emphasizes the influence of these SPMs on health pathways or trajectories, its impact on individual health within and across generations and its impact at specific sensitive periods of development.

Selection criteria for SPMs included availability of accurate data available, sufficient sample size, consistent data collection methodology over time, comparability to national data or benchmarks, , relevance to program planning and monitoring, and stakeholder buy-in. //2012// Data on performance measures are included in two parts of this report - on the data forms and in the narrative.

The three priorities currently identified targeting the CSCHN population were a result of the needs assessment conducted by CMS. The 2011-2015 CMS Five-year Needs Assessment process identified several priorities with the top three priorities included as part of this report. Following key informant interviews, focus group discussions, online-surveys, review of the 2005 CMS Needs Assessment priorities, consultation with CMS Branch state staff, and data analysis, 13 CMS priorities were identified and ranked. Stakeholders individually used the weighted criteria they had developed together and a tool provided by FHOP to rate each of the priority objectives. The individual rating scores were then aggregated to rank the priority objectives. The top 3 CMS priorities are listed as 1 to 3 below. **/2014/ Reference to Children's Medical Services (CMS) is being gradually phased out and replaced by Systems of Care Division (SCD).//2014//**

All ten of California's priorities have one or more related national or state performance measures. /2012/For NPMs, new SPMs and outcome measures that will be monitored for the 2011 to 2015 period, several meetings were held to discuss objective setting processes and methods. This included assessing program-related activities that impact each measure,

/2012/ In addition, the relationship between the seven MCAH priority needs with health systems capacity indicators and health status indicators were included as MCAH moves

toward incorporating the Social Determinants and Life Course approach to its health planning and decision framework incorporating knowledge of effective interventions, identifying time frames for objective setting and determining a value for each performance objective that is challenging yet realistic. MCAH conducted a literature search on target setting methods that have been used including the rationale for its use, the advantages and disadvantages for each method and what compromises should be made when there is no existing evidence, or if evidence is weak or its relevance is limited. After an extensive review of multiple target setting methods, MCAH identified a straightforward approach that would be transparent for partners. Following the lead set by Healthy People 2020 in establishing standardized 10% improvement objectives, MCAH established 5% improvement over the 2008-2009 aggregate rate as the standard for California Title V Objectives. To ensure appropriate objectives were set for Title V measures with rates that have fluctuated from year to year, a 10% improvement objective was selected if the measure met or exceeded the 5% improvement objective since 2000. Likewise, a 15% or a 20% improvement objective was selected for measures with fluctuating rates that exceeded the 10% or 15% improvement objectives since 2000. For those measures that demonstrate worsening trends, a 0% improvement objective was established (or maintenance of current rate). In this way, State and Local MCAH Programs and stakeholders have an easily identifiable and reasonably attainable objective to strive towards over the next five years for each measure. //2012//

B. State Priorities

The ten priorities for Title V activities in California and the associated performance measures and health indicators are:

>Priority 1: Modify the CCS program, with appropriate funding, to cover the whole child.

SPM 1 (new): The percent of children birth to 21 years enrolled in the CCS program who have all their health care provided by and coordinated by one health care system. /2013/ This was revised to: The percent of children birth to 21 years enrolled in the CCS program who have all their health care provided by and coordinated by one health care system.//2013//

SPM 3(new): The percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey.

NPM 4: CSHCN age 0 to 18 whose families have adequate private and/or public insurance.

NPM 5: CSHCN whose families report the community-based service systems are organized so they can use them easily.

NPM 6: Youth with special health care needs who received the services necessary to make transition to all aspects of adult life.

>Priority 2: Expand the number of qualified providers of all types in the CCS program.

SPM 2 (new): The percent of primary care physicians, approved to participate in the CCS program, who are receiving authorizations for care. /2013/ This was inactivated and

reply by SPM 10: The percent of CCS clients who have a designated primary care physician and/or a specialist physician who provides a medical home.//2013//

- NPM 3: CSHCN who receive coordinated, ongoing, comprehensive care within a medical home.
- NPM 4: CSHCN age 0 to 18 whose families have adequate private and/or public insurance.
- NPM 5: CSHCN whose families report the community-based service systems are organized so they can use them easily.
- NPM 6: Youth with special health care needs who received the services necessary to make transition to all aspects of adult life.

>Priority 3: CCS will work with appropriate partners to define and create and implement standards for Medical Homes for CCS children.

SPM 3 (new): The percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey.

/2014/ SPM 10 The percent of CCS clients who have a designated primary care physician and/or a specialist physician who provides a medical home.//2014//

- NPM 2: CSHCN whose family's partner in decision making at all levels and are satisfied with the services they receive.
- NPM 3: CSHCN who receive coordinated, ongoing, comprehensive care within a medical home.

>Priority 4: Improve maternal health by optimizing the health of girls and women across the life course.

NPM 15: Percentage of women who smoke in the last three months of pregnancy.

SPM 3 (old): The percent of women, aged 18-44 years, who reported 14 or more "not good" mental health days in the past 30 days (frequent mental distress").

SPM 4 (old): The percent of women who reported drinking any alcohol in the first or last trimester of pregnancy.

SPM 8 (old): The percent of births resulting from an unintended pregnancy.

SPM 10 (old): The percent of women, aged 18 years or older, reporting intimate partner physical, sexual or psychological abuse in the past 12 months.

/2012/ SPM 4 (new): The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.

SPM 6 (new): The percent of women of reproductive age who are obese.

SPM 7 (new): The percent of women whose live birth occurred less than 24 months after a prior birth.

SOM 1 (new): The pregnancy-related mortality rate per 100,000 live births.

HSI 5a: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia

HSI 5b: The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

HSI 9a (2): Percent in household headed by a single parent.

HSI 9a (3): Percent in TANF (Grant) families. //2012//

>Priority 5: Promote healthy nutrition and physical activity among MCAH populations throughout the lifespan beginning with exclusive breastfeeding of infants to six months of age.

NPM 11: The percent of mothers who breastfeed their infants at 6 months of age.

NPM 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

/2012/SPM 6 (new): The percent of women of reproductive age who are obese. //2012//

>Priority 6: Reduce maternal morbidity and mortality and the increasing disparity in maternal health outcomes.

NPM 15: Percentage of women who smoke in the last three months of pregnancy.

NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates

NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

SPM 10 (old): The percent of women, aged 18 years or older, reporting intimate partner physical, sexual or psychological abuse in the past 12 months.

NOM1: The maternal mortality rate per 100,000 live births.

/2012/ SPM 4 (new): The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.

SPM 5 (new): The percent of cesarean births among low risk women giving birth for the first time.

SPM 6 (new): The percent of women of reproductive age who are obese.

SPM 7 (new): The percent of women whose live birth occurred less than 24 months after a prior birth.

SOM 1: The pregnancy-related mortality rate per 100,000 live births.

HSCI 4: The percent of women (15 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.

HSCI 5c: Percent of women entering care in the first trimester: Payment source from birth certificate (Medicaid and non-Medicaid comparison).

HSCI 5d: Percent of women with adequate (observed to expected prenatal visits is greater or equal to 80% (Kotelchuck Index) prenatal care (Medicaid and non-Medicaid comparison).

HSCI 6c: The percent of poverty for eligibility in the State's Medicaid and SCHIP programs for pregnant women (Medicaid and SCHIP eligibility levels).

//2012//

>Priority 7: Reduce infant mortality and address disparities by promoting preconception health and health care and by preventing causes such as birth defects, low birth weight/prematurity, SIDS, and maternal complications in pregnancy.

NPM 15: Percentage of women who smoke in the last three months of pregnancy.

- NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
- NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
- SPM 4 (old): The percent of women who reported drinking any alcohol in the first or last trimester of pregnancy.
- SPM 6 (old): 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
- /2012/ SPM 4 (new): The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.
- SPM 6 (new): The percent of women of reproductive age who are obese.
- SPM 7 (new): The percent of women whose live birth occurred less than 24 months after a prior birth.
- NOM 1: The infant mortality rate per 1,000 live births.
- NOM 2: The ratio of the black infant mortality rate to the white infant mortality rate.
- NOM 3: The neonatal mortality rate per 1,000 live births.
- NOM 4: The post-neonatal mortality rate per 1,000 live births.
- NOM 5: The perinatal mortality rate.
- HSCI 4: The percent of women (15 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.
- HSCI 5a: Percent at low birth weight (<2,500 grams): Payment source from birth certificate (Medicaid and non-Medicaid comparison).
- HSCI 5b: Infant deaths per 1,000 live births: matching data files (Medicaid and non-Medicaid comparison).
- HSCI 5c: Percent of women entering care in the first trimester: Payment source from birth certificate (Medicaid and non-Medicaid comparison).
- HSCI 5d: Percent of women with adequate (observed to expected prenatal visits is greater or equal to 80% (Kotelchuck Index) prenatal care (Medicaid and non-Medicaid comparison).
- HSCI 6a: The percent of poverty for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1) (Medicaid and SCHIP eligibility levels).
- HSI 1a: The percent of live births weighing less than 2,500 grams.
- HSI 1b: The percent of live singleton births weighing less than 2,500 grams.
- HSI 2a: The percent of live births weighing less than 1,500 grams.
- HSI 2b: The percent of live singleton births weighing less than 1,500 grams.
- //2012//
- /2013/ SPM 9 (new): Low income infant mortality rate.//2013//

>Priority 8: Support the physical, socio-emotional, and cognitive development of children, including the prevention of injuries, through the implementation of prevention, early identification and intervention strategies.

- NPM 1: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored NBS programs. (?)
- NPM 2: The percent of children with special health care needs age 0 to 18 years whose family's partner in decision making at all levels and are satisfied with the services they receive.
- NPM 3: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.
- NPM 4: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.
- NPM 5: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.
- NPM 6: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
- NPM 7: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
- NPM 9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
- NPM 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.
- NPM 12: Percentage of newborns who have been screened for hearing before hospital discharge.
- NPM 13: Percent of children without health insurance.
- NPM 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.
- /2012/ NOM 6: The child death rate per 100,000 children aged 1-14.
- HSCI 1: The rate per 10,000 for asthma hospitalizations among children less than five years old.
- HSCI 2: The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.
- HSCI 3: The percent of Children's Health Insurance Program (CHIP) enrollees' age is less than one year during the reporting year who received at least on periodic screen.
- HSCI 6a: The percent of poverty for eligibility in the State's Medicaid and CHIP programs for infants (0 to 1) (Medicaid and CHIP eligibility levels).
- HSCI 6b: The percent of poverty for eligibility in the State's Medicaid CHIP programs for children (age ranges: 1 through 5 and 6 to 19) (Medicaid and CHIP eligibility levels).
- HSCI 7a: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.
- HSCI 7b: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental service during the year.

- HSI 3a: The death rate per 100,000 due to unintentional injuries among children aged 14 years & younger.
- HSI 3b: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.
- HSI 4a: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.
- HSI 4b: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.
- HSI 9a(2): Percent in household headed by a single parent.
- HSI 9a(3): Percent in TANF (Grant) families //2012//
- >Priority 9: Promote positive youth development strategies to support the physical, mental, sexual and reproductive health of adolescents.
- NPM 8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
- NPM 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19.
- SPM 5 (old): The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries.
- SPM 9 (old): The percent of 9th grade students who are not within the Healthy Fitness Zone for Body Composition.
- //2012/ SPM 7 (new): The percent of women whose live birth occurred less than 24 months after a prior birth.
- SPM 8 (new): The percent of women whose live birth occurred less than 24 months after a prior birth.
- HSCI 6b: The percent of poverty for eligibility in the State's Medicaid SCHIP programs for children (age ranges: 1 through 5 and 6 to 19) (Medicaid and SCHIP eligibility levels).
- HSCI 9b: Data Capacity - Adolescent Tobacco Use (data capacity information).
- HSI 3c: The death rate per 100,000 from unintentional violence due to motor vehicle crashes among youth aged 15 through 24 years.
- HSI 4c: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.
- HSI 5a: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.
- HSI 9a(9): Rate per 100,000 juvenile crime arrest
- HSI 9a(10): Percent of high school drop-outs grades 9 through 12. //2012//
- >Priority 10: Link the MCAH population to needed medical, mental, social, dental, and community services to promote equity in access to quality services.
- NPM 1: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored NBS programs.
- NPM 2: The percent of children with special health care needs age 0 to 18 years whose families' partner in decision making at all levels and are satisfied with the services they receive.
- NPM 3: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.

- NPM 4: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.
- NPM 5: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.
- NPM 6: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
- NPM 7: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
- NPM 9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
- NPM 12: Percentage of newborns who have been screened for hearing before hospital discharge.
- NPM 13: Percent of children without health insurance.
- NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
- NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
- //2012/ SPM 4 (new): The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.
- SPM 6 (new): The percent of women of reproductive age who are obese.
- SPM 7 (new): The percent of women whose live birth occurred less than 24 months after a prior birth.
- HSCI 2: The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.
- HSCI 3: The percent of Children's Health Insurance Program (CHIP) enrollees' age is less than one year during the reporting year who received at least one periodic screen.
- HSCI 4: The percent of women (15 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.
- HSCI 5: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State (a) Percent of low birth weight (<2,500 grams), (c) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester and (d) Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])
- HSCI 6: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women.
- HSCI7a: The percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program
- HSCI 7b: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year. //2012//

C. National Performance Measures

Performance Measure 01

The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

Tracking Performance Measures

[Sees 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100	100	100	100	100
Numerator	607	574	561	663	
Denominator	607	574	561	663	
Data Source	Genetic Disease Screening Program, 2008	Genetic Disease Screening Program, 2009	Genetic Disease Screening Program, 2010	Genetic Disease Screening Program, 2011	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?	Final	Final	Final	Final	Final
Year	2013	2014	2015	2016	2017
Annual Performance Objective	100	100	100	100	100

Field Level Notes

1. Section Number: Form11_Performance Measure #1

Field Name: PM01

Row Name:

Column Name:

Year: 2011

Field Note:

A manual indicator is reported for 2011 based on 2010

2. Section Number: Form11_Performance Measure #1

Field Name: PM01

Row Name:

Column Name:

Year: 2010

Field Note:

State of California, Department of Public Health, Genetic Disease Screening Program, 2010 NBS Records.

NBS includes screening for the following conditions: Phenylketonuria (PKU), congenital hypothyroidism, galactosemia, sickle cell disease (Hb S/S, Hb S/+Thalassemia, and Hb S/B⁰Thalassemia only), congenital adrenal hyperplasia, over 40 non-PKU inborn errors of metabolism tested by tandem mass spectrometry, cystic fibrosis, biotinidase deficiency, , and pilot testing for severe combined immunodeficiency disorders (SCID). In 2010, one confirmed case of sickle cell disease died before completion of confirmatory testing.

The number of affected newborns receiving timely follow-up is the number of cases summed over all screened disorders. It is extremely rare for a newborn to be a case for more than one screened disorder.

a. Last Year's Accomplishments

In 2011, GDSP detected and confirmed over 850 genetic and congenital abnormalities as a result of its NBS Program. California has effectively achieved universal coverage for NBS for genetic, metabolic and hematological disorders, with nearly 100 percent of newborns screened for all conditions for which screening was mandated.

All the conditions for which the NBS Program screens, including over 40 metabolic disorders, endocrine disorders, and hemoglobinopathies, are CCS-eligible. GDSP and SCD have been collaborating to ensure that infants identified with abnormal metabolic, endocrine, sickle cell, cystic fibrosis, or severe combined immunodeficiency disorder (SCID) screening results from the current and expanded testing receive prompt diagnostic evaluations at one of the CCS-approved Special Care Centers (SCC) in the state. The county CCS programs expedite GDSP referrals, so that infants with suspected illness can be identified and treated promptly in order to maximize prevention of premature death or serious disabilities. The guidelines for diagnostic follow-up and treatment of the over 40 additional metabolic disorders and congenital adrenal hyperplasia are in place.

The pilot study for SCID began in August 2010 and has proved that SCID is far more common than first thought. Prior to the inception of SCID screening in California, the incidence of classical SCID was thought to be 1 in 100,000. Screening nearly 1.2 million newborns (through December 2012), has identified 20 babies with SCID requiring bone marrow transplants (1:60,000) and another 48 babies with immune disorders that required monitoring and/or treatment. The total incidence of SCID and other significant immune disorders is 1 in 17,500.

Pregnant women in California can participate in the California Prenatal Screening Program in several different ways:

- Patients who only submit a blood specimen in the 2nd trimester (15 to 20 weeks) get Quad Marker Screening [risk assessment made based on 4 analytes: AFP, human chorionic gonadotropin (hCG), uE3, and Inhibin]
- Patients who submit a blood specimen in the 1st trimester (10 to 13 weeks 6 days) and another blood specimen in the 2nd trimester (15 to 20 weeks) get Serum Integrated Screening: [risk assessment made based on Pregnancy Associated Plasma Protein and hCG in the first trimester, plus the Quad Marker Screening analytes in the second trimester]
- Patients who submit both 1st and 2nd trimester specimens as well as have a Nuchal Translucency (NT) Ultrasound measurement taken get Sequential Integrated Screening [risk assessment made based on all analytes from the Serum Integrated Screening plus the NT measurement].

Sequential Integrated Screening identifies 90% of fetuses with Down syndrome. Participation in the California Prenatal Screening Program includes diagnostic follow-up services for those with risks assessments above the cut-off.

Table 4a, National Performance Measures Summary Sheet Pyramid Level of Service

Activities	DHC	ES	PBS	IB
1. GDSP screens for genetic and congenital disorders, including testing, follow-up and early diagnosis of disorders to prevent adverse outcomes or minimize clinical effects.			X	
2. GDSP ensures quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance with them.				X
3. GDSP fosters informed participation in its programs through a combination of patient, professional, and public education, and accurate and up-to-date information and counseling.			X	
4. GDSP and SCD collaborate to ensure that infants identified with abnormal screening results receive prompt diagnostic evaluations at one of the CCS-approved Metabolic Special Care Centers (SCC) in the state.		X		

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

b. Current Activities

SCD and GDSP programs work together to address issues as they arise and update policies and reporting forms as needed in an effort to ensure that babies who screen positive receive expedited care at a CCS approved Special Care Center. Although CCS makes a special effort to expedite these cases some slight delays may occur due to the CCS staffing cuts.

CCS provides services for conditions identified on NBS tests, develops standards, and approves Metabolic, Endocrine, Sickle Cell, Cystic Fibrosis, and SCID SCCs for treatment.

c. Plan for the Coming Year

GDSP will continue to screen for genetic and congenital disorders, including testing, follow-up and early diagnosis, in order to prevent adverse outcomes and minimize clinical effects. GDSP ensures the quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance with them. GDSP fosters informed participation in its programs through a combination of patient, professional, and public education, as well as accurate, up-to-date information and counseling (e.g., Hemoglobin Trait Carrier Follow-up Program, Maternal PKU Program, Gene HELP Resource Center and the Sickle cell Counselor Training and Certification Program).

GDSP will continue to work collaboratively with state and local agencies, including SCD, CCS-approved SCCs, GDSP NBS Contract Liaisons and other NBS Program staff, local County CCS programs, and Area Service Center Project Directors and Medical Consultants to ensure that newborns identified with positive screening reports are quickly evaluated, diagnosed, and appropriately treated, and that families are informed and supported throughout the process.

GDSP will continue to administer and evaluate the Prenatal Screening Program. Non-Invasive Prenatal Testing (NIPT) will be added to the list of covered follow-up services for those with elevated risk for having a baby with Down syndrome. NIPT would be offered as a choice for women alternative to amniocentesis and chorionic villus sampling (CVS).

SCD and GDSP will continue to work together to address issues as they arise and update literature as needed. Despite the decreased staff, CCS will attempt to expedite authorizations appropriate for diagnosis and treatment of babies with positive results from newborn screening NBS.

Comment [LR1]: Placeholder for NPM 2 to be submitted by SCD

Performance Measure 03

The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	51	42.5	43	44	44
Annual Indicator	42.2	42.2	42.2	38.3	38.3
Numerator					
Denominator					
Data Source	National Survey of CSHCN				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?	Final	Final	Final	Final	Final
Year	2013	2014	2015	2016	2017
Annual Performance Objective	44	44	44	44	44

Section Number: Form11_Performance Measure #3

Field Name: PM03

Row Name:

Column Name:

Year: 2012

Field Note:

This measure is the percent of CSHCN in the State age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2009-2010.
<http://childhealthdata.org/browse/snapshots/cshcn-profiles?rpt=9&geo=6>

Section Number: Form11_Performance Measure #3

Field Name: PM03

Row Name:

Column Name:

Year: 2011

Field Note:

This measure is the percent of CSHCN in the State age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2009-2010.

Section Number: Form11_Performance Measure #3

Field Name: PM03

Row Name:

Column Name:

Year: 2010

Field Note:

This measure is the percent of CSHCN in the State age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005 - 06.

a. Last Year's Accomplishments

NPM 03 is from the National CSHCN Survey. Based on the 2009-2010 survey, 38.3 percent of the CSHCN in California receive coordinated, ongoing, comprehensive care within a medical home. The percentage in this survey is of all CSHCN and is not restricted to CCS children. The survey estimate of 1 million CSHCN in California would indicate that only 25% of CSHCN have been CCS clients. While many CSHCN are not eligible for CCS services, they do benefit from the standards and infrastructure developed by the CCS program.

**Table 4a, National Performance Measures Summary Sheet
Pyramid Activities Level of Service**

Activities	DHC	ES	PBS	IB
1. County CCS programs assess CCS eligible children to determine if they have a documented medical home and explore improvement strategies.				X
2. The "Hospital Discharge Questionnaire" developed by FVCA and the PHL Network, is provided to families to improve the coordination of care for their child when they come home from the hospital.				X
3. Child Health Notebooks to help organize healthcare information and medical records are distributed (hard copy and electronically) in the 26 CRISS counties.				X
4. FVCA provides trainings for families and professionals on the Medical Home Initiative and distributes binders to help families organize healthcare information and medical records.				X
5. FVCA Agencies provide a "resource referral pads" to physicians that list local resources for families.				X

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

b. Current Activities

- 1) CRISS encompasses 26 counties in Northern and Central California and continues to promote medical homes and family-centered care.
- 2) CRISS continues to expand and improve the Alameda County Medical Home Project. The project targets clinics in Alameda with high numbers of CCS children. CRISS continues to recruit new sites, focusing on CHDP sites with high volumes of CCS children.
- 3) CRISS, through a grant from the San Francisco Foundation, extended their medical home activities from one CRISS county (Alameda) into three CRISS counties: Contra Costa, San Francisco, and San Mateo.
- 4) CRISS works to implement regional and local strategies to promote medical homes for CSHCN, including distribution of updated hard copy medical home materials customized for each county in the CRISS region. Electronic medical home materials, including Child Health Notebooks, are available on the CRISS website.
- 5) CRISS participates with the State in development of state policy on medical homes for CCS children, as opportunity arise.
- 6) FVCA continues to provide information and trainings to families and professionals on issues relating to medical homes, including organizing healthcare information and navigating health systems
- 7) The Sonoma County FQHC continues activities to promote medical homes for children with epilepsy.

c. Plan for the Coming Year

Plans for the coming year include:

1. CRISS will continue to share Alameda County Medical Home Project activities and resources with 3 other counties, San Mateo, Contra Costa, and San Francisco.
2. CRISS will continue to provide technical assistance to sustain medical home approaches for CSHCN .
3. FVCA will continue to provide linkages to healthcare information to families and providers statewide through the FVCA listserv and website.
4. State CCS will work with counties to develop new medical homes performance measures for CCS children. The new performance measure will include a current definition of medical homes for the CCS/CSHCN client derived from the AAP, HRSA, and the National Center for Medical Home Implementation evolving standards.

5. State CCS will work with counties and stakeholders, such as CRISS and FVCA, to develop a program policy specific to medical homes for CCS clients and will monitor the number of CCS clients who have a medical home identified in the database.
6. For counties not in a 1115 Waiver Pilot Project, CCS will continue to monitor the number of CCS clients with a designated Medical Home.
7. CCS 1115 Waiver Pilot Projects will incorporate Medical Home into the comprehensive health care delivery system and will be one of the major areas of performance evaluation for the project.

Performance Measure 04

The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.

(CSHCN Survey)

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	65.5	60	60.3	61	61
Annual Indicator	59.6	59.6	59.6	59.1	59.1
Numerator					
Denominator					
Data Source	National Survey of CSHCN				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?	Final	Final	Final	Final	Final
Year	2013	2014	2015	2016	2017
Annual Performance Objective	61	61	61	61	61

Field Level Notes:

Section Number: Form11_Performance Measure #4

Field Name: PM04

Row Name:

Column Name:

Year: 2012

Field Note:

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2009-2010.
<http://lpfch-cshcn.org/data/adequacy-of-insurance-coverage-for-children-with-special-health-care-needs/>

Section Number: Form11_Performance Measure #4

Field Name: PM04

Row Name:

Column Name:

Year: 2011

Field Note:

This measure is the percent of CSHCN age 0 to 18 years whose families have adequate private and/or public insurance to pay for the services they need.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2009-2010.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2009-10.

a. Last Year's Accomplishments

NPM 04 is from the CSHCN Survey and is related to population-based services. For the 2009-2010 survey, 59.1 percent of families of CSHCN age 0 to 18 years in California had adequate private and/or public insurance to pay for the services they needed. The most recent National Survey of CSHCN (2009-2010), conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics, identified 10.6 percent of California's children have special health care needs and 96.5 percent of all CSHCN in California, as well as in other U.S. states, were insured.

**Table 4a, National Performance Measures Summary Sheet
Pyramid Activities Level of Service**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Systems of Care Division continues to determine whether CCS eligible children have access to private health coverage utilizing DHCS' Other Health Coverage (OHC) file.		X		
2. CHDP programs and providers are identifying and "deeming" certain infants less than one year of age as eligible for ongoing, full scope, no cost Medi-Cal at the time of a CHDP Health Assessment.		X		
3. Systems of Care Division continues to work with HF and the AIM program to facilitate enrollment of eligible infants into HF and those with CCS eligible conditions into the CCS program.		X		
4. Systems of Care Division will continue to implement the CHDP Gateway and identify CCS-eligible children through the Gateway process.		X		

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

b. Current Activities

- 1) Systems of Care Division continues to collaborate with various stakeholders in helping to ensure that families of CSHCN continue to receive necessary services.
- 2)The CHDP Gateway pre-enrollment process serves as a means of assisting Medi-Cal eligible children and youth to access periodic preventive health assessments and SCD continues to support this process.

c. Plans for the Coming Year

- 1) Systems of Care Division (SCD) will continue collaborative efforts with various stakeholders to identify and provide necessary services for CSHCN.
- 2) The CHDP Gateway pre-enrollment process will continue to serve as a means of assisting Medi-Cal eligible children and youth to access periodic preventive health assessments and the SCD will continue to support this process.
- 3) SCD will continue to review the impact that Health Care Reform may have on families of CSHCN that are currently being served by CCS, AIM, HF and Medi-Cal.
- 4) As resources become available, SCD will continue to review initiatives that have the goal of promoting insurance coverage for children.
- 5) Through the 1115 Waiver's CCS pilot projects, infants, children, and youth with special health care needs will receive comprehensive care instead of care being fragmented.

Performance Measure 05

Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
2Annual Performance Objective	85.5	86	86.5	87	87
Annual Indicator	85.3	85.3	85.3	64.8	64.8
Numerator					
Denominator					
Data Source	National Survey of CSHCN				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?	Final	Final	Final	Final	Final
Year	2013	2014	2015	2016	2017
Annual Performance Objective	87	87	87	87	87

Section Number: Form11_Performance Measure #5

Field Name: PM05

Row Name:

Column Name:

Year: 2012

Field Note:

This measure is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily. Measure in 09-10 survey:: who can easily access community based services. Because of the change wording from the previous years' survey, this number is not comparable to the previous years' data reported.

Section Number: Form11_Performance Measure #5

Field Name: PM05

Row Name:

Column Name:

Year: 2012

Field Note:

This measure is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily. Measure in 09-10 survey:: who can easily access community based services. Because of the change wording from the previous years' survey, this number is not comparable to the previous years' data reported.

Section Number: Form11_Performance Measure #5

Field Name: PM05

Row Name:

Column Name:

Year: 2011

Field Note:

This measure is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily. Measure in 09-10 survey:: who can easily access community based services.

Because of the change wording from the previous years' survey, this number is not comparable to the previous years' data reported.

Section Number: Form11_Performance Measure #5

Field Name: PM05

Row Name:

Column Name:

Year: 2010

Field Note:

This measure is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Source of data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

a. Last Year's Accomplishments

NPM 05 is a National CSHCN Survey measure and is the percent of CSHCN age 0 to 18 years who can easily access community based services. For California in 2009-2010, the result was 64.8 percent.

The most recent National Survey of CSHCN \), conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics, identified approximately 750 parents of CSHCN in each state.

FVCA Council Agencies continued to work with their local CCS agency to provide trainings to CCS employees, and connect families to Family Resource Centers (FRC) for community resources, support and information.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CRISS Medical Eligibility Work Group meets quarterly with CCS medical consultants, hospital and pediatric representatives, to improve consistency in inter-county interpretation of CCS law, regulation.				X
2. CHDP, HCPCFC, and CCS programs report on a performance measure evaluating effective care coordination.				X
3. LAPSNC focuses on increasing parent involvement by inviting representatives from the Family Resources Centers (FRC)				X

to meetings, and joining committees.				
4. FVCA Council Agencies work with their local CCS agency to provide trainings to CCS employees, and connect families to FRC for community resources, support and information.				X
5. The FCC Work Group meets bimonthly to review county FCC activities, share resources, and plan conferences, trainings, and activities.				X
6. SCD and Medi-Cal collaborate on the implementation of a pediatric Palliative Care program.				X

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

b. Current Activities

Current activities include:

- 1) Intercounty transfer policy was developed with stakeholder input and released to increase consistency of policies across counties.
- 2) CRISS Medical Eligibility Work Group (CCS medical consultants, hospital and pediatric Representatives) meets quarterly to improve consistency in inter-county interpretation of CCS law, regulation and policy regarding medical eligibility and benefits in the now 25-county CRISS region. Statewide medical consultant group was established and meets (frequency?). Biannually a Southern CA medical consultant comes to the CRISS meeting, and a CRISS consultant attends the Southern California meeting.
- 3) CHDP and foster care (HCPCFC) programs report on a performance measure evaluating effective care coordination.
- 4) LAPSNC works on increasing parent involvement by inviting representatives from the FRC to meetings, and supporting a CCS Workgroup that meets bimonthly and seeks parent engagement in CCS.
- 5) FVCA collaborates with DHCS on an ongoing basis and its member agencies work with their local CCS agencies to provide trainings to CCS employees, and connect families to FRCs for community resources, parent-to-parent support and information.
- 6) The FCC Work Group meets bimonthly to review county FCC activities, share resources, and plan conferences, trainings, and activities.

c. Plan for the Coming Year

Plans for the coming year include:

- 1) CRISS Medical Eligibility Work Group (CCS medical consultants, hospital and pediatric Representatives) will continue to meet quarterly to improve consistency in inter-

county interpretation of CCS law, regulation and policy regarding medical eligibility and benefits in the now 25-county CRISS region.

2) CHDP, HCPCFC, and CCS programs will continue to report on a performance measure evaluating effective care coordination.

3) LAPSNC will continue to focus on increasing parent involvement by inviting representatives from FRC to meetings, and joining committees and by supporting the CCS workgroup.

4) FVCA will continue to collaborate with DHCS on an ongoing basis and FVCA's member agencies will work with their local CCS agencies to provide trainings to CCS employees, and connect families to FRCs for community resources, parent-to-parent support and information.

5) The FCC Work Group will continue to meet 4 or 5 times per year to review county FCC activities, share resources, and plan conferences, trainings, and activities. The group is planning the 2011 annual FCC conference focusing on best practices.

Performance Measure 06

The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

Tracking Performance Measures

[Sees 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	37.5	37.5	38	39	39
Annual Indicator	37.1	37.1	37.1	37.4	37.4
Numerator					
Denominator					
Data Source	National Survey of CSHCN				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?	Final	Final	Final	Final	Final
Year	2013	2014	2015	2016	2017
Annual Performance Objective	39	39	39	39	39

Section Number: Performance Measure #6

Field Name: PM06

Row Name:

Column Name:

Year: 2012

Field Note:

This measure is the percent of youth with special health care needs in California who receive the services necessary to make transitions to all aspects of adult life.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2009-2010.

Section Number: Performance Measure #6

Field Name: PM06

Row Name:

Column Name:

Year: 2010

Field Note:

This measure is the percent of youth with special health care needs in California who receive the services necessary to make transitions to all aspects of adult life.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

a. Last Year's Accomplishments

NPM 06 is a National CSHCN Survey measure and is the percentage of youth who received the services necessary to make transitions to all aspects of adult life. For California in 2009-2010, the result was 37.4 percent. This percentage in this survey is of all CSHCN and not restricted to CCS children. The survey estimate of 1 million CSHCN in California would indicate that only 25% of CSHCN have been CCS clients. While many CSHCN are not eligible for CCS services – they do benefit from the standards and infrastructure developed by the CCS Program. The survey is also not generalizable to CCS as children with educational needs, asthma, and ADHD may not reflect CCS.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Counties continue to be involved in the implementation and evaluation of transition strategies.				X
2. CCS staff continue to instruct CCS-approved SCCs and those newly applying for approval on the importance and methods of integrating transition planning into patient care beginning at age 14 years.				X
3. SCD staff continue to meet quarterly with FVCA council members and PHL to develop strategies to improve transition for CSHCN to adult health care providers.				X

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

b. Current Activities

- 1) Effective transition planning is occurring in several County CCS programs: Alameda, Los Angeles, San Diego, and Sonoma.

- 2) The California Health Incentives Improvement Project (CHIIP) no longer has the Youth Transition Advisory Committee in the capacity of previous years. The Medicaid Infrastructure Grant (MIG) funding that supported the committee ended December 31, 2012.

- 3) The "Transition Toolkit, funded by the MIG and developed by CHIIP, targets youth with disabilities who are transitioning to adulthood. Topics include: transition, healthcare, employment, education, social/recreation, financial, and independent living.

- 4) CRISS continues to promote family-centered care in CRISS counties, including transition planning efforts.

- 5) FVCA supports a youth council that provides input to CCS on transition issues.

6) CCS recommend counties beginning long-term healthcare transition planning for clients' age 14 years and older and collaborates with counties, CRISS, and FVCA on transition issues for CSHCN.

7) State CCS identified 38,963 clients who turned 20 years old in 2012. Of this number, 1,880 clients had a case note identified for transition planning.

8) State CCS staff are reviewing current CCS program transition procedures for CCS clients.

c. Plans for the Coming Year

1) CHIIP will continue to seek additional funding and/or other groups to take the lead for the Youth Transition Advisory Committee.

2) CHIIP will continue disability youth transition activities as identified on their website www.chiip.org

3) CHIIP's "Transition Toolkit" will remain available at www.tknlyouth.info .

4) CRISS will continue to promote family-centered care in CRISS counties, including transition planning efforts.

5) FVCA will continue to support, as funding allows, a youth council that provides input to CCS on transition issues.

6) CCS will continue collaboration with counties, CRISS, and FVCA on transition issues for CSHCN.

7) CCS will train county staff on appropriate case record documentation regarding transition planning activities in order to capture all transition activities implemented and will monitor the number of CCS clients who have transition planning activities identified in the database.

8) State CCS will work with county programs, such as Alameda, Los Angeles, San Diego, and Sonoma, who have high percentage of staff compliance in transition planning activities to share their transition successes and ideas with other CCS counties via committees, conferences and/or webinars.

9) State CCS will work with counties to develop new transition planning performance measures for CCS children. The new performance measures will align with HRSA's guidelines for family-centered transition planning services.

Performance Measure 07

Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	78.9	79.4	79.9	82.1	82.1
Annual Indicator	80.6	75.8	76.5	81.7	81.7
Numerator	433234	413608	423707	404197	
Denominator	537511	545,657	553866	494733	
Data Source	National Immunization Survey, 2008	National Immunization Survey, 2009	National Immunization Survey, 2010	National Immunization Survey, 2011	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	Provisional
Year	2013	2014	2015	2016	2017
Annual Performance Objective	82.1	82.1	82.1	82.1	82.1

Field Level Notes

Section Number: Form11_Performance Measure #7

Field Name: PM07

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form11_Performance Measure #7

Field Name: PM07

Row Name:**Column Name:****Year:** 2011**Field Note:**

Source of percent immunized: Estimated Vaccination Coverage with 4:3:1:3:3 Among Children 19-35 Months of Age by Race/Ethnicity[‡] and by State and Local Area -- US, National Immunization Survey, Q1/2011-Q4/2011. Data requested from CDC.

Denominator: The number of two-year olds in the given year is from the State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age and Gender, 2010–2060. Sacramento, CA, January 2013. Numerators are estimates derived by multiplying the percent of immunized children by the denominator.

The 4:3:1:3:3 series coverage is based on the original definition for this series. CDC made this series coverage unavailable starting with the 2010 survey results; it is not recommended for comparison to years prior to 2009 because of the changes made in the way the Haemophilus influenzae type b (Hib) vaccine is now measured. Coverage estimates are based on 4 or more doses of DTaP, 3 or more doses of poliovirus vaccine, 1 or more doses of any MMR vaccine, 3 or more doses of Hib vaccine, and 3 or more doses of hepatitis B vaccine.

a. Last Year's Accomplishments

In 2011, the immunization rate for children age 19-35 months was 81.7 percent, a 7% increase from the 2010 immunization rate; due to methodological changes in data collection, it cannot be compared to rates prior to 2010.

MCAH and SCD advocated for families to enroll in Medi-Cal or HF. LHJs, including AFLP and BIH, continued to assess the immunization status of adolescent and women clients and their children on a periodic schedule, and promoted the importance of maintaining up-to-date immunizations by assisting program clients to access ongoing preventive care.

In 2010, California saw a pertussis outbreak kill ten children and affect 8,383 others — the largest epidemic in 63 years. In the same year, California passed Assembly Bill 354 to make a pertussis booster vaccination mandatory for 7th to 12th graders in the 2011 school year. The legislation had been stalled for several years amid concerns that California would have to pay hundreds of thousands of dollars for vaccinations for children on Medi-Cal. Studies show that undiagnosed family members are most likely to infect infants with whooping cough and teens that have not been immunized have been a factor in the spread of the disease. Those most vulnerable to whooping cough are infants too young to be immunized. In 2011, there were no recorded deaths attributed to pertussis.

MCAH worked with the IZB in its roll-out of the new adolescent immunizations. Many MCAH LHJs conducted outreach at health fairs and other venues to provide education and resources for childhood immunizations and health insurance. Programs such as CHVP, AFLP and BIH discuss and encourage clients to keep immunizations up-to-date. With the late start of the flu season (Winter 2012) and widespread geographic distribution, CDPH recommended influenza vaccination for everyone except for those with contraindications.

Many local MCAH programs focused activities on immunizations and participated on

Immunization Collaboratives and coalitions to increase access to immunizations through health fairs, seasonal flu clinics and public health immunization clinics.

The Perinatal Hepatitis B program was able to enhance the capacity of providers to integrate Hepatitis B Vaccine (HBV) testing, counseling and informed consent into their prenatal care services and in labor and delivery.

Alameda County continued to screen clients for immunization assistance, increase the number of Medi-Cal provider participation in California Immunization Registry (CAIR), and provide schools with training about immunization laws; it also coordinated community education and outreach to promote “Flu for Everyone” and “Toddler Immunization Month” campaigns. Shasta County had an education campaign targeted at worried parents by creating shastashots.com, a website that provides facts on vaccines and an “ask the nurse” email link. Ventura County has organized vaccination clinics at area parks and schools, and offered a drive-through flu shot station.

SCD and IZB encouraged all California VFC providers to attend the CDC’s 1st Online (‘Virtual’) National Immunization Conference held last March 2012.

**Table 4a, National Performance Measures Summary Sheet
Pyramid Activities Level of Service**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCAH and SCD advocate for eligible children to join Medi-Cal, both of which cover immunization.		X		
2. Healthy Start (HS), the Health Insurance Plan of California, and Access for Infants and Mothers (AIM) provide health care access, including immunizations, for children.			X	
3. Health promotion for adequate immunizations is also done through the CHDP Gateway and AFLP, BIH, and CPSP.				X
4. Nine regional immunization registries, covering 53 of 58 California counties, provide the foundation for a centralized system of maintaining immunization records.				X
5. Based on data from the regional immunization registries, pockets of need are identified, and interventions are developed.				X
6. Efforts are underway to improve the electronic exchange of information for patients moving between regions, and to allow schools, childcare centers, Medi-Cal, WIC, and Cal-WORKS to link into regional registries.			X	
7. MCAH participates in ongoing activities: serving on local Immunization Coalitions, participating in health fairs,			X	

providing provider trainings, making referrals, evaluating data & establishing immunization clinic sites.				
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NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

b. Current Activities

CMS and IZ Branches, Medi-Cal, and MCMC continue to meet three times per year to discuss results of the ACIP-VFC National Meetings. CMS and IZ branches work together on adding new vaccines and modifying existing vaccine benefits in concordance with the ACIP recommendations.

MCAH partners with the IZB to provide immunization updates to the MCAH Perinatal Services coordinators, review immunization brochures on immunization during pregnancy, development of educational materials on H1N1 in pregnancy and the importance of influenza vaccination. MCAH will continue to work closely with IZB to provide information on pertussis to MCAH providers.

MCAH and SCD continue to advocate for and assist families to enroll in low/no cost public and private health insurance entities. Local MCAH programs, including CHVP, AFLP and BIH, continue to discuss and encourage clients to keep immunizations up-to-date.

LHJs continue with ongoing efforts to improve immunization rates by participating in local collaboratives. The Perinatal Services Coordinators (PSCs) in many LHJs disseminate information on immunizations to local providers participating in the Comprehensive Perinatal Services Program. Local MCAH programs coordinate with schools to provide outreach and education to parents and children to improve immunization rates among elementary and middle school children. Local MCAH programs are actively planning to address childhood immunization in their communities. For example, El Dorado County is developing a vaccine safety and local resources campaign to target school districts with high Personal Belief Exemption rates.

Immunization rates have an impact on vaccine-preventable disease rates for the population. In general, in order for unvaccinated people to be protected against communicable diseases, approximately 75 to 95 percent of the population has to be vaccinated against them.

MCAH and the IZ Branch partnered with Text4Baby to remind mothers to immunize their babies and educate parents that all incoming 7th grade students will need a whooping cough booster immunization before enrollment.

c. Plan for the Coming Year

SCD and IZ Branches, Medi-Cal, and MCMC continue to meet three times per year to discuss results of the ACIP-VFC National Meetings. SCD and IZ branches work together on adding new vaccines and modifying existing vaccine benefits in concordance with the ACIP recommendations.

MCAH partners with the IZB to provide immunization updates to MCAH Perinatal Services Coordinators, review immunization brochures on immunization during pregnancy, and emphasize the importance of influenza [and Tdap](#) vaccination [for pregnant women and others in contact with young infants](#). MCAH continues to work closely with IZB to provide information on pertussis to MCAH providers.

ACA provider payment increase will include significant increase in payment to physicians performing health assessments and administering vaccinations to children.

Performance Measure 08

The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	19.7	19.4	19.1	17.4	17.4
Annual Indicator	19.1	17.5	15.2	14.8	14.8
Numerator	17008	15418	13308	11839	
Denominator	888169	883101	874581	801527	
Data Source	CA Birth Statistical Master File, 2008	CA Birth Statistical Master File, 2009	CA Birth Statistical Master File, 2010	CA Birth Statistical Master File, 2011	
Is the Data Provisional or Final?		Final	Final	Final	Provisional
Year	2013	2014	2015	2016	2017
Annual Performance Objective	17.4	17.4	17.4	17.4	17.4

Field Level Notes

Section Number: Form11_Performance Measure #8

Field Name: PM08

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form11_Performance Measure #8

Field Name: PM08

Row Name:

Column Name:

Year: 2011

Field Note:

Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File. Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations were done by the MCAH Program.

Data reported for 2011 should not be compared to data reported in 2010 due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 16.4.

Last Year's Accomplishments

In 2011, births to teens aged 15-17 years continued to decline. The overall birth rate to teens aged 15-17 dropped from 16.4 in 2010 to 14.8 per 1,000 in 2011, representing a 9.8% decline. Over this same time period, the Hispanic teen birth rate decreased 11.0%, from 26.3 to 23.4 (per 1,000 female teens aged 15-17 years) and the African American teen birth rate declined 1.1%, from 17.4 to 17.2 (per 1,000 female teens aged 15-17 years). The teen birth rate for Whites decreased 10.2%, from 4.9 to 4.4 (per 1,000 female

teens aged 15-17 years) and the Asian/Pacific Islander teen birth rates decreased 15.6%, from 3.2 to 2.7 (per 1,000 female teens aged 15-17 years). Rates for White and Asian/Pacific Islander teens continue to be lower than rates for Hispanic and African American teens.

OFPP, Family Planning, Access Care & Treatment program (Family PACT), and the Information & Education Program (I & E) continued their teen pregnancy prevention efforts. However, budget reductions resulted in less program evaluation, education, and outreach for teen pregnancy prevention programs.

OFPP developed Requests for Applications (RFAs) for I & E. I&E program design will integrate outreach strategies previously funded under Teen Smart Outreach. Twenty-four I & E grantees were awarded in 2011. I & E conducts primary pregnancy prevention through educational programs that equip teens at high risk for pregnancy with the knowledge, understanding, and behavioral skills necessary to make responsible decisions regarding risky behaviors.

CDPH/OFPP was awarded Personal Responsibility Education Program (PREP) funds from the U.S. Department of Health and Human Services, Administration on Children, Youth and Families, administered by the Family and Youth Services Bureau. This Title V funding made available through the ACA provides approximately \$6.5 million annually to California through 2014. PREP funds will be used to replicate effective evidence-based program models that have been proven to change behavior, which means delay in sexual activity, increase in condom or contraceptive use among sexually active youth, and/or reduce pregnancy. CA PREP Eligible entities include 19 California counties with the highest teen birth rates.

MCAH continued to fund and monitor AFLP, the case management program for pregnant and parenting teens. AFLP uses a case management model to enhance, through associations with families and community resources, the health, educational potential, economic opportunity, and self-sufficiency of adolescents during pregnancy and parenthood, and to promote healthy, family relationships. In November 2011, MCAH conducted a competitive RFA process for AFLP with 35 existing contractors applying and successfully awarded. Two current contractors did not apply due to limited funding availability and lack of capacity to respond to the RFA. Following award announcements and subsequent Title V funding reductions, two additional contractors declined to continue the program due to insufficient resources. The number of AFLP sites has declined from 41 in 2009 to 33 in 2012.

MCAH continued to implement a Support for Pregnant and Parenting Teens at High Schools and Community Service Centers award from the U.S. Department of Health and Human Services, funded through the ACA Pregnancy Assistance Fund (PAF) and administered by the federal Office of Adolescent Health that provides \$2 million annually for federal project periods 2010 – 2013. MCAH is developing a standardized case management model with integrated life planning for AFLP. MCAH is also exploring Group Level Interventions. This grant is called AFLP PYD (Positive Youth

Development), and it is being implemented in 11 AFLP sites. Activities included capacity building through a series of five trainings: Core Competencies for Providers of Adolescent Sexual and Reproductive Health; Positive Youth Development (PYD); Motivational Interviewing and Case Management; Life Planning; and “Pulling It All Together.” The “Pulling It All Together” training provided skill building for local partners to practice using the newly developed, PYD-informed My Life Plan modules and corresponding Goal Setting tools in preparation for pilot implementation.

Cal-SAFE continued serving pregnant and parenting students. School districts now have full flexibility in directing Cal-SAFE funds. Some school districts have closed or decreased their Cal-SAFE programs, since flexible spending was implemented.

MCAH worked with the Internet Sexuality Information Services to develop the youth component of the First Time Motherhood grant. The text messaging campaign developed 52 weekly texts to forward to teens on areas related to preconception health. A web site has been developed to provide preconception health information and links to teen pregnancy prevention websites. In addition, an electronic photo contest addressing preconception health issues will be held.

**Table 4a, National Performance Measures Summary Sheet
Pyramid Activities Level of Service**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. AFLP provides case management services to pregnant and/or parenting teens to improve birth outcomes and prevent additional pregnancies.		X		
2. The Family PACT Program provides reproductive health services, education, and counseling to 300,000 adolescents annually, including comprehensive clinical exams and access to contraception.	X			
3. The CCG Program funds 116 community agencies.		X		
4. Cal-SAFE, operating in 137 school districts, enables expectant/parenting adolescents to improve academic achievement and parenting skills, and provides quality child care/developmental programs.			X	
5. MCAH, OFP, Office of AIDS, and the Sexually Transmitted Disease Branch collaborate with key stakeholders at the state level, to better coordinate efforts in Human Immunodeficiency Virus (HIV), Sexually Transmitted Disease (STD), and teen pregnancy prevention.				X
6. MCAH, OFP and key stakeholders collaborate on data integration to generate STD, HIV, and birth data for 2000-				X

2004.				
7. MCAH, OFP and key stakeholders collaborate on Core Competencies, a document intended as an interdisciplinary guide for staff and professionals who work on adolescent sexual health issues.				X
8. The Teen SMART Outreach program funded 21 agencies through September 2008.		X		
9. The Male Involvement Program funded 21 agencies through September 2008.		X		
10. The Information & Education program funded 24 agencies in 2011.		X		

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

b. Current Activities

OFP’s primary teen pregnancy prevention programs, I & E and CA PREP, transitioned to MCAH following the Governor’s budget decision to move OFP clinical services, specifically Family PACT, from CDPH to DHCS.

MCAH developed and released an RFA for CA PREP funding. Eligible entities in 19 California counties with the highest teen birth rates were awarded CA PREP funds and will begin start-up activities in July, 2012. MCAH is establishing the necessary infrastructure to support effective program implementation including training, technical assistance, and systems for data collection, monitoring and evaluation. I&E continues its teen pregnancy prevention efforts.

MCAH continues to support LHJs and CBOs that implement the AFLP program, particularly as they address the challenges of ongoing funding reductions. MCAH is piloting the AFLP PYD intervention in its 11 funded sites through a formative evaluation by an independent evaluator in order to develop a standardized case management intervention. This formative process include extensive and iterative local involvement and feedback. Activities have focused on revising the intervention tools based on program implementation with active participation by all sites through site calls, surveys, key informant interviews, and focus groups with clients.

In April 2013, MCAH will be applying for the U.S. Department of Health and Human Services, Office of Adolescent Health (OAH) grant for the Support for Expectant and Parenting Teens, Women, Fathers and Their Families. The funding will be used to continue and enhance the existing activities begun under the previous OAH grant. This funding would continue the Adolescent Family Life Program (AFLP) Positive Youth Development (PYD) case management with integrated life planning intervention for an additional 4 years. The focus of this intervention is to implement a standardized evidence-informed program strategy and conduct subsequent outcome evaluation to strengthen CDPH/MCAH’s AFLP.

c. Plan for the Coming Year

Seventeen MCAH Local Health Jurisdictions (LHJs) will implement specific teen pregnancy prevention effort that they have planned.

With newly integrated primary teen pregnancy prevention programs, MCAH looks forward to developing an enhanced focus on primary and secondary teen pregnancy prevention, youth sexual health and adolescent health promotion. These efforts will include an emphasis on positive youth development and healthy relationships with the goal of promoting adolescent sexual health as well as overall health and well-being. In addition, opportunities to leverage coordination of primary and secondary teen pregnancy prevention efforts will be identified in terms of local and expert input; professional development and training; replication and effective adaptation of evidence-based practice; process and program evaluation; and continuous quality improvement. This youth focus is supported by the local MCAH needs assessments which have identified adolescent health and adolescent reproductive health as local priorities.

MCAH will continue primary teen pregnancy prevention efforts through I & E and CA PREP but with a broader goal of youth sexual health. The recent transition provides an opportunity to work collaboratively with local partners to support their efforts to maintain optimal teen pregnancy prevention programs within existing resources. CA PREP will continue program implementation and MCAH will work with UCSF, and the CA Prevention Training Center to support and monitor local implementation and program quality in an effort to meet or exceed federal performance measures.

MCAH will continue to implement AFLP and apply the best practices learned from the AFLP PYD efforts into the overall statewide AFLP program. As additional funding is secured through the OAH grant opportunity, MCAH plans to conduct an outcome evaluation in subsequent years in order to develop an evidence-informed intervention for AFLP.

Performance Measure 09

Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	28.1	28.6	29.1	29.0	29.0
Annual Indicator	27.6	27.6	27.6	27.6	27.6
Numerator	129671	126908	127505	129101	
Denominator	469824	459813	461974	467758	
Data Source	Dental Health Foundation, 2006				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Provisional	
Year	2013	2014	2015	2016	2017
Annual Performance Objective	29.0	29.0	29.0	29.0	29.0

Field Level Notes

Section Number: Form11_Performance Measure #9

Field Name: PM09

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011

Section Number: Form11_Performance Measure #9

Field Name: PM09

Row Name:

Column Name:

Year: 2010

Field Note:

Data source for percent of third grade children with sealants: Dental Health Foundation, California Smile Survey, "Mommy It Hurts to Chew," February 2006. Accessed 03/20/13.

Denominator source: California Department of Education. Accessed 03/20/13 at <http://dq.cde.ca.gov/dataquest/Enrollment/GradeEnr.aspx?cChoice=StEnrGrd&cYear=2011-12&cLevel=State&cTopic=Enrollment&myTimeFrame=S&cType=ALL&cGender=B>

*Based on weighted results from a completed survey of a representative sample of elementary schools in California conducted during 2004-05. Dental sealant information is based on one-minute, non-invasive oral health screening of all third graders in selected schools using protocols from the Association of State and Territorial Dental Directors at http://www.dentalhealthfoundation.org/index.php?option=com_content&task=view&id=43&Itemid=60. Accessed 02/21/12.

a. Last Year's Accomplishments

Children's access to preventive dental services is assessed in relation to the percent of third grade children who have received protective sealants on at least one permanent molar tooth. The percent with sealant in California is estimated to be 27.6 percent since 2005 since no new survey has been implemented to update this rate.

The numerator for this performance measure is from the Oral Health Needs Assessment a survey of a representative sample of elementary schools in California in 2004-2005. Dental sealant information is based on a one-minute, non-invasive oral health screening of all third graders in selected schools. The California Office of Oral Health (OOH) partnered with MCAH and the Dental Health Foundation (DHF) to conduct the Oral Health Needs Assessment. In 2010, DHF changed its name to Center for Oral Health (COH) and OOH is now known as the Oral Health Unit (OHU).

To meet the demand for TA at both the state and local levels, MCAH contracts with UCSF School of Dentistry for a dental hygienist to serve as the MCAH Oral Health Policy Consultant. MCAH, SCD, Medi-Cal and OHU are members of the California Oral Health Access Council (OHAC) and the Oral Health Work Group (OHW). OHAC is a diverse panel of stakeholders that are working to improve the oral health status of the state's traditionally underserved populations. OHW assists in the coordination of state oral health activities and serves as a clearinghouse for member organizations. In addition, MCAH, OHU and Medi-Cal are liaisons to the CHDP State Dental Subcommittee whose goal is to increase access to dental care for the CHDP eligible population.

Thirty-three LHJs report oral health activities for children; 22 LHJs report activities focused on pregnant women. Thirteen LHJs have a dental coordinator on staff. Other LHJs rely on collaboration with local oral health coalitions to bring outreach programs and preventive services to MCAH target populations. Many LHJs select WIC sites, pre-schools, and public school locations to deliver these services. MCAH case management programs, such as CPSP, BIH and AFLP, enroll women and their families into Medi-Cal and provide them with necessary dental referrals. The CPSP Statewide PSC Meeting included a presentation and resources for its coordinators on improving oral health care for pregnant women. However, dental providers are difficult to find in many locations because few will accept public insurance or agree to treat low-income pregnant women or children under the age of 3.

California law requires that children receive a dental check-up within the last 12 months and up to May 31 of their first year in public school (kindergarten or first grade). Schools are encouraged to collect and submit data but are not mandated to do so because of state

budget cuts. Last year California Dental Association (CDA) collected assessment data from 45% of the school districts; 112,997 out of 182,040 eligible children submitted an assessment during the school year. Approximately 18.7% were found to have untreated decay, a reduction over last year’s results of 22%.

One of OHAC’s members is The Children’s Partnership (TCP), a child advocacy group focusing on health care, including oral health. TCP’s main goals under their Dental Health Agenda for Children are increasing dental insurance coverage, promoting the creation of new dental workforce models, supporting policies centered on tele-dentistry, and integrating electronic dental and health records. TCP co-sponsored a legislative bill (SB694) with the CDA to enhance the OHU with a licensed dentist to serve as State dental director. The bill would also have authorized a study to assess the feasibility of additional dental workforce models to provide care for the underserved populations. However, this bill did not pass the Assembly.

OHU is working with the University of the Pacific and other partners to implement two Oral Health Workforce Grants; one grant is in its final year. Activities include: developing a dental prevention and treatment pilot project in schools and FQHCs using tele-dentistry and direct service models; conducting an assessment of the impact of the elimination of the adult Denti-Cal optional benefit on the number of safety net workforce; identifying strategies to increase the current dental health workforce; creating a low-cost culturally competent curriculum; and developing two tool kits to implement school-based dental prevention programs.

**Table 4a, National Performance Measures Summary Sheet
Pyramid Activities Level of Service**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medi-Cal provides access to a comprehensive package of primary and preventive services, including dental care, for California’s low-income children.		X		
2. CHDP provides dental screenings for over 1.8 million children a year and is developing an Oral Health for Infants and Toddlers Provider Training Manual for county programs.		X		
3. SCD is undertaking activities to encourage orthodontists and dentists to accept more CCS children into their practices, including more rapid reimbursement.		X		
4. MCAH Program, with key State stakeholders (e.g. Medi-Cal, State First 5 Commission, SCD and APP), develops and promotes policy strategies that will improve the oral health of its targeted population.				X
5. MCAH Program has contracted with UCSF School of Dentistry for a dental hygienist to serve as the Branch’s oral health policy consultant to provide TA at the state and				X

local levels.				
6. Children are required to receive a dental check-up within 12 months of their enrollment into kindergarten or first grade, whichever is their first year of public school.				X
7. LHJs are working with medical, dental and education providers in community dental health advisory boards to promote preventive oral health practices and provide fluoride varnish applications.				X
8. OHU, COH and partners were awarded a three year HRSA Oral Health Workforce grant to develop dental prevention and treatment models for underserved populations.				X
9. MCAH is disseminating State perinatal clinical oral health guidelines created for providers engaged in the care of pregnant women and their children.				X

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

b. Current Activities

MCAH promotes the California perinatal clinical oral health guidelines to assist health care professionals deliver oral health services to pregnant women and their children. MCAH dispatches updated information, web links, grant resources and educational materials to local oral health advocates and coordinators. MCAH also assists LHJs in developing oral health activities to increase community access and outreach.

About 860,000 children enrolled in Healthy Families Program (HFP) are now transitioning into Medi-Cal’s Targeted Low Income Children’s Program covering children with income up to and including 250 percent of federal poverty level. However, dental advocates are expressing concern about the potential impact on beneficiaries and provider networks. To address these concerns, DHCS enrollment process for new providers has become easier. Newly licensed providers are notified on a bi-annual basis for recruitment into Denti-Cal's network. Providers who practice in communities with low Denti-Cal participation are targeted with additional recruitment methods. Denti-Cal also maintains a website that includes a referral list of providers and a link to the Insure Kids Now website.

DHCS established a new policy that allows FQHCs to contract for dental services provided outside the "four walls" of the clinic, and a mechanism whereby dental hygienists working in FQHCs could be considered billable providers in those settings. Both policies are expected to increase access to care.

c. Plan for the Coming Year

State and local programs will continue to promote oral health. MCAH will encourage LHJs to strengthen strategies to increase the number of children and pregnant women

receiving preventive dental services. MCAH will update and integrate oral health educational components into MCAH program guidelines and curricula.

MCAH will provide TA to LHJs, including presentations, resources, and links to grant funding. Educational materials that address early childhood dental decay prevention for mothers and young children will be distributed through MCAH programs. For example, CHDP Dental subcommittee and MCAH have collaborated on developing brochures regarding oral health care and resources for establishing a dental home by age 1 and made available through the MCAH website. CDE has chosen one of these brochures to print in English and Spanish to be offered to Early Head Start and Head Start families this year.

MCAH will continue to promote and disseminate the California perinatal clinical oral health guidelines to health care providers. Since the guidelines were released in 2010, MCAH hopes to detect an increase in the number of pregnant women receiving prenatal oral health counseling. Two multi-part questions from the 2009 MIHA survey were added back into the 2012 MIHA survey to discern any change among respondents.

MCAH is collaborating with DHCS to develop a State Action Plan to address two national Medicaid goals for oral health improvement in children. The first goal is to increase by 10 percentage points the proportion of children enrolled in Medicaid that receive a preventive dental service, over a 5-year period. The second goal is to increase by 10 percentage points the proportion of children ages six to nine enrolled in Medicaid that receive a dental sealant on a permanent molar tooth. MCAH has created a draft action plan for local LHJs that contains a number of objectives aimed at increasing children's access to preventive dental services, and proposes collaboration of local medical and dental organizations and providers, advocacy organizations and the Medi-Cal dental program.

MCAH is a member of the Public Health Council to the California Dental Hygienists' Association. The Council serves as a resource for public health projects, such as linking RDHs with MCAH programs to help with local dental activities and services.

California law allows Registered Dental Hygienists (RDHs) to provide preventive dental services unsupervised in public health programs. Consequently, DHCS is in the process of establishing a mechanism to enroll RDHs and allow them to be Denti-Cal billing providers for preventive services provided in public health programs, such as WIC and Head Start centers, schools and childcare settings. This is expected to increase the number of children receiving preventive services. DHCS is also exploring the issues involved in arranging Head Start staff to provide fluoride varnish applications to children and be able to bill for them.

Performance Measure 10

The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	3	2.9	2.9	1.6	1.6
Annual Indicator	1.7	1.8	1.0	1.0	Copy from left
Numerator	143	148	84	Update	Leave blank
Denominator	8,184,698	8184071	8199138	Update	Leave blank
Data Source	CA Death Statistical Master File 2008	CA Death Statistical Master File 2009	CA Death Statistical Master File 2010	Update	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	Provisional
	2012	2014	2015	2016	2017
Annual Performance Objective	1.6	1.6	1.6	1.6	1.6

Field Level Notes

Section Number: Form11_Performance Measure #10

Field Name: PM10

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form11_Performance Measure #10

Field Name: PM10

Row Name:

Column Name:

Year: 2011

Field Note:

Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Death Statistical Master File [The International Classification of Diseases (ICD)-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6),

V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

a. Last Year's Accomplishments

CIPPP provided 52 issues of the SafetyLit Bulletin- a weekly update of research literature published in scholarly journals and added items to the searchable SafetyLit literature database. Approximately 280 current journal articles summarized each week and at least an equal number of articles from journal back files were added to the searchable bibliographic database. These articles are drawn from health and social work journals as well as journals representing at least 30 other distinct professional disciplines. Author abstracts are modified when necessary to allow practitioners and researchers to understand jargon and concepts that might be foreign. To assist with evidence-based decision-making, SafetyLit provided information about the occurrence of and risk factors for unintentional injuries, interpersonal violence, and self-harm to LHJs and non-governmental agencies. SafetyLit.org received > 65,000 unique visitors each week. Many used the site multiple times for an average total of 400,000 visits/ week. About 3% of these are from California. CIPPP worked closely with the California Coalition on Childhood Safety and Health (a group of insurance company representatives and other stakeholders) to provide guidance for forming policies and justifications for positions on safety regulations and legislation. One example was the information CIPPP provided to support zero tolerance for texting while driving under California's graduated driver licensing system. In consideration of the declining funds available to support LHJ's independent injury prevention activities, CIPPP began assisting with their collaboration with community groups (Safe Kids chapters, parent-teacher organizations) that could serve needs of LHJ clients.

**TABLE 4A
NATIONAL PERFORMANCE MEASURES SUMMARY FROM THE ANNUAL
REPORT YEAR**

Major Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1). Local MCAH funded programs participating in the SAFE KIDS Coalitions to implement traffic safety training, child passenger safety checks and safety seat distribution, and bicycle helmet education programs.		X	X	X
2.) AFLP, BIH, and CPSP provide educational materials on use of car seats and child injury prevention.		X		
3.) To raise funds to support child injury and abuse prevention programs, the State sells special car license plates, called Kid's Plates.				X
4.) The SAC Branch maintains an up-to-date list of locally operated CPS seat programs for use by traffic courts, community agencies, hospitals and clinics.		X		

5.) CIPPP builds state and local capacity for injury prevention by providing technical assistance to state agencies and LHJs, including regular reviews of the current injury prevention literature and a database of relevant material published as far back as the mid-seventeenth century.				X
6.) Office of Traffic Safety (OTS) funds “click it or ticket” campaigns for seatbelt safety.			X	
7.) SAC runs Vehicle Occupant Safety Program and the SCOTS program			X	X
8.) The OTS maintains a Facebook page to discourage drunk driving and share other information on traffic safety.			X	
9.) The OTS measures safety seat usage.			X	X

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

b. Current Activities

CIPPP maintains a calendar of online training opportunities and webinars to partially fill the gap created by declining resources and travel restrictions for in-person training opportunities. CIPPP developed age-appropriate recommendations to parents of infants, toddlers, children and adolescents for keeping their children safe at home, at play, and when traveling. These "Be Safe, Not Sorry" sheets are available in English, Spanish, and Vietnamese languages. SafetyLit services were enhanced through a complete redesign of the website interface, an improved search system, and the addition of gray literature (conference proceedings, doctoral theses, and technical reports), and of books and book chapters to the existing articles drawn from >12,000 scholarly journals published in 142 of the world’s nations. These prevention articles (from places with different populations and cultures, different fiscal situations, and different levels of personnel and personal training and skills) can be readily adapted to inform activities in California’s rural and inner city areas.

c. Plan for the Coming Year

The planned activities of MCAH, CIPPP and LHJs include continuation of current activities as resources allow. CIPPP will continue to maintain and update SafetyLit and a calendar of online training opportunities and webinars on injury prevention. Among the planned SafetyLit improvements are those to enable readers to find the full text of the documents contained in the Weekly Update and the results of a search of the archive database. CIPPP will continue to provide developmental age-appropriate recommendations to parents for keeping their children safe at home, at play, and when traveling. Future "Be Safe, Not Sorry" information sheet series will be updated when appropriate--such as with the change in the booster seat law and the sheets will be made available in English, Spanish, and Vietnamese languages.

Performance Measure 11

The percent of mothers who breastfeed their infants at 6 months of age.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	71.5	72.0	65	64.2	64.2
Annual Indicator	59.9	62.3	59.5	59.5	
Numerator	227520	237585	210982		
Denominator	379768	381282	354888		
Data Source	MIHA, 2008	MIHA, 2009	MIHA, 2010		
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?		Final	Final	Provisional	
Year	2013	2014	2015	2016	2017
Annual Performance Objective	64.2	64.2	64.2	64.2	64.2

Comment [LR2]: As of 6/4/13, Awaiting MIHA data update

Field Level Notes

Section Number: Form11_Performance Measure #11

Field Name: PM11

Row Name:

Column Name:

Year: 2011

Field Note:

A manual indicator is reported for 2011 based on 2010.

Section Number: Form11_Performance Measure #11

Field Name: PM11

Row Name:

Column Name:

Year: 2010

Field Note:

Source: 2010 MIHA Survey, MCAH Program, California Department of Public Health.

Numerator: The number of women who delivered a live birth and who reported any breastfeeding at 3 months of age.

Denominator: The number of women who delivered a live birth that reported whether or not they breastfed at 3 months of age. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year and exclude mothers who could not answer the question because they responded to the survey before 3 months post-partum.

a. Last Year's Accomplishments

In 2010, 59.5 percent of mothers reported breastfeeding their infants at three months post-partum which is slightly lower than previous years. African American (47.4%) and Hispanic (51.2%) mothers were less likely than White (69.9%) and Asian/PI (75.0%) mothers to breastfeed their infants at three months of age.

Comment [LR3]: Update using 2011 data when it becomes available

MCAH programs promoted exclusive breastfeeding until complementary foods are introduced and continued breastfeeding for at least the first year of life.

MCAH shared information with its programs during World Breastfeeding Week and encouraged county and community-based organizations to participate. MCAH coordinated with the California Obesity Grant, WIC, WIC Association, and Breastfeeding Coalition to celebrate World Breastfeeding Week with a breastfeeding walk.

MCAH supported CDPH and DHCS in adhering to California Health & Safety Code § 123360 in creating a public health campaign to provide breastfeeding information and referrals, making available an 8-hour training course that promotes exclusive breastfeeding, and assisting hospitals in developing policies to support breastfeeding by keeping the Model Hospital Policy Recommendations Toolkit and hospital quality improvement resources updated.

Per California Health & Safety Code §123365, WIC and MCAH finalized a hospital administrators web-based breastfeeding policy curriculum.

PAC-LAC, a RPPC region and MCAH published a report outlining elements and lessons learned from BBC. MCAH offers technical assistance to implement BBC and worked with FHOP to develop a BBC/breastfeeding webinar and breastfeeding fact sheet.

MCAH hospital initiation breastfeeding data was posted online and used by the California WIC Association and UCD to produce a Hospital Breastfeeding Rates Report & County Fact Sheets. MCAH collaborated with CDC to show that evidence-based policies and practices measured by mPINC are associated with increased exclusive breastfeeding rates in California hospitals; results were shared at the annual Hospital Breastfeeding Summit.

MCAH participated in RPPC's emergency preparedness efforts for birthing hospitals and posted related resources on the web.

For home visiting efforts, MCAH developed breastfeeding benchmark indicators and researched WIC's Peer Counselor Curriculum.

MCAH has representation on the U.S. Breastfeeding Committee and the Association of State and Territorial Public Health Nutrition Directors (ASTPHND) MCH Nutrition Council which address breastfeeding strategies, programs and services.

MCAH collaborates within CDPH via a Center for Family Health Nutrition Coordination Workgroup, the Obesity Prevention Group.

There were several local/LHJ activities that promoted breastfeeding. For example, Kings County collaborated with the local breastfeeding coalition to develop a “breastfeeding friendly sites” directory. Marin Breastfeeding Coalition created a Facebook page. Marin assisted the county to adopt a workplace breastfeeding policy and provide training for department heads on their roles and responsibilities around supporting a breastfeeding-friendly workplace. Mendocino developed at least one protocol incorporating breastfeeding support in the MCAH Field Nursing home visiting program. Solano County completed its 7th year of implementing the “More Excellent Way,” an African American, peer counseling, church-placed infant feeding and parenting training and intervention program.

El Dorado County had an "Express Stop" to loan breast pumps to local employers to help them meet workplace requirements and had a World Breastfeeding Week “Fun Run.” Fresno prepared a training "How to Provide Breastfeeding Education and Support in CPSP" in collaboration with the WIC program. Fresno also co-sponsored the Central California Breastfeeding Summit and Dr. Jack Newman’s seminar on A Guide to Breastfeeding Infants with Special Needs. Humboldt developed a “Model of Breastfeeding Support” that demonstrates the three levels of self, family/community, policy and areas of emergency preparedness, family education, provider education, outreach in the community, and more. Kern County received input from nurses in their LHJ to improve the breastfeeding curriculum at California State University, Bakersfield. They also developed a Breastfeeding Coalition Resource Guide, which contains baby-friendly hospitals, breastfeeding classes, IBCLCs, and pump rental locations.

**Table 4a, National Performance Measures Summary Sheet
Pyramid Activities Level of Service**

Major Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. AFLP promotes breastfeeding among adolescent mothers, an age group that is less likely to breastfeed.		X		
2. CDAPP promotes breastfeeding as beneficial for both mother and child in reducing the risk for diabetes.		X		
3. BIH collaborates with local breastfeeding coalitions to promote breastfeeding in several counties.		X		
4. CPSP promotes breastfeeding through nutrition assessment and counseling.	X			
5. MCAH is participating on the CDPH Obesity Prevention Group as breastfeeding promotion is one of the interventions for childhood obesity prevention.				X
6. MCAH staff help promote local breastfeeding coalitions, including participating at the California Breastfeeding Coalition meetings.				X
7. MCAH is providing toolkits, training and TA (via RPPC) to staff at labor and delivery hospitals to improve hospital lactation policies.		X		
8. MCAH maintains the CDPH and MCAH website’s breastfeeding pages which includes breastfeeding information and answers many questions that local programs and the public may have.				X

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services
IB=Infrastructure Building.

Current Activities

MCAH developed a webpage and authored a letter to hospitals from WIC and MCAH providing them with resources and notification regarding California Health & Safety Code §123366, the Hospital Infant Feeding Act.

MCAH authored a letter from WIC and MCAH to CDC to support the continuation of mPINC, a national survey of maternity care practices and policies conducted every 2 years by the CDC.

The infant feeding guidelines for AFLP, CDAPP Sweet Success and CPSP were updated with more current and science-based information.

MCAH developed a Systems and Environmental toolkit and webinar that support breastfeeding. The resources chosen appear to be feasible projects for MCAH Program involvement. A success story shared in the toolkit is that during this year, the City of Pasadena's MCAH program is working to implement a citywide workplace breastfeeding policy as well as a department-wide Mother-Baby Friendly workplace. They hope to make Pasadena a Mother-Baby Friendly community by 2015.

MCAH collaborated with the California Breastfeeding Coalition, the California WIC Association and State programs to host the 3rd Annual California Breastfeeding Summit on January 31 – February 1, 2013. MCAH continued collaborations from the previous year and began collaborating with the Coordinated Chronic Disease Program.

c. Plan for the Coming Year

MCAH will continue to lead the U.S. with the most Baby-Friendly certified hospitals and plans to increase the number from 58.

MCAH is collaborating with the Office of Emergency Preparedness to develop an infant feeding plan for first responders and shelter/other emergency personnel that focuses on keeping the mother-infant dyad together and supports breastfeeding as the preferred and safest infant feeding method.

To improve breastfeeding duration rates in California's high-risk communities, MCAH is collaborating with the California Obesity Prevention Program (COPP) to enhance the capacity of community safety-net clinics to provide quality breastfeeding services. Using CDC funds, this statewide pilot project focuses on increasing breastfeeding duration rates in California's low-income communities of color. Community health centers have been funded to create an environment that promotes and supports mothers' decision to breastfeed and sustain breastfeeding post-hospital discharge. Starting in January 2013, one-time competitive grant funds were provided to 15 clinics for specified local breastfeeding support and promotion services. Grantees are receiving training, technical assistance, and resources to assist them in two key strategies: 1) implementation of "breastfeeding-friendly" environmental and policy changes in selected clinic sites, and 2)

provision of direct breastfeeding services, reimbursable through Medi-Cal. Successful pilot strategies will be highlighted and shared to build evidence base and momentum for clinics statewide to adopt specific model “breastfeeding-friendly” clinic policies/practices.

MCAH will continue to support conferences/meetings such as the Hospital Breastfeeding Summit, California Breastfeeding Coalition and Childhood Obesity Conferences. MCAH will continue to meet bimonthly with state WIC breastfeeding staff to coordinate efforts.

MCAH will continue to have a representative on the USBC. She will participate in the following workgroups: Emergency Preparedness, Media/Public Relations and the Reduce Infant Formula Marketing. MCAH will continue to work with other existing collaboratives.

MCAH will continue to monitor California infant feeding patterns, including breastfeeding initiation, duration and exclusivity and maternity care policies/practices that support breastfeeding through the NBS Program-to monitor in-hospital infant feeding practices; California MIHA Survey to monitor breastfeeding initiation, duration and exclusivity, as well as hospital experiences and worksite accommodations that affect breastfeeding; and CDC mPINC Survey to monitor maternity care policies and practices that affect breastfeeding.

Performance Measure 12

Percentage of newborns who have been screened for hearing before hospital discharge.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	85	95	95	99	99
Annual Indicator	93.2	98	99	98	98
Numerator	515062	517247	505847	492337	
Denominator	552618	527897	510981	503016	
Data Source	Office of Vital Records birth certificate data	Office of Vital Records birth certificate data; NHSP program data	Office of Vital Records birth certificate data; NHSP program data	Office of Vital Records birth certificate data; NHSP program data	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?		Final	Final	Final	
Year	2013	2014	2015	2016	2017
Annual Performance Objective	99.0	99.0	99.0	99.0	99.0

Notes -2012

Manual indicator is reported for 2012 based on 2011 results.

Notes -2011

Measure based on hospitals carrying out universal newborn hearing screening in California. This measure is the percent of newborns who have been screened for hearing before hospital discharge.

Source: Numerator and denominator data are from the State of California, Department of Public Health, Office of Vital Records, birth certificate data.

Numerator: Number of newborns who have been screened for hearing before discharge for FY 2011.

Denominator: Number of live births by occurrence in California in FY 2011.

a. Last Year's Accomplishments

- 1) SCD provided TA and consultation support to HCCs to ensure that all general acute care hospitals with licensed perinatal services provide hearing screening tests to all newborns in a manner consistent with NHSP standards and requirements.
- 2) SCD continued to facilitate the NHSP Quality Improvement learning collaborative.

- 3) SCD was awarded continued funding from MCHB for the tele-audiology project to improve the quality of and access to audiology services and minimize the shortage of pediatric audiology providers in Northern California.
- 4) SCD collaborated in the implementation of the parent support grant from MCHB.
- 5) SCD worked with the NHSP DMS vendor, Neometrics, to implement the DMS in all HCCs and to begin implementation in hospitals statewide.

Table 4a, National Performance Measures Summary Sheet Pyramid Activities Level of Service

Activities	Level of Service			
	DHC	ES	PBS	IB
1. SCD will work with the CDE to support the implementation of the parent support activities in the grant from MCHB.		X		
2. The statewide data management service for the NHSP will be rolled out to additional hospitals.				X
3. TA and consultation support will continue for all HCCs.		X		
4. SCD will ensure that all general acute hospitals with licensed perinatal services participate in the NHSP.			X	
5. SCD continues to work with Medi-Cal and its fiscal intermediary to address issues affecting access to outpatient hearing screening and audiology services.				X

b. Current Activities

- 1) All new general acute care hospitals with licensed perinatal services will be certified for participation in the NHSP.
- 2) SCD continues collaboration in the implementation of the parent support grant from MCHB.
- 3) The NHSP DMS vendor is implementing the DMS in additional hospitals.
- 4) SCD is an active participant in the NHSP QI learning collaborative.
- 5) SCD provides technical support to the HCCs.
- 6) SCD continues to collaborate with UC Davis Hospital to execute the activities in the tele-audiology grant.

- 6) SCD continues to work with Medi-Cal and its fiscal intermediary to address issues affecting access to outpatient hearing screening and audiology services.

c. Plan for the Coming Year

- 1) SCD will finalize the certification of any new hospitals.
- 2) SCD will continue to collaborate in the implementation of the parent support grant from MCHB.
- 3) The DMS for NHSP will be rolled out to all remaining certified hospitals throughout the state.
- 4) SCD will continue participation and facilitation of the NHSP QI learning collaborative.
- 5) TA and consultation support will continue for all HCCs to ensure compliance with NHSP standards and requirements.
- 6) The Audiology Telehealth pilot project in the rural northern region of California will allow rural families to receive local diagnostic services without lengthy travel.

Performance Measure 13

Percent of children without health insurance.

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	13.3	13.1	12.9	10.0	10.0
Annual Indicator	11.0%	11.2	11.2	11.3	11.3
Numerator	1167278	1190554	1185414	1102686	
Denominator	10611615	10616624	10613742	9796707	
Data Source	Current Population Survey, 2008	Current Population Survey, 2009	Current Population Survey, 2010	Current Population Survey 2011	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Final	Provisional
Year	2013	2014	2015	2016	2017
Annual Performance Objective	10.0	10.0	10.0	10.0	10.0

Field Level Notes

Section Number: Form11_Performance Measure #13

Field Name: PM13

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form11_Performance Measure #13

Field Name: PM13

Row Name:

Column Name:

Year: 2011

Field Note:

Source: Numerator of uninsured children (age 0-18) is from the Kaiser Family Foundation analysis of the March 2011 release of the Current Population Survey. Denominator (estimate of the number of children 18 years of age and younger): State of California, Department of Finance,

Report P-3 Population Projections by Race/Ethnic, Detailed Age, and Gender, 2010-2060, Sacramento, CA, January 2013.

The percent of uninsured children 0-18 years was calculated by dividing the numerator by the denominator. The percent uninsured is rounded to the fifth decimal point.

a. Last Year's Accomplishments

The percent of uninsured children in California has decreased since 2000 when the percent of children without health insurance was 15.7 percent. After slight increases in 2005-06, the percent without insurance remains at 11.2 percent in 2011. Despite this success, over a million children still lack coverage. Data for NPM 13 are based on the U.S. Current Population Survey. Medi-Cal continues to fill the gap in coverage created by the decline in private insurance. In 2011 almost 3.7 million children were enrolled, up from 2.6 million in 2001.

Children received coverage from four main sources of coverage: job-based insurance, privately purchased insurance, Medi-Cal and HF. According to the California HealthCare Foundation, among California residents age 18 or younger, 56% had private insurance, 41% had public coverage, and 11% were uninsured in 2011. Over three-quarters of uninsured children are eligible for Medi-Cal. Public coverage through Medi-Cal and Healthy Families expanded 46% from 2002 to 2011, while employer-based coverage declined by 16%.

MCAH programs, including AFLP, BIH, and CPSP, encouraged and facilitated enrollment in Medi-Cal, HF and CHI. Efforts included public awareness media campaign, referrals, and other community education and outreach efforts. Counties continue to provide assistance in Medi-Cal applications at County social service offices.

California continued a comprehensive outreach and education campaign to increase enrollment in Medi-Cal and Healthy Families. In California, infants are eligible for Medi-Cal in families at less than 200% FPL, children ages 1-5 at less than 133% FPL, and ages 6-18 at less than 100% FPL. California Children's Services provides coverage for certain medical conditions for families with incomes less than \$40,000 or expenses more than 20% of income.

Since December 2010, Californians have been able to use a self-service, online application for Healthy Families and for the Medi-Cal Program for Children and Pregnant Women. This enrollment option, called Health-e-App Public Access (HeA PA), offers faster, more convenient access to public insurance for children. Its first full year of operation was 2011.

Through the CHDP Gateway, any child under 19 years with family income at or below 200 percent FPL (and not already in the Medi-Cal Eligibility Data System (MEDS) system) is "presumed eligible" for Medi-Cal or HF and given a temporary Medi-Cal Benefits Identification Card. This provides access to no-cost, full scope fee-for-service Medi-Cal benefits for up to 60 days. Over half a million children (503,649) were pre-enrolled into Medi-Cal and received 60-day temporary coverage through the CHDP Gateway in fiscal year (FY) 2010-11. An additional 74,247 infants were deemed eligible for one year of full-scope Medi-Cal coverage through the CHDP newborn Gateway.

Most families with children pre-enrolled through the CHDP Gateway (91 percent) request a Medi-Cal/Healthy Families application for ongoing coverage at the time of the pre-enrollment through the CHDP Gateway. 76 percent of CDPH applications come from the Gateway. 23 percent of children enrolled in CHDP from the Gateway go on to enroll in full-scope Medi-Cal.

Local CHDP programs informed new providers about the Gateway and directed them to CHDP Gateway resources. The SCD analyzed CHDP Gateway data reports to monitor program operations and the needs of CHDP local programs and providers.

Many counties continued to provide coverage through 3Children's Health Initiatives (CHI) to locally fund insurance programs for children ineligible for Medi-Cal or HF coverage. CHI is a collaboration of 29 local CHI's dedicated to ensuring that all California children have access to quality health coverage. Together, the CHI's emphasize streamlined enrollment into HF, Medi-Cal and Healthy Kids insurance programs, and share a goal of creating and maintaining a sustainable health care program for all children in California. Since 2009, the number of counties with Healthy Kids programs declined sharply from 25 to 15, and four of those counties have waitlists totaling 6,808 children. CalKids is active in 27 counties, and Kaiser Child Health Plan is in 29.

**Table 4a, National Performance Measures Summary Sheet
Pyramid Activities Level of Service**

Major Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1). MCAH programs and LHJs encourage and facilitate enrollment in Medi-Cal, HF, CHI and other low cost insurance programs via community outreach and education activities and local Toll-Free Telephone referral lines.			X	
2.) SCD works to maximize the effectiveness of the Gateway for enrolling eligible children in Medi-Cal or HF.				X
3.) CHDP provides information and materials in multiple languages for the Gateway.				X
4.) CDPH and MRMIB continue to implement and support improvements in the process of eligibility determination and enrollment for Medi-Cal and HF.		X		

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

b. Current Activities

California has determined that it will be more efficient to combine the Medi-Cal and HFP. As of January 1, 2013 there are no new enrollments of children into HF. Medi-

Cal coverage will now extend to the HF income level and provide coverage to all children that were previously HF eligible. Families with uninsured children can continue to apply for coverage via the online Health-e-Application, toll-free telephone application (or to request an application be mailed); or by downloading an application. DHCS will transition approximately 875,000 HFP enrollees in four separate phases over the course of one year, minimize disruption in services, maintain adequate provider networks, and ensure access to care.

California continues to plan for the implementation of the Affordable Care Act, including enrollment through Covered California, the state's health benefits exchange program.

Local MCAH programs provide outreach and referrals to health insurance and care for pregnant women, infants and families, focusing on high risk populations. Activities may include targeted outreach, case finding and care coordination. High risk groups include CSHCN, low income pregnant women, and women of childbearing age who are at risk for adverse perinatal outcomes.

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

c. Plan for the Coming Year

MCAH programs, including AFLP, BIH, and CPSP, will continue to encourage and facilitate enrollment in Medi-Cal, and CHI through outreach, education and referral programs.

DHCS will continue to implement and support improvements in the process of determining eligibility and enrollment in Medi-Cal. DHCS and MRMIB will continue moving children from Healthy Families to Medi-Cal. The third phase is scheduled to begin in August 2013, and the fourth phase in September 2013

California will continue the process of implementing the health benefits exchange to provide coverage under the Affordable Care Act and will begin enrollment in October 2013 for coverage to begin January 1, 2014. The Urban Institute estimates that there will be 1.8 million Medicaid/CHIP eligible children with potentially exchange eligible parents, 0.7 million Medicaid eligible children with undocumented parents, and 3 million children with at least one absent parent. In 2014, as many as one million uninsured children may be eligible for Medi-Cal or private coverage through the California Health Benefits Exchange; 144,000 may qualify for subsidized coverage through the Exchange. Local MCAH programs will continue to provide outreach and referrals to health insurance plans for pregnant women, infants and families and provide supportive activities to ensure continuous access to recommended health care services. These activities may include identification of high risk populations, targeted outreach, provision of case finding and care coordination for women, children and adolescents who are not linked to a source of care. Other high risk groups targeted are CSHCN, low income

pregnant women, and women of childbearing age who are at risk for adverse perinatal outcomes.

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

Performance Measure 14

Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	33.6	33.5	33.5	33.5	33.5
Annual Indicator	33.3	32.9	33.4	33.4	33.4
Numerator	100447	109446	95025		
Denominator	301643	332663	284506		
Data Source	PedNSS, 2008	PedNSS, 2009	PedNSS, 2010		
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?			Final	Provisional	
Year	2013	2014	2015	2016	2017
Annual Performance Objective	31.4	31.4	31.4	31.4	31.4

Field Level Notes

Section Number: Form11_Performance Measure #14

Field Name: PM14

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2010.

Section Number: Form11_Performance Measure #14

Field Name: PM14

Row Name:

Column Name:

Year: 2011

Field Note:

A manual indicator is reported for 2011 based on 2010. The Pediatric Nutrition Surveillance System (PedNSS) used as the data source for this measure was discontinued by CDC in 2011 and the latest data available is for calendar year 2010.

Last Year's Accomplishments

As part of a life course approach to prevent obesity, a MCAH webpage shares strategies and community-based interventions that support healthy weight for reproductive-aged women. MCAH assisted in developing interconception guidelines/handouts for women with risks, e.g., gestational diabetes, in a prior pregnancy. MCAH collaborated with FHOP to create a healthy weight webinar and fact sheet.

MCAH updated nutrition and physical activity guidelines for AFLP, BIH, CDAPP Sweet Success and CPSP.

MCAH is evaluating the Perinatal Food Group Recall for accuracy and ease of implementing by CPSP Community Health Workers; it sets a goal and identifies food group and calorie deficiencies/excesses.

MyPlate for Moms was finalized and encourages pregnant/breastfeeding women to eat healthy meals, with limited sugar, solid fats and salt. It is a primary message for CPSP and AFLP. MCAH developed MyPlate for Gestational Diabetes for pregnant and postpartum women who experience gestational diabetes.

MCAH published weight gain recommendations for women with diabetes in each pre-pregnancy BMI category that are in accordance with the 2009 IOM guidelines.

MCAH researched nutrition, physical activity and breastfeeding benchmarks for home visiting and disseminated WIC child nutrition and baby behavior educational materials to local MCAH.

MCAH helped author national guidelines released in 2011 promoting optimum nutrition, breastfeeding and physical activity in childcare centers.

Two laws were passed to support CDPH efforts to reduce obesity: one makes obtaining federal funds easier for CDPH and one establishes a “Safe Routes to School Program.”

State and local CHDP nutritionists developed and implemented nutrition education, provided consultation/training and monitored childhood obesity. Online train the trainer modules for assessing and managing overweight children were utilized by MCMC Health Plans and CHDP providers. CHDP trained providers using the CDC PedNSS WHO growth chart training curriculum.

MCAH finalized English and Spanish healthy cookbooks for AFLP to encourage healthy eating and physical activity.

The MCAH Nutrition and Physical Activity Coordinator was a Board member of the Association of State & Territorial Public Health Nutrition Directors (ASTPHND) and MCH Nutrition Council, which works to strengthen nutrition strategies, programs and environments at state and national levels. MCAH and SCD participated on the Obesity Prevention Group (OPG), which aims to integrate obesity prevention into CDPH programs.

MCAH collaborates within CDPH via a Center for Family Health Nutrition Coordination Workgroup and the Obesity Prevention Group to implement Nutrition, Physical Activity and Breastfeeding interventions.

Examples of local MCAH activities include Alameda’s nurses’ training on how to promote healthy eating habits and increased physical activity in their female clients of childbearing age. Alpine determined the BMI of 7- 8th grade students and provide type 2 diabetes information. Los Angeles recruited child care centers to participate in a study to improve the nutrition and physical activity practices in licensed child care centers. Modoc presented on Harvest of the Month to preschools and kindergartens. Monterey partnered with the Nutrition Network and local schools to increase physical activity and healthy nutrition and provide cooking demonstrations to migrant families. Riverside updated a Child and Adolescent Obesity Provider toolkit. San Benito provided nutrition and physical activity education to 5th grade students using the Power Play Curriculum. San Francisco developed guidelines to improve physical activity and nutrition in child care centers and after school programs. Stanislaus promoted a built environment that is supportive of physical activity.

**Table 4a, National Performance Measures Summary Sheet
Pyramid Activities Level of Service**

Major Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1). Data collection from CHDP nutrition assessments for the Pediatric Nutrition Surveillance System (PedNSS) continues.		X		
2.) CHDP program benefits include cholesterol and fasting blood glucose screening tests for children at risk for obesity, the complications of obesity and at risk for cardiovascular disease.	X		X	
3.) State and local CHDP nutritionists develop and implement nutrition education, provide consultation and training modules for CHDP providers and office staff, and coordinate follow-up and referrals to related programs.		X		X
4.) MCAH develops and/or provides nutrition education materials and initiatives, nutrition assessment materials, technical assistance and consultation, and funding opportunities to MCAH programs and colleagues.				X
5.) BIH, AFLP, CDAPP and CPSP promote optimal weight gain in pregnancy, breastfeeding, and glycemic control as an effort to reduce the risk of obesity.		X		
6.) MCAH partners with other state programs and agencies to dialogue with advocates, experts and local MCAH directors to prevent overweight among infants and pre-school aged children.				X
7.) BIH, AFLP, CDAPP and CPSP promote physical activity and proper nutrition by encouraging healthy eating through discussions on how to cut fat, lower calories and move more.		X		
8.) MCAH Offers MCAH LHJs a “Here is Where Healthy Starts” award for strategies/programs in place to support good nutrition, physical activity, safety and breastfeeding.				X
9.) MCAH and SCD collaborate with the California Nutrition Network for Healthy, Active Families to promote healthy eating and a physically active lifestyle among low income Californians.				X

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

Current Activities:

An online toolkit to provide nutrition, physical activity and breastfeeding resources for LHJ-MCAH Programs to address the built environment was developed and includes a sample PowerPoint and webinar featuring Dr. Richard Jackson. Speakers from Mono and Los Angeles MCAH also presented.

The revised CDAPP Sweet Success Guidelines for Care include medical nutrition therapy, breastfeeding and exercise sections. The Spanish California MyPlate for Gestational Diabetes handout was developed. To support and train CDAPP Sweet Success Affiliates, the CDAPP Sweet Success Resource and Training Center provided webinars on diabetes and pregnancy, e.g., on nutrition, eating for the holidays and exercise.

CPSP's Steps to Take Guidelines were updated to include a new section on breastfeeding and MyPlate for Moms. CPSP nutrition, physical activity and breastfeeding handouts are posted online. Prenatal weight gain grids were created for pregnant women with twins.

In collaboration with UCLA, a CPSP Perinatal Food Group Recall was evaluated. Findings and recommendations were presented to Perinatal Services Coordinators.

Extensive activities were implemented to promote breastfeeding (see NPM 11).

MCAH provided expert input including on the built environment for the 2013 Childhood Obesity Conference.

The physical activity section of the AFLP Nutrition and Physical Activity Guidelines was revised.

MCAH continued existing collaborations and began collaborating with the Coordinated Chronic Disease Program.

Plan for the Coming Year:

MCAH will continue to collaborate with state programs, advocates, experts and local MCAH Directors to prevent overweight and obesity in children. Messages and products will be shared with MCAH partners via the MCAH website, email and other mechanisms.

MCAH will continue to collaborate with experts and LHJ MCAH Directors to address MCAH's role in utilizing strategies and tools to advocate for environmental changes to support optimum nutrition, physical activity and breastfeeding. MCAH will continue to promote Food Day to LHJs as an opportunity to inform, engage and empower MCAH populations on matters related to nutrition. Food Day 2013 is a nationwide celebration and movement for healthy, affordable and sustainable food.

The CDAPP Sweet Success Resource and Training Center will continue to provide webinar trainings for CDAPP Sweet Success Affiliates and education resources for both health care providers and pregnant women with diabetes.

MCAH is investigating developing alternative nutrition assessment forms for pregnant and postpartum women based on recent evaluation of the CPSP Perinatal Food Group Recall form.

MCAH will complete nutrition, physical activity and breastfeeding group curricula for the BIH program.

MCAH will explore ways to promote optimal nutrition, physical activity and breastfeeding in home visiting.

MCAH will strengthen and coordinate child nutrition and physical activity messaging with WIC and SCD.

MCAH will complete the revisions to the disordered eating, weight management and nutrition assessment sections for the AFLP Nutrition and Physical Activity Guidelines.

MCAH is exploring options for expanding nutrition, physical activity and breastfeeding for AFLP, BIH and RPPC.

MCAH and SCD will work with OPG to integrate obesity prevention into CDPH programs. MCAH is on the Planning Committee for the 2013 Childhood Obesity Conference. The Nutrition and Physical Activity Coordinator of MCAH will be the 2013-2014 president of ASTPHND. She will continue to promote nutrition and physical activity strategies. MCAH will continue to work with existing collaboratives, such as Center for Family Health Nutrition Coordination Workgroup, ASTPHND, Coordinated Chronic Disease Program and the OPG to implement Nutrition, Physical Activity and Breastfeeding interventions.

MCAH is exploring how to ensure that nutrition, physical activity and breastfeeding are adequately covered and marketed in the Affordable Care Act.

Performance Measure 15

Percentage of women who smoke in the last three months of pregnancy.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	3.6	3.5	3.4	2.6	2.6
Annual Indicator	3.3	2.8	3.1	2.9	2.9
Numerator	18078	14417	14824	14269	
Denominator	542822	505206	483282	489359	
Data Source	MIHA, 2008	MIHA, 2009	MIHA, 2010	MIHA, 2011	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?		Final	Final	Final	Provisional
Year	2013	2014	2015	2016	2017
Annual Performance Objective	2.6	2.6	2.6	2.6	2.6

Field Level Notes

Section Number: Form11_Performance Measure #15

Field Name: PM15

Row Name:

Column Name:

Year: 2012

Field Note: A manual indicator is reported for 2012 based on 2011.

Section Number: Form11_Performance Measure #15

Field Name: PM15

Row Name:

Column Name:

Year: 2011

Field Note:

Source: 2011 MIHA survey, MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported any smoking in the third trimester of pregnancy. Denominator: The number of women who delivered a live birth and reported whether or not they had smoked during their third trimester of pregnancy.

Numerator and denominator are weighted to the number of resident women in the state who delivered a live birth in 2010.

a. Last Year's Accomplishments

In 2011, 2.9 percent of women aged 15 years and older who had a recent live birth reported smoking in the last trimester of pregnancy. Though the prevalence of smoking during the last trimester of pregnancy increased slightly between 2009 and 2010, the prevalence has shown substantial decline since 1999, when the prevalence was 5.7

percent among all women in California. The data from 2011 are in alignment with this overall decreasing trend.

In 2011, Black and White women had the highest rates of smoking in the last trimester of pregnancy (5.9 and 5.3 percent, respectively) compared to Hispanic (1.7 percent) and Asian/Pacific Islander (1.0 percent) women. Reported smoking declined in each of these groups since 2008, with the exception of Hispanic women, whose rate did not change.

Pregnant women benefit when smoking rates are low in society because the norm shifts to never smoking in the first place; also there are fewer avenues for secondary or tertiary smoke exposure. In California, pregnant women continued to benefit from low smoking rates and a built environment that makes it difficult for one to smoke. The state's adult smoking prevalence has hit a record low of 11.9 percent in 2010, making California one of only two states to reach the HP 2020 target of reducing the adult smoking prevalence to 12 percent.

One of California's biggest examples of its influence on public health law is tobacco regulation. In 1988, California was the first state to tax cigarettes to fund a tobacco control program. Ten years later, California banned smoking in public places such as trains, planes, buses, workplaces and restaurants. Now, about half of the states have similar policies about smoking in public places. California became a leader for developing anti-smoking policies.

In 2011, two new tobacco-related bills were signed into law. AB 795 provides authority to the governing bodies of the California State University and each community college district to enforce smoking policies by citation and fine. SB 332 was signed into law and would authorize a landlord of a residential dwelling unit to prohibit the smoking of tobacco products on the property premises or in a dwelling unit. Nine municipalities in California (including San Rafael in 2012) enacted legislation prohibit smoking inside all multiunit residences, such as condos or apartments, where housing units share walls, floor, ceilings or ventilation systems.

Efforts to reduce and prevent smoking were prominent features of MCAH programs that serve pregnant women and teens. AFLP provided smoking exposure assessment and cessation assistance to pregnant teens. BIH provided health education and health promotion related to smoking cessation in groups and case management for Black pregnant and parenting women. CPSP included smoking cessation as one goal for improving pregnancy outcomes. CPSP guidelines, "Steps to Take," assisted providers with health education, nutrition, and psychosocial interventions. Handouts, in English and Spanish, were available for CPSP to educate women about smoking cessation.

Smoking cessation is a key part of preconception care. The Preconception Health Council of California (PHCC) provided information, tools and resources focusing on the importance of achieving optimal health before pregnancy, including refraining from tobacco use. This message is reflected in all of the low-literacy fact sheets on www.everywomancalifornia.org. As part of a prenatal harm reduction strategy, the

EVERYDAY mnemonic includes a recommendation to “Avoid tobacco, alcohol and drugs or, use birth control until you can.”.

CTCP supported statewide and local smoking cessation projects to create effective and innovative tobacco control interventions throughout California. The California Smokers' Helpline provided intensive tobacco cessation counseling, which includes tailored counseling services for pregnant women, teens, and adults in multiple languages.

Executive Order B-19-12 established an initiative and a statewide task force to develop a 10-year plan for improving the health of Californians. One of the priority areas is “Health Across the Lifespan” which names eliminating tobacco use as a goal and a strategy to affect numerous outcomes including MCAH targets such as infant mortality and low birth weight.

**Table 4a, National Performance Measures Summary Sheet
Pyramid Activities Level of Service**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. AFLP assess clients for smoking habits and exposure to second hand smoke and discuss the risks of smoking for the mother and baby during pregnancy and after birth.		X		
2. BIH clients receive education about smoking and health; the BIH Scope of Work includes smoking cessation to reduce low birth weight.		X		
3. CPSP guidelines assist providers and practitioners with health education, nutrition, and psychosocial intervention guidelines; handouts are also available, in English and Spanish, to educate women about smoking cessation.		X		
4. The California Tobacco Control Program supports statewide and local smoking cessation projects to create effective and innovative tobacco control interventions throughout California.		X		
5. The California Smokers' Helpline provides tailored counseling services for teens, adults, and pregnant women in English, Spanish, Korean, Mandarin, Cantonese, and Vietnamese.		X		
6. Diabetes educators throughout California have joined forces with the California Diabetes Program and the California Smokers' Helpline to assist patients with diabetes to quit smoking.				X
7. PHCC has developed a website with information for consumers and providers about health for women of reproductive age. It includes information about smoking during pregnancy and links to resources in English and Spanish.				X

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

b. Current Activities

CDPH released “State Health Officer’s Report on Tobacco Use and Promotion,” highlighting successes (low rates) and problems (sale to minors, smokeless tobacco, marketing to low-income/minorities). Culturally targeted ads were critical to MCAH given the diverse birthing demographics in CA.

AFLP/other teen programs, BIH, and CPSP provide smoking interventions which include historical use assessment, education, goal setting, and cessation activities, and referrals for pregnant and parenting women.

MCAH accepted the Association of State and Territorial Health Organizations/March of Dimes Preterm Birth Challenge.

California launched the Preconception Peer Educators (PPE) program (see SPM 4) Smoking prevention and cessation are central activities for PPE. MCAH and PPE help disseminate anti-smoking messages as part of the CDC preconception health campaign, *Show Your Love*.

Medi-Cal funds 60% of births and enrollees have high smoking rates. In response, Medi-Cal used ACA funded incentives to encourage enrollees to use the Smokers’ Helpline and enroll in free cessation services.

Data on non-pregnant women ages 18-44 suggest that fewer than half discussed smoking or future pregnancy plans during their most recent health care visit. To standardize the content of the preconception well-woman visit, the PHCC developed provider screening guidelines.

A new law, AB 1301, will increase tobacco control efforts by enhancing enforcement and fees for retailers who sell tobacco products to minors.

c. Plan for the Coming Year

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

The PHCC will continue to provide information, tools and resources—including the preconception and interconception guidelines—to local communities focusing on the importance of achieving optimal health before pregnancy. Messages emphasize refraining from tobacco use and avoiding relapse triggers. The PHCC will collaborate with First Response to propose preconception health messaging in pregnancy test kits which will include guidance on smoking cessation.

CTCP will continue to support the Smokers' Helpline as well as other projects that facilitate community norm change and support local tobacco control efforts.

MCAH will continue efforts to prevent and reduce tobacco use by pregnant women and women of reproductive age. A stronger focus will be placed on efforts to prevent postpartum smoking relapse in conjunction with SIDS prevention efforts. Coordination with existing programs and initiatives, such as those developed statewide and locally via CTCP can also be explored.

MCAH will continue efforts to prevent and reduce tobacco use by pregnant women and women of reproductive age. Coordination with existing programs and initiatives, such as those developed nationally by the CDC and statewide and locally via CTCP can be explored. In the coming year a stronger focus will be placed on efforts to prevent postpartum smoking relapse in collaboration with SIDS prevention efforts. Additionally, opportunities exist—due to provisions of the ACA—to reduce tobacco use/exposure and the burden of health-related outcomes for the MCAH population: 1) implementation of the Health Exchange in 2014 and 2) the preventive services currently covered without cost-sharing include smoking cessation for adults, with expanded counseling for pregnant women.

MCAH is preparing to participate in the CoIIN (See SPM 5) to reduce infant mortality and improve birth outcomes. One of the state-identified priorities is increasing smoking cessation among pregnant women.

At the legislative level, MCAH will collaborate with CTCP to monitor their new local laws and ordinances database. MCAH will explore opportunities to examine smoking trends in relationship to changes in local legislation. Among the policies on the horizon is the statewide ban on tobacco products at all University of California campuses starting in 2014. In response to evidence that the age of smoking onset was increasing in California, this policy was proposed to both prevent smoking onset among people 18-24 and to prevent second-hand smoke exposure. Pending proposals include a system-wide smoking ban in the California State University System and Assembly Bill 746 to prohibit smoking inside all multiunit residences statewide.

Performance Measure 16

The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

Tracking Performance Measures

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	4.7	4.6	4.6	4.1	4.1
Annual Indicator	4.4	4.7	4.9	5.8	5.8
Numerator	134	144	150	163	
Denominator	3019105	3055826	3054421	2819402	
Data Source	CA Death Statistical Master File, 2008	CA Death Statistical Master File, 2009	CA Death Statistical Master File, 2010	CA Death Statistical Master File, 2011	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional
Year	2013	2014	2015	2016	2017
Annual Performance Objective	4.1	4.1	4.1	4.1	4.1

Field Level Notes

Section Number: Form11_Performance Measure #16

Field Name: PM16

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form11_Performance Measure #16

Field Name: PM16

Row Name:

Column Name:

Year: 2011

Field Note:

2011 California Death Statistical Master File (ICD-10 Group Cause of Death Codes 331-337). Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH Program.

Data reported for 2011 should not be compared to data reported in 2010 due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 5.3.

a. Last Year's Accomplishments

As of July 1, 2012, Medi-Cal related mental health functions were transferred from the Department of Mental Health (DMH) to the Department of Health Care Services (DHCS) as a result of 2011 legislation (AB 102). The former Office of Suicide Prevention (OSP) was established in 2008 by the DMH, and it is now the Department of Health Care Services Suicide Prevention Program (SPP). SPP will continue to serve as a statewide resource on suicide prevention to further the CA Strategic Plan on Suicide Prevention. In addition, Mental Health Services Act (MHSA) funding is dedicated to statewide suicide prevention programs which are currently being implemented by CalMHSA.

MCAH continues to work with programs in the local jurisdictions, including the CPSP, AFLP, and BIH programs, to identify and refer youth at risk for suicide to appropriate assessment and treatment. MCAH collaborates to maintain and improve appropriate linkages between other State departments to address systemic barriers and create pathways to service delivery. MCAH promotes provider screening, education, and referral to treatment and services for adolescence at risk of substance youth, domestic violence, depression, and stress and encourage LHJs to incorporate mental health and behavioral issues into LHJ activities as they work toward improving the health and well-being of adolescents. CIPPP provides regional summaries of data on the occurrence of self-harming behavior among youth, through data reports and the SafetyLit Weekly Update.

CIPPP provided LHJs, local school districts and parent teacher organizations with summaries of research on suicide and self-harm selected from journals of several fields (e.g., anthropology, behavioral sciences, civil engineering, criminology, medicine, nursing, social work, sociology) that were derived from the SafetyLit service. CIPPP continues to work with AAP-CA, the California Academy of Family Physicians, and members of the American Academy of Child and Adolescent Psychiatrists to provide similar summaries of recent scholarly research on the occurrence and prevention of child and adolescent self-harming behaviors. CAHC developed a tool for LHJs to use in assessing local community support for positive youth outcomes.

**TABLE 4A
NATIONAL PERFORMANCE MEASURES SUMMARY FROM THE ANNUAL
REPORT YEAR**

Major Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1). The Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University is a resource center on child and adolescent injury prevention, including youth suicide.				X
2.) AFLP case managers refer adolescent clients with suicide risk		X		

and other mental health problems to needed mental health services.				
3.) AFLP case management strategies include both youth development and risk reduction activities and services		X		
4.) MCAH works with the Adolescent Health Collaborative and other key partners to promote best practices in mental health and suicide prevention. This includes particular attention to the foster youth population.				X
5.) Local MCAH Programs work with local collaboratives to address Adolescent Health issues including youth development, drug abuse prevention and intervention, and mental health issues including suicide prevention.				X
6.) Local MCAH Programs screen clients for signs of depression.			X	
7.) The Department of Education authorizes school districts to use a portion of their Professional Development Block Grant funding to pay for suicide prevention training for school teachers				X
8.) The Department of Mental Health administers grants to local programs under the Mental Health Services Act (MHSA). Local programs provide direct services.	X	X	X	X

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

b. Current Activities

MCAH will continue to work with CAHC and others to promote best practices in mental health and to investigate best practices in suicide prevention, domestic violence, depression, and stress and encourage LHJs to incorporate mental health and behavioral issues into LHJ activities as they work toward improving the health and well-being of the MCAH population within their boundaries, such as develop additional strategies for evaluating suicide prevention interventions; establish mechanisms for state- and local-interagency collaboration to improve monitoring systems for suicide and suicidal behaviors. MCAH will continue to work with programs in the local jurisdictions, including the CPSP, AFLP, and BIH programs, to identify and refer adolescents at risk for suicide to appropriate assessment and treatment. MCAH will work to maintain and improve appropriate linkages between other State departments to address systemic barriers and create pathways to service delivery. MCAH will also continue to promote providers' screening, assessment, education, and referral to treatment and services for adolescent clients at risk of alcohol use, drug abuse. CIPPP provides regional updates of recently published research summaries on self-harm and, upon request, custom literature reviews using the SafetyLit service as a resource.

c. Plan for the Coming Year

CIPPP, through its existing funding, has been and will be quite actively working with LHJs and their

agency and NGO partners to provide research results on all issues concerning suicide and self-harm prevention, violence and bullying, domestic violence. The primary focus is best practices for prevention but the information also includes new drug risks and other related topics.

MCAH will promote partnership with DHCS SPP to provide suicide prevention technical assistance to counties and local organizations. MCAH will continue to work with CAHC and others to promote best practices in mental health and to investigate best practices in suicide prevention, domestic violence, depression, and stress and encourage LHJs to incorporate mental health and behavioral issues into LHJ activities as they work toward improving the health and well-being of the MCAH population within their boundaries.

Performance Measure 17

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	67.5	67.8	68.1	68.4	68.7
Annual Indicator	73.8	75.9	75.6	77.7	77.7
Numerator	4641	4618	4379	4437	
Denominator	6288	6083	5790	5714	
Data Source	CA Birth Statistical Master File 2008; CCS, 2008	CA Birth Statistical Master File 2009	CA Birth Statistical Master File, 2010; CCS-Approved NICU List 2010	CA Birth Statistical Master File, 2011; CCS-Approved NICU List 2011	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional
Year	2013	2014	2015	2016	2017
Annual Performance Objective	78.6	78.6	78.6	78.6	78.6

Field Level Notes

1. Section Number: Form11_Performance Measure #17

Field Name: PM17

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

2. Section Number: Form11_Performance Measure #17

Field Name: PM17

Row Name:

Column Name:

Year: 2011

Field Note:

Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File and California Children Services (CCS), Approved Hospitals for NICUs as of December 2011.

Tabulations by place of occurrence were done by the MCAH. Data exclude births with unknown birth weight or births weighing <227g or >8165g. MCAH included births at three birthing hospitals that share a hospital campus or building with a CCS-approved Children's Hospital that has an appropriate level NICU (i.e., the birthing hospital and children's hospital are administratively different hospitals, but are co-located in the same building or campus). Data for 2008-2011 should be not compared to data reported in previous years due to a change in exclusion criteria and methodology.

a. Last Year's Accomplishments

NPM 17, the percent of Very Low Birth Weight < 1500 grams (VLBW) infants delivered at facilities for high-risk deliveries and neonates, was 77.7 percent in 2011. This was an improvement from the 75.6 percent in 2010, but still far short of the Healthy People 2010 objective of 90 percent. There is some variation by race/ethnicity in the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates. In 2011, Pacific Islanders had the lowest percentages of these VLBW deliveries at NICU facilities at 66.7 percent. Asians had the highest percent (80.0), followed by African Americans (78.0), Hispanic (77.7), and Whites (74.8).

The California figures are based on data from hospitals designated by the CCS program as Regional, Community or Intermediate NICUs. For 2012, there were 130 CCS-approved NICUs in California; however, not all facilities providing care for VLBW infants seek certification by CCS. Fourteen RPPCs provide planning and coordination to ensure that all high-risk patients are matched with the appropriate level of care. The RPPCs develop communication networks on many perinatal topics, disseminate education materials including toolkits, assist hospitals with data collection for quality improvement, and provide hospital linkages to CPeTS.

MCAH has two data projects which monitor perinatal outcomes: IPODR (<http://www.cdph.ca.gov/data/indicators/Pages/InfantPerinatalOutcomesDataReport.aspx>) and the California Perinatal Profiles (<http://perinatalprofiles.berkeley.edu/>). The IPODR website includes an annual county profile report based on California Birth/Death Vital Statistics and Hospital Discharge Data aggregated at the zip code level. The California Perinatal Profiles website provides both public (state and regional) and confidential (hospital-specific) data to aid quality improvement in maternity hospitals in California.

Efforts continue to improve data collected from birth certificates. Since 2004, OVR has collaborated with MCAH working with RPPC leaders to plan and present a statewide series of birth data quality trainings. The interactive presentations include discussions of difficulties in data collection, and explanations of medical terminology including illnesses, complications and procedures of labor and delivery. Twelve recently developed fact sheets from the Birth Defects Monitoring Program have been included in the training packets. Awards for excellence and improvement in data collection have been presented to hospitals.

SCD collaborates with CPQCC to monitor outcomes of infants/children, 0-3 years of age in the HRIF Program. This monitoring capability, coupled with perinatal/neonatal CPQCC data elements, allows the assessment of infant outcomes in association with perinatal/neonatal care.

MCAH, in collaboration with CPQCC and CPeTS, continues to implement an electronic data system for tracking of neonatal transports and monitoring of outcomes. This web-

based perinatal transport data collection system helps to identify data elements to guide perinatal transport quality improvement.

RPPC, with OVR, provided eight trainings beginning in March 2011, emphasizing the importance of hospital administration, nurses, and birth clerks working collaboratively to accurately report birth data. MCAH is working with OVR to capture more complete information on complications/procedures of pregnancy and complications/procedures of labor and delivery on the birth certificate.

**Table 4a, National Performance Measures Summary Sheet
Pyramid Activities Level of Service**

Major Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) RPPCs provide regional planning and coordination and ensure that the needs of high-risk patients are matched with the appropriate level of care.				X
2) The CA Perinatal Transport System (CPeTS) assists in the referral of high-risk pregnant women and newborn infants by providing bed availability status for regional CCS-approved NICUs, updated daily, on the CPeTS website.		X		
3) RPPC and CPeTS assist hospitals with data collection and quality improvement activities.				X
4) MCAH shares information with the Emergency Preparedness Office (EPO) regarding Perinatal Disaster Preparedness.				X
5) CPQCC reports on the neonatal care of its NICU members, providing to CCS a useful and uniform reporting scheme for comparative assessment of hospitals on neonatal levels of care.				X
6.) The Improved Perinatal Outcome Data Reports (IPODR), which include county profiles, provide information for health planning, evaluation, and allocation decisions.				X
7.) MCAH and OVR collaborate to improve birth data quality by developing and convening a series of trainings with the assistance of RPPC regional leaders to improve the data quality of the California birth certificate.				X
8.) The California Perinatal Profiles website provides both				

public (state and regional) and confidential (hospital-specific) data to aid continuous quality improvement in maternity hospitals.				X
9.) RPPC regional cooperative transport agreements are based on the toolkit developed by RPPC and SCD, which includes policy development, outreach education, and review of outcomes data to assist hospitals with transfer/transport agreements.				X

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

b. Current Activities

RPPC and CPeTS continue matching high-risk patients with the appropriate level of care. RPPCs review birth outcomes data, Perinatal Profiles, and transport agreements with hospitals during site visits. As of FY 2012-2013 RPPC regions were consolidated to 9 regions plus regions for Northern and Southern Kaiser.

All CCS approved NICUs are required to submit data annually, and CPQCC continues to analyze NICU data. There were 130 CPQCC member hospitals in 2012. The 2011 CPQCC dataset included 9,918 “Big Babies” (>1500 grams), 7,009 “Small Babies” (<1500 gram), and 6,750 acute transports. CPeTS maintains a web-based bed availability list where maternity hospitals can obtain information 24 hours a day, 7 days a week for assistance in the transfer coordination of high-risk infant or maternity patients. CPeTS also provides the collection and analysis of perinatal and neonatal transport data for regional planning, outreach program development, and outcome analysis. This information is utilized by RPPC and is reported back to the participating hospitals and to MCAH.

c. Plan for the Coming Year

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

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

Performance Measure 18

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	86.9	87.1	87.3	86.8	86.8
Annual Indicator	82.4	82.9	83.5	83.5	83.5
Numerator	445108	428449	416759	410,213	
Denominator	539978	516879	499218	491,034	
Data Source	CA Birth Statistical Master File, 2008	CA Birth Statistical Master File, 2009	CA Birth Statistical Master File, 2010	CA Birth Statistical Master File, 2011	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
Year	2013	2014	2015	2016	2017
Annual Performance Objective	86.8	86.8	86.8	86.8	86.8

Field Level Notes

Section Number: Form11_Performance Measure #18

Field Name: PM18

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form11_Performance Measure #18

Field Name: PM18

Row Name:

Column Name:

Year: 2011

Field Note:

Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program.

Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

a. Last Year's Accomplishments

The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester is 83.5 percent in 2010 and 2011. Asians and Whites met the statewide annual objective for 2011 at 87.4 percent and 87.5 percent, respectively. Asians were

more likely to receive prenatal care in the first trimester than women who were White, Hispanic (81.1 percent), African American (78.1 percent), American Indian (71.4 Percent) or Pacific Islander (69.4 percent).

CPSP, AFLP, BIH, WIC, AIIHI and local MCAH continued to provide case management services and linkages to medical care for their target populations. CPSP provides perinatal support services to approximately 165,000 women a year. Approximately 1500 providers receive a higher reimbursement rate for offering additional health education, nutrition, and psychosocial support services.

PHCC’s EveryWomanCalifornia website provides information to consumers about the importance of being healthy before pregnancy. It also focuses on the importance of planning for pregnancy and emphasizes early entry to prenatal care. In October 2011, PHCC released the **MOD/ACOG** Interconception Care Project of California Guidelines to help clinicians provide information and counseling to clients about healthy behaviors between pregnancies, including optimal pregnancy spacing and the importance of early access to prenatal care, especially for high risk women with chronic medical conditions.

MCAH provides ethnically diverse staff for recruiting clients into care, and LHJs employ a variety of methods to target diverse populations. LHJs provide local toll free lines for residents to obtain referrals to low cost health insurance and prenatal care. In addition, each jurisdiction delivers outreach in ways tailored to its population’s needs.

About 40 percent of all births in California are unintended. [34] The Family PACT Program provides no-cost family planning services to all California residents with incomes at or below 200 percent FPL. Such services contribute indirectly to timely prenatal care, since women with planned pregnancies seek care earlier.

The AIM program administered by MRMIB provided low-cost coverage for over 7000 pregnant women with incomes from 201-300% FPL.

In spite of efforts to increase first trimester prenatal care, the following obstacles remain: delays due to lack of awareness of Medi-Cal Presumptive Eligibility Program, delays due to the Medi-Cal enrollment process, economic downturn leading to more uninsured reproductive age women and high rates of unintended pregnancy.

**Table 4a, National Performance Measures Summary Sheet
Pyramid Activities Level of Service**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CPSP provides Medi-Cal eligible women with prenatal care, health education, nutrition and psychosocial support services.	X	X	X	X

2. BIH identifies pregnant and parenting African American women who are at risk for poor birth outcomes and provides them assistance in accessing and maintaining health care and other support services.		X	X	X
3. AFLP provides case management services to pregnant adolescents at risk for poor birth outcomes. AFLP is increasing capacity of current services by promoting Positive Youth Development (PYD) through reproductive life planning.		X	X	
4. AIIHI serves prenatal and parenting AI women with direct health care services and case management services.	X	X		
5. MCAH works to provide ethnically diverse staff for recruiting clients into care, and LHJs employ a variety of methods to target diverse populations.		X	X	X
6. The Family PACT Program provides no-cost family planning services to low-income residents; these services help to reduce the rate of unintended pregnancy, and contribute indirectly to increased utilization of prenatal care.	X			X
7. The PHCC plays a pivotal role in relaying the message of the importance of intended pregnancy, pregnancy spacing and preconception care to local communities.			X	X
8. The AIM program provides low-cost health coverage to pregnant women without adequate health insurance and whose income is too high for no-cost Medi-Cal.		X		

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each Performance Measure.

b. Current Activities

CPSP continues to provide comprehensive perinatal services, including routine obstetric care, nutrition, health education, and psychosocial services to its clients. MCAH is working collaboratively with MCMC to ensure that CPSP is offered to enrolled pregnant women. Family PACT continues to make available no-cost family planning services to all California residents with incomes at or below 200 percent of the FPL. The AIM program continues to make available low-cost health coverage to pregnant women with inadequate coverage and whose incomes are too high for Medi-Cal.

AFLP is increasing capacity of current services by promoting Positive Youth Development (PYD) through reproductive life planning.

BIH, which targets at-risk African American pregnant and parenting women, is implementing the new group intervention model. Both AFLP and BIH continue to encourage and assist clients to receive early PNC.

CPSP continues to expand provider trainings to include a web-based provider overview training and is working on collecting local data on CPSP billing patterns to evaluate CPSP programs in LHJs. CPSP provides incentive payments for early prenatal care.

LHJs continue outreach to pregnant women and assist with referrals and enrollment in Medi-Cal and other health plans.

c. Plan for the Coming Year

MCAH will continue to work with LHJs to improve outreach to women of childbearing age and pregnant women, provide appropriate linkages , and streamline processes for Presumptive Eligibility to increase access to early prenatal care for pregnant women .

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

Local CPSP coordinators will continue provider recruitment. Coordinators will strengthen utilization of the CPSP scope of benefits by training providers in documentation, program services, development of materials and evaluative reports on the efficacy of services. MCAH and LHJs undertake these activities to ensure the availability and effectiveness of CPSP services, even in this era of budget constraints, and to achieve improvements in first trimester entry into prenatal care. MCAH is working to consolidate data on beneficiaries, paid claims, birth outcomes, and hospital discharge to develop baseline data on the efficacy of CPSP services. MCAH will continue to work closely with MCMC to facilitate enrollment of Medi-Cal-eligible pregnant women into CPSP and promote early access to prenatal care.

AFLP will continue to implement the Positive Youth Development component into existing services.

BIH will continue to implement the new group intervention, as well as complementary case management, in order to improve the health and social conditions for African-American women and their families.

D. State Performance Measures

State Performance Measure 1

The percent of children birth to 21 years enrolled in the CCS program who have all their health care provided by and coordinated by one health care system.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				0	30
Annual Indicator			0	0	
Numerator			0	0	
Denominator			1	1	
Data Source					
Is the Data Provisional or Final?				Final	Provisional
Year	2013	2014	2015	2016	2017
Annual Performance Objective	40	40	40	40	40

Comment [LR4]: Update the information reported by SCD in TVIS

Field Level Notes:

Section Number: Form11_State Performance Measure #1

Field Name: SM1

Row Name:

Column Name:

Year: 2010

Field Note:

This measure is the percent of children birth to 21 years enrolled in the CCS program who have all their health care provided by and coordinated by one health care system. This is a new measure from the 2010 Needs Assessment. The 1115 Federal Waiver CCS Pilot Programs will begin January 2012 so there will be no data for this measure until 2013 for calendar year 2012.

The numerator is the number of children birth to 21 years enrolled in the CCS program who are also enrolled in a specified pilot program. The denominator is the number of children birth to 21 years enrolled in the CCS program with open cases.

Comment [LR5]: Update the information reported by SCD in TVIS

a. Last Year's Accomplishments

Bridge to Reform waiver planning continued. Five demonstration project sites were selected with 4 different models of care through which CCS children will have all their care needs met through a single coordinated health system. The models are 1. Utilization of MCMC Plans, Specialty Health Care Plan (SHCP), Enhanced Primary Care Case Management (EPCCM), Provider-based Accountable Care Organization (ACO). These innovative models have projected phase in start dates anticipated for late 2012 through 2013.

**Table 4b, State Performance Measures Summary Sheet
Pyramid Activities Level of Service**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Convened Stakeholder Group to help determine components of Pilot Program				X

Models				
2. Draft RFP to request Pilot Program Proposals				X
3. Select Pilot Programs				X
4. Implement Pilot Programs	X			
5. Monitor and Evaluate Pilot Programs	X			

b. Current Activities

The initial 1115 Waiver Model, Medi-Cal Managed Care began April 1, 2013 in San Mateo County. Rate analysis by Mercer (Actuary) was completed.

c. Plan for the coming year

The 1115 Evaluation Oversight Committee will include a “dashboard” for rapid determination of any areas which require more attention, and extensive family/providers satisfaction to access, integration of care, and identify barriers to reform. A family satisfaction survey is being developed for pilot counties and will be expanded to non-pilot counties.

Existing coordinated systems in CA include Kaiser and UC. With Kaiser, CCS has recently approved 2 tertiary care centers within the Kaiser system, but there is no data at this time on the CCS population served. Within the University of California system, there are varying levels of integration of care. CCS will be developing systems to collect this data within the next year.

State Performance Measure 3

The percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective					
Annual Indicator			0	0	0
Numerator			0		
Denominator			1		
Data Source			Online Survey and CCS County Programs		
Is the Data Provisional or Final?			Final	Provisional	
Year	2013	2014	2015	2016	2017
Annual Performance Objective	50	55	55	55	55

Comment [LR6]: Update the information reported by SCD in TVIS

Section Number: Form11_State Performance Measure #3

Field Name: SM3

Row Name:

Column Name:

Year: 2012

Field Note: Survey is currently being developed for children and families in the 1115 waiver by the UCLA Center for Health Policy Research. The CCS Pilot Evaluation Planning Committee, consisting of State and County CCS staff and family representatives, and the CCS Pilot Projects Stakeholder group, provide input into the survey. It is expected that survey will be expanded to representative sample of families with CCS eligible children who do not reside in county participating in 1115 waiver.

Section Number: Form11_State Performance Measure #3

Field Name: SM3

Row Name:

Column Name:

Year: 2011

Field Note: Survey is currently being developed for children and families in the 1115 waiver by the UCLA Center for Health Policy Research. The CCS Pilot Evaluation Planning Committee, consisting of State and County CCS staff and family representatives, and the CCS Pilot Projects Stakeholder group, provide input into the survey.

Section Number: Form11_State Performance Measure #3

Field Name: SM3

Row Name:

Column Name:

Year: 2010

Field Note:

This measure is the percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey. This is a new measure from the 2010 Needs Assessment. No data will be available until 2013

The numerator is the number of families randomly selected by region who complete a satisfaction survey. The denominator is the number of families randomly selected by region to complete a satisfaction survey.

The Title V 2010 Needs Assessment CCS stakeholder group identified several priority objectives whereby successful implementation can be assessed through a family satisfaction survey. These include: define and implement medical homes; increase family partnership in decision making and satisfaction with services; link families to information and

support; and conduct regular assessments of the level of parent/patient satisfaction as part of CCS outcomes. The CCS program cannot directly measure whether children enrolled in CCS are receiving their primary care in a medical home. However, through a family satisfaction survey, CCS can attempt to assess through specific questions whether children are receiving care in a medical home. This measure also allows the CCS program to evaluate family satisfaction as changes are made to the CCS program over the next 5 years.

a. Last Year's Accomplishments

SPM 03 is the percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey. The Pilot evaluation group has been meeting bimonthly to discuss development of an appropriate survey for the CCS Pilots.

**Table 4b, State Performance Measures Summary Sheet
Pyramid Activities Level of Service**

Major Activities	Pyramid Level of Service			
	DH C	ES	PBS	IB
Expand potential base of surveys (from 1115 Waiver’s CCS Pilot Projects) including with evaluations to assess satisfaction of families enrolled and not enrolled				X
Work with 1115 Waiver CCS Stakeholder Group to develop family survey				X
Utilize translation services to translate surveys into most frequently used languages for the region.				X
Work with Regional Office Staff and local programs to administer the surveys				X

b. Current Activities

Developing a plan to utilize 1115 Waiver’s CCS Pilot Projects’ Evaluation Oversight Group and their work on a family survey to administer to CCS families enrolled and not enrolled in the Pilot Projects. Some of the clients not enrolled will be selected to be part of the control population. This method will result in not duplicating work already planned for the coming years.

c. Plan for the Coming Year

- 1) Expand potential base of surveys (from 1115 Waiver’s CCS Pilot Projects) including with evaluations to assess satisfaction of families enrolled and not enrolled.
- 2) Utilize translation services to translate surveys into most frequently used languages for the region
- 3) Work with Regional Office Staff and local programs to administer the surveys.

State Performance Measure 4

Percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				12.7	
Annual Indicator	n/a	13.4	15.0	15.0	
Numerator		68828	74243		
Denominator		513143	421738		
Data Source		MIHA, 2009	MIHA, 2010		
Is the Data Provisional or Final?			Final	Provisional	
Year	2013	2014	2015	2016	2017
Annual Performance Objective	12.7	12.7	12.7	12.7	12.7

Comment [LR7]: Will need to be updated once MIHA 2011 becomes available

Field Level Notes

Section Number: Form11_State Performance Measure #4

Field Name: SM4

Row Name:

Column Name:

Year: 2011

Field Note:

A manual indicator is reported for 2011 based on 2010.

Section Number: Form11_State Performance Measure #4

Field Name: SM4

Row Name:

Column Name:

Year: 2010

Field Note:

Source: 2010 MIHA Assessment survey, MCAH Program, California Department of Public Health. Numerator: The number of women who reported that they had 4 or more drinks in one sitting at least once during the 3 months before they got pregnant with their most recent live-born infant. Denominator: The number of women who reported whether or not they had 4 or more drinks in one sitting at least once during the 3 months before they got pregnant with their most recent live-born infant plus the number of such women who reported drinking no alcoholic drinks in the past 2 years.

Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth in 2010.

a. Last Year's Accomplishments

SPM 04 is the percent of women with a recent live birth that reported binge drinking during the three months prior to pregnancy. In 2011, X percent of mothers with a recent live birth reported binge drinking during the three months prior to pregnancy, a/n descriptor from 15% in 2010. This rate differed by racial and ethnic group. White women (X%) were most likely to binge drink during the three months prior to pregnancy, followed by Hispanic (X%), Asian/Pacific Islander (X%) and Black women (X%). An estimated 4,460 to 6,050 babies with FASD are born each year in California.

Comment [FG8]: It is appears that my revisions were accepted without any modification however I drafted this section with placeholders for Epi to include the required data. I need to revisit the section to ensure the text is appropriate once the data have been added.

FASD describes the range of effects in individuals whose mothers used alcohol during pregnancy, including physical, cognitive, behavioral and learning difficulties with lifelong implications.

MCAH promotes preconception health, of which alcohol use prevention in women of reproductive age is a key feature. MCAH participates in PHCC, providing information, tools and resources for communities on the importance of optimal health for women before pregnancy. PHCC developed educational materials informing women of the risk of unintended pregnancy associated with alcohol use. The PHCC website has valuable information on perinatal substance use prevention.

PHCC continued to monitor its website, designed for mixed use by consumers and health professionals. The website connects people working in preconception health and features links to tools and resources related to alcohol use prevention for men, women and teenagers. In evaluating the messaging, focus group testing suggested that the idea of abstaining from alcohol during your reproductive years because of the risk of prenatal alcohol exposure was viewed as too conservative by many men and women. As such, the PHCC revised its EVERYDAY mnemonic recommendation from “Avoid tobacco, drugs and risky drinking” to “Avoid tobacco, alcohol and drugs. Or, use birth control until you can.” This message was consistent with our harm reduction philosophy of behavioral intervention.

MCAH participates in the FASD Task Force comprised of state/local agency representatives. An FASD Task Force website has been developed to complement its work on increasing legislators’ awareness of FASD. The FASD Task Force continues to work on bringing more prominence to the annual celebration of FASD Awareness Day in September. It partnered with DSS to produce an educational brochure on alcohol use prevention targeted to youth.

**Table 4b, State Performance Measures Summary Sheet
Pyramid Activities Level of Service**

	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Community-based prevention and support programs, including AFLP, BIH, CPSP and CDAPP, educate clients about the dangers of alcohol use during pregnancy and refer high-risk women for alcohol treatment services.		X		
2. MCAH participates in the statewide FASD Task Force and the SIT ADP Workgroup.				X
3. LHJs conduct prenatal substance use screening programs, with several using the 4-Ps Plus model.				X
4. Santa Cruz County Public Health nurses provide home-based		X		

support, education, and professional assistance for families with premature and/or substance exposed babies, or mothers with mental health issues.				
5. PHCC continues to augment and monitor its website which connects people working in preconception health and features links to tools and resources related to alcohol use prevention among women of reproductive age.				X
6. Alameda County continues to implement the Pediatric System of Care Strategic Plan to improve care of substance-exposed children at risk for social/emotional, developmental, behavioral, psychological and physical problems.				X

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

b. Current Activities

MCAH works to improve birth outcomes for women at risk for alcohol abuse through screening and referral for treatment services. Community-based prevention programs such as AFLP, BIH and CPSP identify at-risk mothers and refer them for treatment services.

LHJs continue to develop and strengthen coalitions with public/private agencies and providers to assess women at risk and develop appropriate referrals to resources including the statewide FASD Taskforce. Many are working to develop coordinated and integrated systems of care to address issues of perinatal substance use.

The CA Preconception Peer Educators (PPE) Program is a local implementation of the Federal Office of Minority Health Program. PPE teaches college students about preconception health risks and trains them to become campus and community ambassadors. Given the popularity of binge drinking among teenagers and college students, a key focus of PPE is alcohol. The PPE curriculum links high-risk drinking to risks relevant to women who are not actively planning a pregnancy including sexual assault, domestic violence, trauma, homicide, criminal prosecution, unintended pregnancy, risk taking behavior as well as traditional focus on FASD. The PPE program collaborated with the CDC Preconception Health *Show Your Love* campaign, which has separate targeted alcohol-related messages about abstinence for those planning a pregnancy and avoiding binge drinking and using contraception for those not planning a pregnancy.

c. Plan for the Coming Year

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

Minority Health established an Advisory Board to Preconception Peer Educators at California Community Colleges and Universities will partner with LHJs and local organizations to plan campus and community outreach campaigns and events to promote harm reduction strategies to reduce preconception alcohol exposure and prenatal alcohol exposure.

Combining data from the CDC Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Survey, the CDC published Vital Signs: Binge Drinking Among Women and High School Girls, 2011. MCAH is examining the results and recommendations for community preventive services and considering activities within the MCAH purview to reduce binge drinking including consistent screening and brief interventions in the clinical setting. California has unique alcohol consumption patterns because of the popularity of locally produced wine. MCAH will continue to explore ways to partner with local distributors to reduce heavy consumption patterns and prevent illegal consumption by minors. Among the strategies will be to engage the newly acquired TPPs, I&E and CA PREP, and strengthen their ability to include substance abuse prevention as a teen pregnancy prevention strategy. MCAH will also publish a MCAH bulletin highlighting the recent developments in preconception alcohol research and data trends, while highlighting best-practice strategies among local programs.

State Performance Measure 5

Percent of cesarean births among low risk women giving birth for the first time.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				25.1	25.1
Annual Indicator	26.3	26.6	26.1	26.3	26.3
Numerator	43021	42603	40713	40777	
Denominator	163355	160307	156112	155169	
Data Source	BSMF, 2008	BSMF, 2009	BSMF, 2010	BSMF, 2011	
Is the Data Provisional or Final?				Final	Provisional
Year	2013	2014	2015	2016	2017
Annual Performance Objective	25.1	25.1	25.1	25.1	25.1

Field Level Notes

Section Number: Form11_State Performance Measure #5

Field Name: SM5

Row Name:

Column Name:

Year: 2012

Field Note: A manual indicator is reported for 2012 based on 2011.

Section Number: Form11_State Performance Measure #5

Field Name: SM5

Row Name:

Column Name:

Year: 2011

Field Note:

Source: 2011 Birth Statistical Master File, MCAH Program, California Department of Public Health. Numerator: The number of births delivered by cesarean section to low-risk women giving birth for the first time. Denominator: The number of live births to low-risk women giving birth for the first time. The numerator and denominator represent live births that occurred in California in 2011. Starting in 2010, births with gestational age greater than 37 weeks were excluded from the analysis. This new exclusion did not affect rates from prior years (2007-2009).

Low-risk is defined as full-term (i.e., greater than or equal to 37 weeks gestation), singleton pregnancy, with vertex fetal presentation (head down in the uterus).

1) Last Year's Accomplishments

The increase in cesarean delivery may be associated with rising rates of pre-existing maternal morbidities such as obesity, as well as rising rates of labor induction and augmentation. In 2011, C-section births among low risk women giving birth for the first time were at 26.3%. Some have suggested that as the perceived safety of cesarean delivery increases, physicians and patients no longer view it as a last resort in the case of emergencies. This shifting view may lead more obstetricians to recommend C-sections earlier in labor than they used to or more women to request C-sections as their preferred delivery method. To explore the multifaceted contributors to maternal morbidity and develop valid indicators to provide surveillance for maternal health statewide, MCAH funded the MQI with UCLA. MCAH also funded CMQCC to improve California maternity care through data driven quality improvement efforts. Results from the MQI

trend analysis on cesarean delivery suggest that significant rise in cesarean deliveries between 1999 and 2005. Of note, this rise in cesarean deliveries also corresponded to a rise in maternal morbidity due to infection and a rise in maternal mortality overall. During 2009, among low-risk patients that delivered between <37 and <39 weeks gestational age, the statewide rate of elective delivery was 34.5%, the majority of which resulted in cesarean delivery (the elective induction rate was 6.1%). MQI trended and composed a manuscript describing the level of medical indication associated with induction and preterm delivery; this knowledge is central to standardizing medical interventions that may reduce cesarean delivery. CMQCC also published a “white paper” on cesarean deliveries that outlined marked regional variation in surgical deliveries independent of population demographics, suggesting differences in obstetrical practices by region.

As a result of surveillance efforts, CMQCC developed and disseminated a toolkit to reduce non-medically indicated labor induction and cesarean section prior to 39 weeks gestational age. MCAH has also collaborated with MOD to publish and disseminate the toolkit throughout the state. The toolkit provides guidelines to hospitals and materials for patient education.

MCAH also funded a Local Assistance for Maternal Health project in San Bernardino to reduce non-medically indicated induction of labor by educating the community about labor induction and promoting best practices among clinicians and providers. Their efforts included labor induction guidelines and recommendations for local area hospitals to follow when scheduling labor inductions; patient consent document to inform patients of options; and, an Advisory Council comprised of public and private organizations. Fourteen hospitals in San Bernardino participate in the project and are regularly involved in webinars and data sharing.

MQI and CMQCC provided expertise and support for development of new obstetrical measures for the National Quality Forum which were then incorporated by the Joint Commission.

**Table 4b, State Performance Measures Summary Sheet
Pyramid Activities Level of Service**

Major Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1).Disseminate and assess impact of state toolkit: “Elimination of Non-Medically Indicated Induction of Labor before 39 Weeks Gestation”		X		
2.) Support Local Assistance for Maternal Health to implement toolkit strategies at hospitals at the local level	X			
3.) Support Local Assistance for Maternal Health to promote patient education regarding the value of waiting until 39 weeks to deliver			X	

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

2) Current Activities

L.A. County is conducting a county-wide campaign to reduce cesarean deliveries. CMQCC is addressing maternity care and birth data quality issues with RRPC. CMQCC will be releasing a toolkit to improve the healthcare response to preeclampsia.

The CMQCC is developing a data center to provide timely information on elective deliveries and induction among high and low risk patients.

MCAH accepted the Association of State and Territorial Health Organizations/March of Dimes Preterm Birth Challenge.

San Bernardino County LAMH outcome data are being analyzed and reported. Preliminary findings in a collaborative paper with MQI suggest that the San Bernardino LAMH quality improvement data collection and reporting project had advantages for monitoring elective delivery as compared with using hospital discharge and electronic medical record data. Because the data collection strategy was implemented in concert with departmental policies and community education, it impacted practice patterns substantially. However, because the effort was locally controlled it was vulnerable to priority shifts with changes in leadership and withdrawal of limited funding.

The PHCC and MCAH Preconception Health and Nutrition and Physical Activity Initiatives conducted activities to ensure women are entering pregnancy with fewer risks that may increase the likelihood of cesarean delivery.(See Major State Initiatives).

3) Plan for the Coming Year

MQI and MCAH will publish a maternal health report to increase our understanding of maternal morbidity in California. Among the components of the report will be an exploratory analysis of the relationship between rising prevalence of cesarean delivery and maternal morbidity. This will involve estimating the contribution of pre-existing (preconception), pregnancy-related, and obstetric maternal morbidity to Nulliparous, Term, Singleton, and Vortex (NTSV) cesarean deliveries and to also estimate the contribution of NTSV cesarean delivery to postpartum maternal readmission rates, postpartum morbidity, and the severity of morbidity. Efforts will also be made to explore cumulative cesarean-related morbidity risk as parity increases. MQI will also continue to develop a composite maternal and infant health indicator and begin exploring the public payer (Medi-Cal) associated costs of morbidity using data from 2007-2010.

The LAMH project funding ended in June 2012; however CMQCC and MQI have begun efforts to address topics of interest from that project including improving quality of care measures to address increasing maternal morbidity and a rising trend in rates of cesarean birth.

CMQCC will continue to provide technical assistance to local and regional maternal health efforts related to cesarean delivery.

MCAH is preparing to participate in the Collaborative Improvement and Innovative Network (CoIIN) developed in partnership with ASHTO, AMCHP, March of Dimes, CityMatCH, SCD, and CDC initiated in March 2012 as a mechanism to support the adoption of collaborative learning and quality improvement principles and practices to reduce infant mortality and improve birth outcomes. One of the state-identified priorities is reducing elective deliveries <39 weeks.

State Performance Measure 6

Percent of women of reproductive age who are obese.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective					
Annual Indicator	21.6	21.8	20.9	21.3	21.3
Numerator	1290393	1299520	1205673	1316522	
Denominator	5987671	5954750	5764922	6181065	
Data Source		BRFS, 2009	BRFS, 2010	BRFS, 2011	
Is the Data Provisional or Final?		Final	Final	Final	Provisional
Year	2013	2014	2015	2016	2017
Annual Performance Objective	21.7	21.7	21.7	21.7	21.7

Field Level Notes

Section Number: Form11_State Performance Measure #6

Field Name: SM6

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form11_State Performance Measure #6

Field Name: SM6

Row Name:

Column Name:

Year: 2011

Field Note:

Source: 2011 California Behavioral Risk Factor Survey (BRFS), California Department of Public Health. Numerator: The number of women aged 18-44 years who have a body mass index (BMI) greater than or equal to 30 kilograms body weight / body surface area in square meters (kg/m^2). Denominator: The number of women aged 18-44 years for whom BMI can be calculated. Results are weighted using 2010 population estimates from the California Department of Finance and exclude women who reported being pregnant at the time of the survey, and women with height < 48 in. or ≥ 84 in., weight < 75 lbs. or > 399 lbs. or those for whom BMI cannot be calculated (i.e. missing height and/or weight information). Data for 2010 and 2011 should not be compared to data reported in previous years due to a change in conversion factor for weight in kilograms used to compute BMI. Obesity rates for prior years using the new conversion factor: 2008 =20.9; 2009 =19.7. Data for 2011 should not be compared to data reported in previous years (including 2010) as 2011 data are weighted using 2010 population estimates and previous years are weighted using 2000 population estimates.

Last Year's Accomplishments

Between 2000 and 2010 there was a 27% increase in obesity among women of reproductive age. In 2011, the prevalence of obesity in this population was 21.3%. Black (32.8%) and Hispanic (26.7%) women were more likely to be obese than white (18.4%) women.

To reduce the burden of obesity among women of reproductive age, MCAH promoted obesity reduction and healthy strategies to achieve optimal preconception weight, prenatal weight gain, and breastfeeding.

The PHCC, in coordination with ACOG District IX and MOD, published provider guidelines for the postpartum visit, entitled the Interconception Care Project of California (ICPC). The guidelines included weight management for women with gestational diabetes and patient handouts in English and Spanish. ICPC was publicized heavily in California and resources have been downloaded 4900 times by healthcare professionals within the state and nationwide.

The PHCC began work on provider guidelines for well-woman visits, a required benefit of the ACA, which features counseling strategies for overweight or obese women.

MCAH had previously developed a preconception health social marketing campaign using First Time Motherhood (FTM) grant funds, which targeted MCAH populations at risk of obesity. The Latina component featured radio PSAs and web resources in Spanish; while folic acid promotion was the main focus, healthy eating, weight and physical activity materials for Spanish-speaking consumers were included. The Black and youth components featured nutrition, physical activity and weight as a key part of overall health; messages were disseminated through text messages and websites. Although campaign funds ended in 2011, web materials and PSAs continued to be made available; additional funds were secured to continue the text messages for young women.

In June 2012, the statewide Every Woman California (EWC) preconception health website, located at www.everywomancalifornia.org, was redesigned to be more user-friendly. It continued to emphasize the importance of healthy weight for women of reproductive age. The FTM resources for Black, Hispanic and young women were more prominently displayed on the redesigned site; however, tailored URLs were maintained.

EWC materials featuring healthy weight tips in English and Spanish were designed, printed and distributed to providers and women of reproductive age.

MCAH researched and identified potential nutrition, physical activity and breastfeeding benchmarks for the California Home Visiting Program (CHVP). MCAH finalized new information on model nutrition, physical activity, and breastfeeding to publish the MyPlate for Moms/My Nutrition Plan for Moms, Adolescent Nutrition and Physical Activity Guidelines for AFLP, CDAPP Guidelines for Care, and the CPSP Steps to Take Guidelines. The 24-hour dietary recall form was updated to complement the new MyPlate materials. BIH and local MCAH LHJs used the resources to prioritize optimal nutrition and physical activity.

To support and train CDAPP Sweet Success Affiliates, the CDAPP Sweet Success Resource and Training Center provided webinars on diabetes and pregnancy, e.g., on nutrition, eating for the holidays and exercise.

Along with leaders in the San Joaquin Valley, MCAH began planning/preparing content for a Preconception Peer Educator (PPE) training in the San Joaquin Valley to teach post-secondary students about preconception health, including healthy weight.

MCAH provided input for the CDC preconception health campaign, Show Your Love, which emphasizes the importance of healthy weight before pregnancy.

MCAH and CDC staff completed a manuscript assessing the contribution of pre-pregnancy overweight/obesity to gestational diabetes among California women giving birth in 2007-2009.

MCAH continued to monitor pre-pregnant weight status and pregnancy weight gain utilizing birth certificate and MIHA Survey data, and considers obesity in risk factor analyses for the Pregnancy-Associated Mortality Review.

MCAH continued to integrate obesity prevention into CDPH programs through OPG, developed a web page entitled “Healthy Weight Among Women of Reproductive Age” and collaborated with FHOP to develop and present a webinar and fact sheet on healthy weight. MCAH participated in several more nutrition/obesity collaboratives (see NPM 14).

**Table 4a, National Performance Measures Summary Sheet
Pyramid Activities Level of Service**

Major Activities	Pyramid Level of Service			
	DH C	ES	PBS	IB
1.) MCAH develops and/or provides nutrition education materials and initiatives, nutrition assessment materials, technical assistance and consultation, and funding opportunities to MCAH programs and colleagues.				x
2.) BIH, AFLP, CDAPP and CPSP promote optimal weight gain in pregnancy, breastfeeding, and glycemic control as an effort to reduce the risk of obesity.		X		
3.) MCAH partners with other state programs and agencies to dialogue with advocates, experts and local MCAH directors to prevent obesity.				x
4.) BIH, AFLP, CDAPP and CPSP promote physical activity and proper nutrition by encouraging healthy eating through discussions on how to cut fat, lower calories and move more.		X		
5.) MCAH Offered MCAH LHJs a “Here is Where Healthy Starts” award for policies/programs in place to support good nutrition, physical activity, safety and breastfeeding.				x
6.) MCAH and SCD collaborate with the California Obesity				

Prevention Program (COPP) the California Nutrition Network for Healthy, Active Families to promote healthy eating and a physically active lifestyle among low income Californians.				X
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NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

b. Current Activities

MCAH collaborated with programs, experts and LHJs to promote healthy weight in reproductive-aged women.

MCAH and the PHCC shared the CDC Show Your Love campaign, which launched on Valentine’s Day; resources featured healthy weight messages for women who are planning a pregnancy in the next two years and those who are not. In partnership with the campaign, the PHCC posts about healthy weight using social media.

MCAH and leaders in the San Joaquin Valley trained PPEs who may now train their peers and community members. Knowledge about pre-pregnancy weight was high initially, but overall knowledge improved.

Preconception guidelines for providers were finalized and published on EWC.

To address the need for gestational diabetes resources in Asian languages, the ICPC gestational diabetes handout was translated into Vietnamese and posted online. It contains healthy weight tips to help prevent type 2 diabetes and reduce risks in a subsequent pregnancy.

Many women of reproductive age live in environments not supportive of healthy weight, so MCAH developed a toolkit and webinar to help LHJs address this need.

Adolescent cookbooks were printed in English and Spanish and distributed to adolescent programs to encourage healthy eating and physical activity.

To address pregnancy weight gain, grids for twin pregnancies were developed. MyPlate for Gestational Diabetes was created in English and Spanish; it includes a food guide and goal setting tips. To learn more, see NPM 14.

c. Plan for the Coming Year

MCAH will continue to collaborate with state programs and agencies, experts and local MCAH directors to reduce overweight and obesity among women of childbearing age.

MCAH is updating CDAPP, CPSP, BIH, and AFLP nutrition and physical activity guidelines. MCAH programs will continue to prioritize optimal nutrition and physical activity as important interventions to reduce obesity in women of childbearing age.

MCAH programs will offer counseling, such as guidance on dietary intake and physical activity, which is tailored to client circumstances/stage of change.

MCAH will investigate leveraging existing campaigns to include preconception messaging, such as the 50 million pound challenge (sponsored by State Farm) and the President's Council on Physical Fitness. Also, MCAH will investigate building linkages with existing nutrition resources, such as Food Day 2013, community garden programs, farmer's markets and diet support programs. Feasibility of new campaigns, such as a "Biggest Loser" spin-off geared toward women of reproductive age with incentives and rewards coming from community and corporate partners with a vested interest in promoting weight loss will be considered. MCAH will also consider expanding partnerships with organizations such as UC Davis.

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

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

MCAH will help to maximize use by women of Affordable Care Act provisions for well-woman care and obesity screening/counseling for all adults. MCAH will publicize resources that support healthy weight to healthcare providers and public health professionals and encourage their use during well-woman and prenatal care.

MCAH will explore new media strategies to popularize preconception health to a younger and more technologically-advanced audience. MCAH plans to revitalize the FTM text messages to more effectively engage young adults and will explore the development of mobile applications or adaptation/use of the GABBY™ interactive system that provides personalized electronic preconception health education and follow-up.

State Performance Measure 7

The percent of women whose live birth occurred less than 24 months after a prior birth.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				11.7	11.7
Annual Indicator	13.2	12.9	12.3	12.3	12.3
Numerator	71683	66674	61798	56424	
Denominator	542684	518167	501837	459010	
Data Source	CA Birth Statistical Master File 2008	CA Birth Statistical Master File, 2009	CA Birth Statistical Master File, 2010	CA Birth Statistical Master File, 2011	
Is the Data Provisional or Final?			Final	Final	Provisional
Year	2013	2014	2015	2016	2017
Annual Performance Objective	11.7	11.7	11.7	11.7	11.7

Field Level Notes

Section Number: Form11_State Performance Measure #7

Field Name: SPM7

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form11_State Performance Measure #7

Field Name: SPM7

Row Name:

Column Name:

Year: 2011

Field Note: Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Women with birth intervals less than five months were excluded from the analysis.

a. Last Year's Accomplishments

Between 2009 and 2010, NPM 7 decreased by 5 percent from 12.9 percent to 12.3 percent, and remained unchanged in 2011. African American women were most likely to have a live birth less than 24 months after a prior birth (14.0 percent), followed by Hispanics (12.5 percent), Whites (12.4 percent) and Asians (10.1 percent).

Preconception and interconception care is a priority for the MCAH Program. The Preconception Health Initiative (PHI) aims to improve the health of women prior to pregnancy to improve birth outcomes and reduce disparities in maternal and infant morbidity and mortality. A critical part of PHI is to ensure at least 18 months (or restoration of health and functioning) between pregnancies—especially among women with previous poor birth outcomes—to encourage healthy child development and to reduce health risks for mothers and subsequent infants. To reduce unintended pregnancy and improve birth spacing, MCAH and the Office of Family Planning (OFP) supported

programs that help women and teens understand the importance of pregnancy timing, decrease risky health behaviors and increase access to and appropriate use of contraceptives.

To meet their family planning needs, low-income individuals have benefited for many years from Family PACT, which provides comprehensive education, assistance and services relating to family planning. On July 1, 2012, the Family PACT program transitioned from CDPH to DHCS; service delivery does not appear to be affected. The I&E and PREP teen pregnancy prevention programs were moved to MCAH.

A boon for women in CA occurred on August 1, 2011 when the federal DHHS adopted the IOM's recommendations on preventive benefits for women with required coverage as part of ACA. These include annual well-woman visits, FDA-approved contraceptive coverage and breastfeeding support with no cost-sharing, which may help with family planning in many ways, including increasing access to the care and support services to help prevent a mistimed pregnancy.

The Preconception Health Council of California (PHCC) disseminated messages about the importance of reproductive life planning (RLP), planned pregnancies, birth spacing and preconception care through stakeholders to local communities statewide. The website, www.everywomancalifornia.org, has resources for consumers and providers. In June 2012, the website was redesigned to integrate RLP into site navigation. Spanish-language webpages were developed to be more visually-appealing.

Targeted preconception health websites for Blacks, Latinas and youth are prominently linked on the new site; these contain resources on effective contraceptive use. Youth can sign up for text messages featuring RLP messages.

The ICPC postpartum clinical guidelines and patient handouts were published; these include content to help providers address pregnancy spacing, care for chronic conditions between pregnancies and timely prenatal care for future pregnancies. Contraception is part of the "ABC" mnemonic featured on each patient handout to remind patients and providers about the importance of sufficient birth spacing.

MCAH programs, such as BIH, CPSP, CDAPP and the PHI, worked to integrate pregnancy timing and spacing messages into their content.

CPSP Services coordinators were trained to use the ICPC with clients. CPSP guidelines assisted practitioners counseling for family planning and adequate birth spacing; the health educator helps the patient develop a plan to achieve future reproductive goals.

AFLP serves pregnant and parenting teens with a goal to reduce repeat teen births and encourage the completion of secondary education. AFLP PYD sites trained case-managers and began pilot testing a RLP client-centered intervention tool.

The BIH program consists of ten prenatal and ten postpartum group sessions and addresses birth spacing and the importance of planning for the next pregnancy to improve maternal and infant outcomes. In the final session, participants create a Life Plan that includes plans for future children and contraception choice.

MCAH participated in ASHWG, which promotes an integrated system of reproductive health resources for youth to ensure access to family planning services to reduce unintended pregnancy.

CFHC, a PHCC member, expanded the preconception health and reproductive life planning demonstration project to more Title X clinics and helped MCAH conduct focus groups with women about the concept of RLP.

**Table 4b, State Performance Measures Summary Sheet
Pyramid Activities Level of Service**

Major Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCAH Program and OFP support several programs that help women avoid unintended pregnancy by decreasing risky behavior and increasing access to and promoting the use of effective contraceptive methods.				X
2. ASHWG works to promote and protect the sexual and reproductive health of California youth, which includes a focus on pregnancy prevention.				X
3. The PHHI supports organizations to increase birthing intervals, prevent unintended pregnancy and improve preconception health by providing best practices and networking opportunities.				X
4. The PHCC plays a pivotal role in relaying the message of the importance of reproductive life planning, pregnancy intention, birth spacing and preconception care to local communities.			X	
5. The Family PACT Program provides family planning services, testing and treatment of sexually transmitted diseases, and education and counseling to low-income Californians.	X			
6. AFLP utilizes a case management and mentoring model to assess and address the risks and resources of adolescent clients and their children, including prevention of subsequent pregnancies.		X		
7. BIH incorporates discussion of contraception and pregnancy spacing into its case management, group sessions and health promotion activities.		X		
8. CPSP and CDAPP incorporate family planning and birth spacing in guidelines and educational materials.		X		

b. Current Activities

MCAH promoted appropriate pregnancy timing and birth spacing in programs and initiatives.

The PHCC preconception care guidelines were released to provide clinical guidance on the well-woman visit covered as preventive care (no cost-sharing) under ACA.

The PHCC disseminated and conducted trainings on the Interconception Care Project of California for health care and public health professionals.

MCAH provided trainings on preconception and interconception health, including to the National WIC Association, and shared the clinical and public health tools available.

MCAH worked with LHJs to promote reproductive life planning and adequate birth spacing through the PPE program. Post-secondary students were trained in preconception health and are able to support community outreach initiatives to address preconception and interconception health.

Family PACT, I&E and AFLP continued teen pregnancy prevention efforts. AFLP began the Positive Youth Development intervention centered on RLP to empower clients, encourage goal setting and reduce repeat teen births. The new BIH model that includes goal setting and RLP was implemented at all sites.

The CDAPP Sweet Success Resource Center website went live and guidance on preconception health and optimal birth spacing for women with diabetes was posted.

The CDC preconception health campaign, Show Your Love, was launched with a strong focus on RLP. It includes videos and checklists with messaging tailored to one's plans to have a baby.

c. Plan for the Coming Year

The MCAH Program will continue to strengthen and expand its interconception and reproductive life planning initiatives toward the aim of ensuring adequate birth spacing and reducing teen births.

Adolescent programs will continue to revisit life planning tools and explore the best strategies for reducing teen pregnancy and repeat births to teens.

Programs that target pregnant women will provide up-to-date messaging about birth spacing and overall preconception/interconception health; for example, the CPSP program is looking into revising postpartum educational materials to better integrate the newly-released ICPC (postpartum) guidelines.

The California Home Visiting Program will promote appropriate pregnancy spacing with contraceptive education, counseling, and referral to clinical services beginning in the final trimester of pregnancy and extending throughout the postpartum period.

The CFHC will continue its efforts to expand its reproductive life planning demonstration project to all clients of Title X-funded clinics by 2015.

MCAH will continue to educate at-risk groups about contraception and birth spacing and will explore the best strategies to effectively engage younger and electronically-inclined populations, empowering them to make healthy reproductive decisions.

The PHCC will continue to explore opportunities to include preconception health messages in pregnancy tests alongside existing prenatal messages. The PHCC is presently working with First Response and March of Dimes to propose additional language for home test kits. Because many women taking pregnancy tests receive a negative result, this is an opportunity to provide contraception messages to reduce unintended pregnancy among women who do not want to be pregnant but are at risk.

MCAH will continue to share national resources, including the preconception campaign materials developed by the CDC and PPE materials provided by the federal Office of Minority Health.

The Affordable Care Act offers opportunities to help prevent unintended or mistimed pregnancies by improving health care coverage for women through the Health Exchange and private health plans. MCAH will help raise awareness about ACA preventive care provisions that require new health plans to provide FDA-approved contraception without cost-sharing.

MCAH will continue to publicize the preconception and ICPC guidelines as clinical tools available to providers who connect with women of reproductive age, either in their well-women visit or postpartum visit (for women who just had a baby). These clinical visits are critical opportunities to help women prevent or delay pregnancy until they are ready. To ensure providers have adequate education regarding interconception health and birth spacing, an online module with continuing medical education credits is being developed for self-paced instruction to coincide with the ICPC.

State Performance Measure 8

The percent of 9th grade students reporting a high level of school connectedness.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				43	43
Annual Indicator	40.4	42	43.2	44.3	44.3
Numerator	93225	102319	105767	107535	
Denominator	230541	243896	244863	242857	
Data Source	CHKS, 2006-2008	CHKS, 2007-2009	CHKS, 2008-2010	CHKS, 2009-2011	
Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional
Year	2013	2014	2015	2016	2017
Annual Performance Objective	43	43	43	43	43

Field Level Notes

Section Number: Form11_State Performance Measure #8

Field Name: SM8

Row Name:

Column Name:

Year: 2012

Field Note: A manual indicator is reported for 2012 based on 2011.

Section Number: Form11_State Performance Measure #8

Field Name: SM8

Row Name:

Column Name:

Year: 2011

Field Note: : Source: California Healthy Kids Survey (CHKS), 2009-11. Unpublished data provided by WestEd on May 16, 2013. CHKS data are collected by WestEd on behalf of the California Department of Education using a two year data collection cycle to provide representative data for students enrolled in California public schools.

a. Last Year's Accomplishments

MCAH reviewed the professional literature to develop health policy and programs that support school retention. Health is intimately connected with education in multiple ways across the life course. Education influences health through its impact on employment and associated determinants of health such as living conditions, access to healthy foods, safe communities and quality health services. Increased education also allows for the opportunity for better paying jobs. Furthermore, increased educational achievement improves MCAH outcomes through its impact on health knowledge and behaviors, as well as sense of control, social standing, and social support.

Longitudinal research supports a broad school-connectedness measure: school connectedness was found to be the strongest protector against substance use, school absenteeism, early sexual initiation, violence, and risk of unintentional injury (such as drinking and driving or not wearing seat belts). Research highlights the protective effect that connectedness i.e. the emotional attachment and commitment a child makes to social

relationships in the family, peer group, school, community, and culture has on adolescent sexual and reproductive health.

In 2009-2011, 44.3% of 9th grade students had a high level of school connectedness, continuing the pattern of increasing school connectedness observed among 9th grade students in recent years. School-connectedness varies by race/ethnicity. Fewer African American and American Indian 9th grade students report a high level of school-connectedness (33% and 37%, respectively) compared to Native Hawaiian/Pacific Islander (47%), White (45%), Asian (45%), Mixed Race (42%) and Hispanic (41%) students.

MCAH supports Positive Youth Development programs (PYD) as an effective public health response. These programs support the capacity and strength of youth. MCAH’s AFLP is one health program that provides an opportunity to incorporate principles of positive youth development that build on strengthening protective factors that support education. By assisting adolescents in identifying important linkages to schools, MCAH AFLP can build on the education-health connection that leads to positive health outcomes.

MCAH continued to implement a Support for Pregnant and Parenting Teens at High Schools and Community Service Centers award from the U.S. Department of Health and Human Services (HHS), Office of Adolescent Health. CDPH/MCAH received \$2 million for federal project period 2010 – 2013. Under this grant, using a positive youth development framework, MCAH seeks to improve and increase capacity of the pregnant and parenting services currently offered to eligible youth served through its AFLP and the Cal-SAFE in 11 AFLP sites. AFLP PYD case management intervention services are provided by the selected AFLP programs in partnership with Cal-SAFE sites that no longer have case management support services, but do continue to offer child and developmental services for the teens’ children. AFLP PYD interventions are premised in a strength-based goal setting process supporting a life planning approach.

**Table 4b, State Performance Measures Summary Sheet
Pyramid Activities Level of Service**

Major Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.) MCAH and its partners develop adolescent positive youth development principles that support adolescent school retention.				X
2.) MCAH develops program and policy recommendations that support school completion.				X
3.) MCAH partners with other state programs and agencies to dialogue with advocates, experts and local MCAH directors to				X

support positive youth development in schools.				
4.) MCAH promotes interventions supported by a positive youth development framework.				X

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

b. Current Activities

MCAH continues to work on developing a framework to integrate positive youth development in three ways: 1) the Adolescent Family Life Program; 2) CAHC, a statewide coalition of individuals and organizations, both public and private, whose main goal is to support adolescent health in California through trainings, data analysis, education, and TA to MCAH and to local MCAH programs; and, 3) ASHWG, comprised of program managers from the CDPH, including Office of AIDS, STD Control Branch, Office of Family Planning, and Maternal, Child and Adolescent Health), CDE, and key CBOs, including CAHC and the State Title X Administrator for California, the CFHC.

With the restoration of the Cal-Learn program by April 2013, MCAH is collaborating with CDSS on the coordination of service delivery for teens to earn high school diplomas or equivalents. Cal-Learn provides case management services in accordance with the AFLP Standards.

In April 2013, MCAH will be applying for the U.S. Department of Health and Human Services, Office of Adolescent Health (OAH) grant for the Support for Expectant and Parenting Teens, Women, Fathers and Their Families. The funding will be used to continue and enhance the existing activities begun under a previous OAH grant. This funding would continue the AFLP PYD case management with integrated life planning intervention for an additional 4 years in order to implement a standardized evidence-informed program strategy.

An important factor in school connectedness is a feeling of security. Out-of-control bullying that is ignored (or even facilitated) by teachers and staff can affect even an eager and otherwise dedicated student. The CIPPP, through its existing funding, provides technical support about best practices and program evaluation to LHJs and to their formal and informal partner agencies and organizations (local parent teacher organizations, student organizations and their faculty advisors, union locals, etc.)

c. Plan for the Coming Year

MCAH will continue to implement AFLP and apply the best practices learned from the AFLP PYD efforts into the overall statewide AFLP program. As additional funding is secured through the OAH grant opportunity, MCAH plans to conduct an outcome evaluation in subsequent years in order to develop an evidence-informed intervention for AFLP in order to improve adolescent school and health outcomes. MCAH will also continue its work with CAHC to support local MCAH programs as they implement adolescent health measures.

State Performance Measure 9

Infant mortality rate among low-income women

Tracking Performance Measures

[Sees 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective		5.4	5.4	5.4	5.4
Annual Indicator	5.7	5.5	5.4	5.4	5.4
Numerator	1493	1358	1338		
Denominator	262459	248705	246234		
Data Source	Birth-Death Cohort File	Birth-Death Cohort File	Birth-Death Cohort File 2010		
Is the Data Provisional or Final?	Final	Final	Provisional		
Year	2013	2014	2015	2016	2017
Annual Performance Objective	5.4	5.4	5.4	5.4	5.4

Field Level Notes

Section Number: Form11_State Performance Measure #9

Field Name: SM9

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2011 and 2012 based on 2010.

Section Number: Form11_State Performance Measure #9

Field Name: SM9

Row Name:

Column Name:

Year: 2010

Field Note:

Source: State of California, Department of Public Health, Center for Health Statistics, 2010 Linked Birth – Death Cohort File

a. Last Year's Accomplishments

The low income infant mortality rate reflects deaths among infants born to women for whom Medi-Cal was the principal source of payment for prenatal care or delivery. In 2010, the low-income infant mortality rate was 5.4 per 1,000 live births.

Sixteen LHJs implement FIMR programs. In Contra Costa, preconception/interconception education has been integrated into the maternal interview, which is an essential component in the spectrum of case management and family support services offered to clients following a fetal or infant death. Given its size and large number of birthing hospitals, L.A. County uses a survey tool (L.A. Health Overview of a Pregnancy Event) to conduct FIMR. The survey questions are designed to focus on

maternal behaviors and health system variables that can be addressed by public health interventions.

All MCAH LHJs conduct outreach to encourage pregnant women to seek early prenatal care through programs such as Prenatal Care Guidance. Many LHJs integrate preconception and interconception messaging into their services as a strategy to prevent poor birth outcomes such as infant mortality.

Various MCAH programs and initiatives, including CPSP, AFLP, BIH, RPPC and PHHI, work on improving infant health and birth outcomes and enroll mostly low-income women. CPSP aims to decrease the incidence of low birthweight (LBW<2500 grams) infants by providing at-risk women with comprehensive services including prenatal care, health education, nutrition and psychosocial support. Over 1,500 Medi-Cal obstetrical practitioners provide CPSP services, serving approximately 165,000 women annually. A primary goal of AFLP is to improve birth outcomes for babies born to adolescent clients, many of whom receive Medi-Cal services. AFLP assists pregnant adolescents to access prenatal and other necessary health care early in pregnancy, provides nutrition counseling, and works with teens to eliminate behaviors contributing to poor birth outcomes. African American infants are more than twice as likely as infants of other racial/ethnic groups to be born LBW in California. BIH identifies pregnant and parenting African American women at risk for poor birth outcomes and assists them in accessing and maintaining appropriate healthcare and support services.

MCAH and SCD collaborate with CPQCC on performance improvement in perinatal and neonatal outcomes. CPQCC has 130 member hospitals, accounting for over 90 percent of newborns requiring critical care. RPPC provides consultation to delivery hospitals, using current outcomes data from Perinatal Profiles, and supports implementation of clinical quality improvement strategies by collaborating with maternal and neonatal providers to address evidence-based quality improvement projects and improve risk-appropriate care.

MCAH participates in PHCC, providing information, tools and resources to local communities on achieving optimal health for women prior to pregnancy. . MCAH and SCD collaborated with MOD on its Prematurity Campaign , which aims to invest in research, education and community programs to identify causes of prematurity and develop strategies to improve birth outcomes. A statewide effort to reduce elective deliveries of less than 39 weeks gestational age is ongoing throughout the state through efforts with multiple stakeholders: MOD, ACOG, the California Hospital Association, and CMQCC with encouragement from RPPC.

L.A. County participated in the Partnership to Eliminate Disparities in Infant Mortality, an 18-month collaborative project (September 2008-February 2010) sponsored by the Association of Maternal Child Health Programs, CityMatCH and National Healthy Start Association, which provided tools to address infant mortality disparities. The L.A. County d an Action Learning Collaborative (LAC ALC) aims to increase capacity at the community, State, and local levels to address the impact of racism on birth outcomes and

infant health. Its website provides information on resources and best practices relating to infant mortality and undoing racism. In December 2011, the ALC held a successful Racial Justice Leadership Institute training on undoing racism for collaborative members' staff, with a total of 42 participants.

TABLE 4B
STATE PERFORMANCE MEASURES SUMMARY FROM THE ANNUAL REPORT
YEAR

Major Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Sixteen LHJs implement FIMR programs that review contributing factors to fetal/infant deaths and identify necessary actions for implementation to prevent these deaths.				x
2. LHJs conduct outreach to encourage pregnant women to seek early prenatal care through programs such as Prenatal Care Guidance.		x		
3. CPSP provides at-risk women with comprehensive services including prenatal care, health education, nutrition and psychosocial support.	x			
4. AFLP assists pregnant adolescents in accessing prenatal and other necessary healthcare early in pregnancy, provides nutrition counseling, and works with teens to eliminate behaviors contributing to poor birth outcomes.		x		
5. BIH identifies pregnant and parenting African American women at risk for poor birth outcomes and assists them in accessing and maintaining appropriate healthcare and support services.		x		
6. MCAH and SCD collaborate with CPQCC on performance improvement in perinatal and neonatal outcomes.				x
7. MCAH, CMQCC and RPPC provide technical assistance to hospitals seeking to reduce elective deliveries less than 39 weeks gestational age	x	x		x
8. RPPC provides consultation to delivery hospitals and supports implementation of clinical quality improvement strategies to address evidence-based quality improvement projects and improve risk-appropriate care.				x
9. LAC ALC works on increasing capacity at the local and state levels to address the impact of racism on birth outcomes and infant health.				x
10. LHJs implement strategies to decrease their preterm birth rates. Prematurity is a leading cause of infant mortality.	x	x	x	x

NOTE: DHC=Direct Health Care ES=Enabling Services PBS=Population Based Services IB=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

b. Current Activities

Various MCAH programs and initiatives, including CPSP, AFLP, BIH, RPPC and PHHI, continue their work on improving infant health and birth outcomes.

L.A. maintains the LAC ALC website to provide information on resources and best practices relating to infant mortality and undoing racism. With its multidisciplinary local partners, LAC ALC continues with its mission of increasing capacity at the local and state levels to address the impact of racism on birth outcomes and infant health.

California accepted the Association of State and Territorial Officials (ASTHO) Healthy Babies Challenge in May 2012. Its specific objective is to reduce prematurity rates by 8% by the year 2014, using 2009 data as baseline. ASTHO is partnering with MOD on implementing this challenge nationally and further promoting MOD's Prematurity Campaign. MCAH has included prematurity prevention specific objectives in the MCAH Scope of Work for LHJs and is working with key stakeholders and partners in addressing this challenge. .

MCAH, CMQCC and MOD continue to promote the Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age Toolkit. . It facilitates improvements and transforms maternity practice care. MCAH has licensed the toolkit to MOD, which is disseminating it nationally as part of its Prematurity Campaign.

c. Plan for the Coming Year

LHJs will continue to perform outreach, client education and case-finding functions, including a toll-free telephone information service and targeted activities designed to assist women in receiving early and continuous prenatal care. Programs also provide critical social support services, case management and client follow-up.

CPSP providers offer comprehensive prenatal care, including obstetrics, nutrition, health education, and psychosocial support. Local AFLP programs use outreach, home visitation, and follow-up with pregnant women to educate clients and stakeholders on the importance of prenatal care. Regional AFLP representatives meet to discuss strategies for improving prenatal care utilization. BIH provides community outreach and health education, to increase community awareness of the importance of prenatal care. The newly revised BIH intervention provides a 20-session group intervention (10 prenatal and 10 postpartum) with complementary case management that provides support to empower clients to make healthier choices for their babies. Case management ensures linkage to prenatal services.

FIMR is working on a Home Interview data collection tool for use by local FIMR programs. In addition to streamlining the data-gathering process, the use of this standardized tool will assist MCAH in multi-year analysis of FIMR data.

L.A. County continues with its ALC work. The ALC plans to hold more health disparities training workshops for healthcare providers as part of its mission to increase local capacity to address the impact of racism on birth outcomes and infant health.

MCAH and SCD continue to collaborate with MOD and ASTHO on the Healthy Babies Challenge/Prematurity Campaign

CMQCC and RPPC continue to provide technical assistance to hospitals and LHJs who wish to reduce elective deliveries for pregnancies less than 39 weeks gestation.

State Performance Measure 10

The percent of CCS clients who have a designated primary care physician and/or a specialist physician who provides a medical home.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective					
Annual Indicator				84	61
Numerator				206,827	132,974
Denominator				246,301	211,538
Data Source					
Is the Data Provisional or Final?			Final	Final	Final
Year	2013	2014	2015	2016	2017
Annual Performance Objective					

Field Level Notes:

Section Number: Form11_State Performance Measure #10

Field Name: SM2

Row Name:

Column Name:

Year: 2012

Field Note:

SPM 10 is the percent of CCS clients with a designated primary care physician or subspecialist physician who provides a medical home. This information is collected as CCS Performance Measure 1. Data Source: Total active CCS clients registered in the CMS Net data collection system for 2012. The current data collection system allows physician or health center to be designated medical home.

Section Number: Form11_State Performance Measure #10

Field Name: SM2

Row Name:

Column Name:

Year: 2011

Field Note:

SPM 10 is the percent of CCS clients with a designated primary care physician or subspecialist physician who provides a medical home. This information is collected as CCS Performance Measure 1. Data Source: Sample of 100 charts or 10% of caseload if caseload under 1,000. The current data collection system allows physician or health center to be designated medical home. Guidance will be given to county programs this year to count only physician, not health center, as Medical Home. Report next year will reflect this change.

a. Last Year's Accomplishments

This is a new performance measure. In 2008, the current set of Performance measures for California Children’s Services were developed, which included that counties should indicate whether each CCS client has an identified medical home.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
Improve the data base to provide the most accurate results for this measure				X

As staffing permit, work with Regional Office staff and local programs to authorize a PCP in conjunction with the Special Care Center or specialist.	X			
Request that counties count only primary care or specialist physicians in this Medical Home measure.				X
As staffing permits, work with Regional Office staff, local program staff and stakeholder groups to promote medical homes for children enrolled in CCS.				X

B. Current Activities

1. Obtain detailed reports from counties on number/percent of CCS children with ‘medical home’ by individual vs. clinic, and primary care doctor vs. specialist
2. Meet with county CCS administrators to review Medical Home definition, discuss how to consistently apply Medical Home definition in the SCD performance measure reporting of medical home provider.
3. Implement the 1115 Demonstration Waiver Project of which The Medical Home is a core component. The project will be evaluating innovative health care delivery models for children with CCS conditions. As outlined 1115 RFP, the Medical Home is the foundation of each of the 4 models of an integrated and coordinated health care delivery system.

C. Plan for the Coming Year

- 1) Develop and issue policy letter to request that County CCS offices identify only providers, not clinics, as designated Medical Homes.
- 2) As staffing permits, work with local program staff and stakeholder groups to promote medical homes for children enrolled in CCS
- 3) Continue implantation of 1115 and analysis of initial and interval data. The California Children’s Services Waiver Evaluation Plan for the 1115 Pilots is in the final stages of development and includes several measures of Medical Home function including being family centered, satisfaction of patient, family and providers, and appropriate healthcare access.

E. Health Status Indicators

Introduction

California utilizes various data sources to complete the indicator data for the various health status indicators (HSI). These include the Birth Statistical Master file (HSI 1, 2 and 7), the Death Statistical Master file (HSI 3 and 8) the Patient Discharge Data from OSHPD (HSI 4), the STD Surveillance report (HSI 5), the Race/Ethnic Population Projection with Age and Sex Detail from the Department of Finance(HSI 6) and the Annual Social and Economic Supplement, Current Population Survey from the U.S. Census Bureau (HSI 11 and 12).

A composite of data gathered from the (1) Race/Ethnic Population Projection with Age and Sex Detail from the Department of Finance, (2) the Annual Social and Economic Supplement, Current Population Survey from the U.S. Census Bureau, (3) the Federal Data Reporting and Analysis Bureau of DSS, (4) Medi-Cal Care statistics from DHCS, (5) the HF Program Monthly Enrollment Reports from MRMIB, (6) WIC data from the WIC, (7) Juvenile Arrests reported by the Criminal Justice Center of the Department of Justice, and (8) Number of Dropouts from California Public Schools from CDE are used to complete the indicators for HSI 9.

Health Status Indicator 01a

The percent of live births weighing less than 2,500 grams.

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator		6.8	6.8	6.8	6.8
Numerator		35774	34624	33956	
Denominator		526692	509884	501942	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final				Final	Provisional

Field Level Notes

Section Number: Form20_Health Status Indicator #01A

Field Name: HSI01A

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form20_Health Status Indicator #01A

Field Name: HSI01A

Row Name:

Column Name:

Year: 2011

Field Note:

Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File.

Tabulations (by place of residence) were done by the MCAH Program. Data exclude births with unknown birth weight or births weighing <227g or >8165g. Data for 2009 should be not compared to data reported in previous years due to a change in exclusion criteria. Rates for prior years using the updated criteria: 2006 = 6.8; 2007 = 6.9; 2008 = 6.8

Section Number: Form20_Health Status Indicator #01A

Field Name: HSI01A

Row Name:

Column Name:

Year: 2008

Field Note:

Source: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File.

Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birth weight were excluded from the denominator.

Health Status Indicator 01b

The percent of live singleton births weighing less than 2,500 grams

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator		5.2	5.3	5.2	5.2
Numerator		26470	25949	25182	
Denominator		509909	493980	485905	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final				Final	Provisional

Field Level Notes

Section Number: Form20_Health Status Indicator #01B

Field Name: HSI01B

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form20_Health Status Indicator #01B

Field Name: HSI01B

Row Name:

Column Name:

Year: 2011

Field Note:

Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File.

Tabulations (by place of residence) were done by the MCAH Program. Data exclude births with unknown birth weight or births weighing <227 grams or >8165 grams. Data for 2009 should be not compared to data reported in previous years due to a change in exclusion criteria. Rates for prior years using the updated criteria: 2006 = 5.2; 2007 = 5.3; 2008 = 5.2.

Section Number: Form20_Health Status Indicator #01B

Field Name: HSI01B

Row Name:

Column Name:

Year: 2008

Field Note:

Source: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File.

Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birth weight were excluded from the denominator.

Health Status Indicator 02a

The percent of live births weighing less than 1,500 grams.

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator		1.2	1.1	1.1	1.1
Numerator		6066	5791	5721	
Denominator		526692	509884	501942	
Check this box if you cannot report the Numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 4 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

Section Number: Form20_Health Status Indicator #02A

Field Name: HSI02A

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form20_Health Status Indicator #02A

Field Name: HSI02A

Row Name:

Column Name:

Year: 2011

Field Note:

Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File.

Tabulations (by place of residence) were done by the MCAH Program. Data exclude births with unknown birth weight or births weighing <227 grams or >8165 grams.

Health Status Indicator 02b

The percent of live singleton births weighing less than 1,500 grams.

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator		0.9	0.9	0.9	0.9
Numerator		4428	4286	4246	
Denominator		509909	493980	485905	
Check this box if you cannot report the Numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Field Level Notes

Section Number: Form20_Health Status Indicator #02B

Field Name: HSI02B

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form20_Health Status Indicator #02B

Field Name: HSI02B

Row Name:

Column Name:

Year: 2011

Field Note:

Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File.

Health Status Indicator 03a

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	4.2	4.4	3.3	3.7	3.7
Numerator	344	357	267	281	
Denominator	8184698	8184071	8199138	7568037	
Check this box if you cannot report the Numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional

Field Level Notes

Section Number: Form20_Health Status Indicator #03A

Field Name: HSI03A

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form20_Health Status Indicator #03A

Field Name: HSI03A

Row Name:

Column Name:

Year: 2011

Field Note:

Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 Death Statistical Master File (ICD-10 Group Cause of Death Codes 295-330).

Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH Program.

Data reported for 2011 should not be compared to data reported in 2010 due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 3.5.

Section Number: Form20_Health Status Indicator #03A

Field Name: HSI03A

Row Name:

Column Name:

Year: 2010

Field Note:

Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2010 Death Statistical Master File (ICD-10 Group Cause of Death Codes 295-330).

Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006-2008 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California.

Narrative:

MCAH funds the Childhood Injury Prevention Program within San Diego State University's Center for Injury Prevention Policy and Practice (CIPPP) to provide technical support to LHJs' injury prevention activities. This support involves priority-setting, program selection, and evaluation. The CIPP's SafetyLit service provides summaries of recently published research relevant to injury prevention. These updates include program evaluations and formal reviews of intervention effectiveness. CIPPP maintains and, when appropriate, updates their website including the "Be Safe Not Sorry" safety sheets for parents of infants, children, and adolescents are available in English, Spanish, and Vietnamese.

Health Status Indicator 03b

The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	1.7	1.8	1.0	1.1	1.1
Numerator	143	148	84	85	

Denominator	8184698	8184071	8199138	7568037	
Check this box if you cannot report the Numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional

Field Level Notes

Section Number: Form20_Health Status Indicator #03B

Field Name: HSI03B

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form20_Health Status Indicator #03B

Field Name: HSI03B

Row Name:

Column Name:

Year: 2011

Field Note:

Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Death Statistical Master File [The ICD-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH Program.

Data reported for 2011 should not be compared to data reported in 2010 due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 1.1.

Health Status Indicator 03c

The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Health Status Indicators Forms HSI 01 through 05- Multi Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	14.0	11.5	9.0	10.4	10.4
Numerator	804	677	539	582	
Denominator	576225 3	587580 9	596995 5	5615748	
Check this box if you cannot report the Numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional

Field Level Notes

Section Number: Form20_Health Status Indicator #03C

Field Name: HSI03C

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form20_Health Status Indicator #03C

Field Name: HSI03C

Row Name:

Column Name:

Year: 2011

Field Note:

Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Death Statistical Master File [The ICD-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.Tabulations (by place of residence) were done by the MCAH Program.

Data reported for 2011 should not be compared to data reported in 2010 due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 9.6.

Health Status Indicator 04a

The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	194.0	192.9	186.8	191.9	191.9
Numerator	15880	15791	15315	14525	
Denominator	8184698	8184071	8199138	7568037	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional

Field Level Notes

Field Name: HSI04A

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form20_Health Status Indicator #04A

Field Name: HSI04A

Row Name:

Column Name:

Year: 2011

Field Note:

Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHDP-PDD), January 1-December 31, 2011. Principal external cause of injury codes were used (E800-E999). Data exclude cases with iatrogenic codes (adverse effects of medical care and drugs), unknown age, newborns, persons who died in the hospital, and records erroneously listing a "place of injury" code (E849.0-E849.9) as the principal code.

Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2011 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010 using these updated population projections was 201.4.

Health Status Indicator 04b

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	19.6	18.6	16.8	16.8	16.8
Numerator	1608	1523	1376	1270	
Denominator	8184698	8184071	8199138	7568037	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional

Field Level Notes

Section Number: Form20_Health Status Indicator #04B

Field Name: HSI04B

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form20_Health Status Indicator #04B

Field Name: HSI04B

Row Name:

Column Name:

Year: 2011

Field Note:

Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHDP-PDD), January 1-December 31, 2011. Principal external cause of injury codes were used (ICD9-CM codes E810-E819). Data exclude cases of unknown age, newborns, and persons who died in the hospital.

Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH.

Data for 2011 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010 using these updated population projections was 18.1.

Health Status Indicator 04c

The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	110.8	99.1	88.9	91.4	91.4
Numerator	6385	5820	5306	5133	
Denominator	5762253	5875809	5969955	5615748	
Check this box if you cannot report the Numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional

Field Level Notes

Section Number: Form20_Health Status Indicator #04C

Field Name: HSI04C

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011.

Section Number: Form20_Health Status Indicator #04C

Field Name: HSI04C

Row Name:

Column Name:

Year: 2011

Field Note:

Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHDP-PDD), January 1-December 31, 2011. Principal external cause of injury codes were used (ICD9-CM codes E810-E819). Data exclude persons who died in the hospital.

Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2011 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010 using these updated population projections was 94.7.

Health Status Indicator 05a

The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	23.5	22.2	22.5	22.9	22.9
Numerator	34616	32987	33440	33860	
Denominator	1470271	1488207	1488238	1476421	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final		Final	Final	Final	Provisional

Field Level Notes

Field Name: HSI05A

Row Name:

Column Name:

Year: 2012

Field Note:

A manual indicator is reported for 2012 based on 2011 data.

Section Number: Form20_Health Status Indicator #05A

Field Name: HSI05A

Row Name:

Column Name:

Year: 2011

Field Note:

Numerator: Chlamydia, Cases and Rates by Race/Ethnicity, Gender, and Age Group, California, 2011 Provisional Data, , California Department of Public Health, STD Control Branch (data reported through 08/07/2012).

Available at <http://www.cdph.ca.gov/data/statistics/Documents/STD-Data-Chlamydia-Provisional-Tables.pdf> Last accessed on February 26, 2013.

Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007. . .

Health Status Indicator 05b

The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	10.2	10.0	10.6	11.4	11.4
Numerator	66734	65290	70011	76119	
Denominator	6524678	6555574	6603274	6683684	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final	Final	Final	Final	Final	Provisional

Field Level Notes

Section Number: Form20_Health Status Indicator #05B

Field Name: HSI05B

Row Name:

Column Name:

Year: 2012

A manual indicator is reported for 2012 based on 2011 data.

Section Number: Form20_Health Status Indicator #05B

Field Name: HSI05B

Row Name:

Column Name:

Year: 2011

Numerator:

Chlamydia, Cases and Rates by Race/Ethnicity, Gender, and Age Group, California, 2011 Provisional Data, , California Department of Public Health, STD Control Branch (data reported through 08/07/2012). Available at <http://www.cdph.ca.gov/data/statistics/Documents/STD-Data-Chlamydia-Provisional-Tables.pdf> Last accessed on February 26, 2013.

Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007

Health Status Indicator 06a

Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

Reporting Year 2011
Is the data for a State Projection? Yes
Is this data final or provisional? Final

Category TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unkn wn
Infants 0 to 1	506,556	398,222	28,005	1,612	50,989	1,529	26,198	0
Children 1 through 4	2,007,912	1,586,556	105,069	7,647	203,835	6,515	98,290	0
Children 5 through 9	2,496,676	1,969,079	132,467	10,052	264,997	8,472	111,609	0
Children 10 through 14	2,556,893	2,016,273	147,860	10,524	270,054	9,129	103,054	0
Children 15 through 19	2,819,402	2,209,545	179,255	12,197	307,005	11,023	100,379	0
Children 20 through 24	2,796,346	2,174,277	177,435	12,169	337,166	11,998	83,301	0
Children 0 through 24	13,183,785	10,353,952	770,091	54,202	1,434,046	48,665	522,831	0

FORM NOTES FOR FORM 21

HSI 06A & B: Source:

State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.

<http://www.dof.ca.gov/research/demographic/reports/projections/P-3/>. Tabulations were done by MCAH Program.

White race is summed from White group and Hispanic group in this file.

Narrative:

There has been a decline in the proportion of California's population who are children. In 1970, children made up 33% of California's population, but it is projected that by 2030, this is expected to drop to 21%. Far-reaching demographic changes including declining birth rates, fewer migration to the state and a smaller population of women of childbearing ages all play a role. California's children are being raised in wide-ranging family types and conditions which can influence their health and well-being. While nearly two thirds live in households headed by married couples, that percentage has decreased in recent decades. Nearly half of children also are being raised in households where English is not the primary language. Many of these children are developing bilingual skills that will prove valuable in their future lives but in the short term, may require tailored social, health and educational services.

Health Status Indicator 06b

Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

Reporting Year 2011
Is the data for a State Projection? Yes
Is this data final or provisional? Final

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	TOTAL NOT HISPANIC OR LATINO	TOTAL HISPANIC OR LATINO	EHTNICITY NOT REPORTED
Infants 0 to 1	251,760	254,796	0
Children 1 through 4	938,525	1,069,387	0
Children 5 through 9	1,198,765	1,297,911	0
Children 10 through 14	1,260,277	1,296,616	0
Children 15 through 19	1,456,151	1,363,251	0
Children 20 through 24	1,538,603	1,257,742	0
Children 0 through 24	6,644,081	6,539,704	0

Form Notes

HSI 06A & B: Source:
State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.
<http://www.dof.ca.gov/research/demographic/reports/projections/P-3/Tabulations> were done by MCAH Program.

Narrative

California's child population is highly diverse with nearly half of the population of Hispanic or Latino origin.

Health Status Indicator 07a

Live births to women (of all ages) enumerated by maternal age and race. (Demographics)

Reporting Year 2011
 Is the data for a State Projection? Yes
 Is this data final or provisional? Final

Category TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women <15	426	334	37	5	4	2	26	18
Women 15 through 17	11839	9596	906	74	223	35	592	413
Women 18 through 19	26489	21206	2177	199	611	105	1365	826
Women 20 through 34	369625	274545	20895	1923	43266	1762	12735	14499
Women 35 or older	93588	64149	3729	292	18203	333	2415	4467
Women of all ages	501967	369830	27744	2493	62307	2237	17133	20223

FORM NOTES FOR FORM 21

HSI 07A & B: Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File. Tabulations (by age and race/ethnicity) were done by the MCAH Program. Women with unknown age are not included in the totals. In 2011, age was known for 501,967 women and unknown for 56 women, for a total of 502,023 live births.

Health Status Indicator 07b

Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)

HSI #07B- Demographics (Total Live Births)

Reporting Year 2011
 Is the data for a State Projection? Yes
 Is this data final or provisional? Final

Category Total live births	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women <15	75	345	6
Women 15 through 17	2451	9234	154
Women 18 through 19	7111	19060	318
Women 20 through 34	178152	185447	6026
Women 35 or older	55386	35589	2613
Women of all ages All ages	243175	249675	9117

Form Notes

HSI 07A & B: Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File. Tabulations (by age and race/ethnicity) were done by the MCAH Program. Women with unknown age are not included in the totals. In 2011, age was known for 501,967 women and unknown for 56 women, for a total of 502,023 live births.

Health Status Indicator 08a

*Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race.
(Demographics)*

HSI 08a: Demographics (Total Deaths)

Reporting Year 2011

Is the data for a State Projection? Yes

Is this data final or provisional? Final

<u>Category</u> Total deaths	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	2397	1664	299	12	180	22	182	38
Children 1 through 4	445	324	34	2	36	2	42	5
Children 5 through 9	223	161	19	1	18	3	18	3
Children 10 through 14	295	224	26	1	24	4	14	2
Children 15 through 19	1086	808	153	13	55	2	45	10
Children 20 through 24	1905	1444	246	12	104	13	69	17
TOTAL Children 0 through 24	6351	4625	777	41	417	46	370	75

Form Notes for Form 21

HSI 08A and B: State of California, California Department of Public Health, Center for Health Statistics, 2011 California Death Statistical Master File. Calculations (by age and race/ethnicity) were performed by the MCAH Program.

Health Status Indicator 08a

Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)

Reporting Year 2011
 Is the data for a State Projection? Yes
 Is this data final or provisional? Final

Category Total deaths	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	1153	1228	16
Children 1 through 4	192	251	2
Children 5 through 9	117	103	3
Children 10 through 14	139	156	0.
Children 15 through 19	557	528	1
Children 20 through 24	1101	799	5
TOTAL Children 0 through 24	3259	3065	27

Form Notes

HSI 08A and B: State of California, California Department of Public Health, Center for Health Statistics, 2011 California Death Statistical Master File. Calculations (by age and race/ethnicity) were performed by the MCAH Program.

Health Status Indicator 09a:

Demographics (Miscellaneous Data) Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race.

Is this data final or provisional? Provisional

Category	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
.Misc Data BY RACE									
All children 0 through 19	10,387,439	8,179,675	592,656	42,032	1,096,880	36,667	439,530	0	2011
Percent in household headed by single parent	31.5	29.2	62.6	58.0	21.7	38.6	29.6	0	2012
Percent in TANF (Grant) Families	11.4	10.7	36.0	23.0	4.2	28.7	5.3	0	2011
Number enrolled in Medicaid	3789512	2953411	343671	151147	210985	12289	640	253402	2011
Number enrolled in SCHIP	852,592	477,343	15,458	2,466	78,797	904	0	277,624	2012
Number living in foster home care	56414	39098	12699	449	1096	0	2931	141	2011
Number enrolled in food stamp program	1844715	1486929	216910	6870	91293	0	36259	6454	2011
Number enrolled in WIC	2063125	577993	134340	756914	90181	12232	187489	303976	2011
Rate (per 100,000) of Juvenile crime arrests	2303	2261	6757	2158	579	2896	0	0	2011
Percentage of high school drop-outs (grades 9 through 12)	14.7	14.7	25.3	21.4	6.1	17.7	11.1	41.9 (not reported only)	2011

FIELD LEVEL NOTES

Section Number: Form21_Indicator 09A

Field Name: HSIRace_Children

Row Name: All children 0 through 19

Column Name:

Year: 2011

Field Note:

For the tabulation for all children 0 through 19, the data source is the State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. <http://www.dof.ca.gov/research/demographic/reports/projections/P-3/>

Section Number: Form21_Indicator 09A

Field Name: HSIRace_SingleParentPercent

Row Name: Percent in household headed by single parent

Column Name:

Year: 2012

Field Note:

For the tabulation on the percent in household headed by a single parent, the data source is the U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, March 2012. CPS Table Creator for 2012. URL: <http://www.census.gov/cps/data/cpstablecreator.html>

The Current Population Survey (CPS) household head information refers to the year the survey is taken, not a reference year prior to the survey.

Numerator is derived by adding (1) Universe, Persons in Male-Headed Primary Families, No Spouse Present , California, Ages 0-19 and (2) Universe, Persons in Female- Headed Primary Families, No Spouse Present, California, Ages 0-19. Denominator is the Universe, Persons- All Children, California, Ages 0-19.

Section Number: Form21_Indicator 09A

Field Name: HSIRace_TANFPercent

Row Name: Percent in TANF (Grant) families

Column Name:

Year: 2011

Field Note:

For the tabulation on the percent in TANF, the numerator is the number of children ages 0 to 9 in CalWORKs assistance units during FFY 1. The CalWORKs database groups children from 0-18 years and not as 0-19 years. The White category includes non-Hispanic White, Hispanic White and Hispanic children of unknown race. Source for the numerator; California Department of Social Services, Federal Data Reporting and Analysis Bureau. Ad hoc SAS analysis completed 3/14/2013 (unpublished).

Denominator: Number of children ages 0 to 19 in CY 2011. State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.

Section Number: Form21_Indicator 09A

Field Name: HSIRace_MedicaidNo

Row Name: Number enrolled in Medicaid

Column Name:

Year: 2012

Field Note:

For the tabulation on the number enrolled in Medicaid, the Medicaid data included all infants and children 0-19 years enrolled in MediCal for the October 2011 month of eligibility. The data source is the RASS CINXMOE SAS Dataset created from the MEDS Eligible file with a 12 month reporting lag. The data source is the California Department of Health Care Services, Medical Care Statistics Section. More Than One Race Reported category included only Amerasian ethnicity code with no other codes to identify persons of more than one race. White category includes persons identified as White or Hispanic.

Section Number: Form21_Indicator 09A

Field Name: HSIRace_SCHIPNo

Row Name: Number enrolled in SCHIP

Column Name:

Year: 2013

Field Note:

For the tabulation of the number enrolled in SCHIP, the count for Asian does not include Native Hawaiian and Other Pacific Islander. The count for White includes Hispanic. The count for Asian for Title V Reporting Year 2011-12 had previously included Native Hawaiian and Other Pacific Islander in the Asian count. The HFP Monthly Enrollment Report does not include a More Than One Race Reported category. The counts for total other and unknown are combined to reflect the TVIS reporting category of other and unknown. The table used to collect this information on enrollments changes month by month. The data source is the Managed Risk Medical Insurance Board, HFP Monthly Enrollment Reports, Current Enrolled for December 2012. Accessed January 3, 2013 at http://mrmib.ca.gov/MRMIB/HFP/Dec_12/HFPRpt5A.pdf

Section Number: Form21_Indicator 09A

Field Name: HSIRace_FoodStampNo

Row Name: Number enrolled in food stamp program

Column Name:

Year: 2013

Field Note:

For the tabulation on the number enrolled in the food stamp program, data represent the number of children ages 0 through 19 in CalFresh food stamp households during FFY 2011, in both public assistance and non-assistance households. No children 19 years of age were reported in the CalFresh survey sample. The count for Asian includes Native Hawaiian and Other Pacific Islander. The count for White race includes Hispanic/White and Hispanic/Unknown race. Mixed Race was added as a new race category beginning FFY 2008. Data was requested from the California Department of Social Services, Federal Data Reporting and Analysis Bureau, completed on 3/11/2013.

Section Number: Form21_Indicator 09A

Field Name: HSIRace_WICNo

Row Name: Number enrolled in WIC

Column Name:

Year: 2012

Field Note:

For the tabulation on the number enrolled in WIC, the data source is the California Department of Public Health; Women, Infants and Children Program; Research and Evaluation Section. WIC Integrated Statewide Information System (ISIS), April 2012. Unpublished data is for the period from October 2010 to September 2011.

Section Number: Form21_Indicator 09A

Field Name: HSIRace_JuvenileCrimeRate

Row Name: Rate (per 100,000) of juvenile crime arrests

Column Name:

Year: 2013

Field Note:

For the tabulation on the rate of juvenile crime arrests, the numerator data include felony and misdemeanor offenses among juveniles age 19 and younger. Data is not available for the More than One Raced Reported category.

Numerator data was requested from the State of California, Department of Justice, Bureau of Criminal Information and Analysis, Criminal Justice Statistics Center, Monthly Arrest and Citation Register, 2011. The denominator is from the State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Available at: <http://www.dof.ca.gov/research/demographic/reports/projections/P-3/>

Section Number: Form21_Indicator 09A

Field Name: HSIRace_DropOutPercent

Row Name: Percentage of high school drop-outs (cohort class 2010-11)

Column Name:

Year: 2013

Field Note:

For the tabulation on the percentage of high school drop-outs, the 4-year adjusted cohort dropout rate is the rate of students that leave the 9-12 instructional system without a high school diploma, GED, or special education certificate of completion and do not remain enrolled after the end of the 4th year. It is calculated by dividing the number of students in the 4-year cohort that dropped out by the end of the 2010-11 school year by the number of first-time grade 9 students in Fall 2007 (starting cohort) plus students who transfer in, minus students who transfer out, emigrate, or die during school years 2007-08, 2008-09, 2009-10, and 2010-11. Due to this change in methodology in calculating the indicator compared to previous years, data currently reported should not be compared with data reported in previous years.

The percentage reported for "White" include all students whose race is reported as "Hispanic" and "White, non-Hispanic". Other and Unknown includes those identified as not reported. The data source is the California Department of Education, California Longitudinal Pupil Achievement Data System (CALPADS). Cohort Outcome Summary Report by Race/Ethnicity, Cohort Outcome Data for the Class of 2010-2011, Statewide Results. Available at: <http://dq.cde.ca.gov/dataquest/cohortrates/GradRates.aspx?cds=00000000000000&TheYear=2010-11&Agg=T&Topic=Dropouts&RC=State&SubGroup=Ethnic/Racial>. Last accessed on 3/12/13.

Section Number: Form21_Indicator 09A

Field Name: HSIRace_FosterCare

Row Name: Number living in foster home care

Column Name:

Year: 2014

Field Note:

For the tabulation on the number living in foster home care, the January 2011 data presented is for a point in time (accessed on 1/22/2013) caseload for children in child welfare supervised foster care ages 0-19 years. It excludes foster care cases placed or supervised by the county probation departments, the state adoptions district offices, the Indian Child Welfare, private adoption agencies, Mental Health, the Kinship Guidance Assistance Program (KinGAP) and out-of-state agencies. The count for Whites includes Hispanics. The counts for Asian includes Pacific Islanders. The data source is:

Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Putnam-Hornstein, E., Williams, D., Simon, V., Hamilton, D., Lou, C., Peng, C., Moore, M., King, B., Henry, C., & Nuttbrock, A. (2012). Child Welfare Services Reports for California. Retrieved 3/5/2012, from University of California at Berkeley Center for Social Services Research website. URL: http://cssr.berkeley.edu/ucb_childwelfare/PIT.aspx

Narrative:

The decline of juvenile arrests over the last decade is notable because it occurred even as the youth population age 10-17 was rising. The 36% drop in violent crime rates from 2000 to 2011 included all demographics: Latinos (down 36%), African Americans (down 10%), Whites (down 45%), Asians (down 62%), females (down 33%) and males (down 37%). California's youth arrests fell by 21% from 2010 to 2011. Juvenile arrests fell 17% last year, including drops in violent and property offenses (each down 16%), misdemeanor and status offenses (down 21%), and murder (down 26%). Around 25% of the youth crime decline from 2010 to 2011 is attributable to a legislative change that reduced simple possession of marijuana from a crime to an infraction, which reduced youthful misdemeanor marijuana arrests. In 2011, Senate Bill 1449 was implemented, which reduced the punishment for simple marijuana possession from a misdemeanor criminal offense to a civil infraction punishable by a fine of no more than \$100.

It is well established that juveniles who have been incarcerated face a greater risk of committing future offenses than those who have never been in custody; further, they often commit a more serious offense after their release. SB 1449 is intended to reduce the probability of this unnecessary and harmful initial contact with the criminal justice system, thereby reducing the risk of youth slipping into a lifetime cycle of criminality and incarceration.

Health Status Indicator 09b

Demographics (Miscellaneous Data) Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity.

Is this data final or provisional? Provisional

Category	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
Misc Data BY RACE				
All children 0 through 19	5,105,478	5,281,962	-	2011
Percent in household headed by single parent	28.4	34.3	0	2012
Percent in TANF (Grant) Families	9.1	13.5	N/A	2011
Number enrolled in Medicaid	1137139	2398971	253402	2010
Number enrolled in SCHIP	408,326	398,338	45,928	2012
Number living in foster home Care	26824	29449	141	2011
Number enrolled in food stamp Program	627,306	1,217,409	-	2011
Number enrolled in WIC	451,699	1611316	110	2011
Rate (per 100,000) of juvenile Crime arrests	2144	2345	-	2011
Percentage of high school drop-outs (grades 9 through 12, cohort class 2010)	11.2	18.2	41.9	2011

Field Level Notes

Section Number: Form21_Indicator 09B

Field Name: HSIethnicity_Children

Row Name: All children 0 through 19

Column Name:

Year: 2011

Field Note:

For the tabulation for all children 0 through 19, the data source is the State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. <http://www.dof.ca.gov/research/demographic/reports/projections/P-3/>

Section Number: Form21_Indicator 09B

Field Name: HSIethnicity_SingleParentPercent

Row Name: Percent in household headed by single parent

Column Name:

Year: 201

Field Note:

For the tabulation on the percent in household headed by a single parent, the data source is the U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, March 2012. CPS Table Creator for 2011. URL: <http://www.census.gov/cps/data/cpstablecreator.html>. The Current Population Survey (CPS) household head information refers to the year the survey is taken, not a reference year prior to the survey. Numerator is derived by adding (1) Universe, Persons in Male-Headed Primary Families, No Spouse Present, California, Ages 0-19 and (2) Universe, Persons in Female-Headed Primary Families, No Spouse Present, California, Ages 0-19. Denominator is the Universe, Persons- All Children, California, Ages 0-19.

Section Number: Form21_Indicator 09B
Field Name: HSIethnicity_TANFPercent
Row Name: Percent in TANF (Grant) families
Column Name:
Year: 2011

Field Note:
For the tabulation on the percent in TANF, the numerator is the number of children ages 0 to 18 in CalWORKs assistance units during FFY 2011. The CalWORKs database groups children from 0-18 years and not as 0-19 years. The White category includes non-Hispanic White, Hispanic White and Hispanic children of unknown race. Source for the Numerator; California Department of Social Services, Federal Data Reporting and Analysis Bureau. Ad hoc SAS analysis completed 3/14/2013(unpublished)

Denominator: Number of children ages 0 to 19 in CY 2011. State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.

Section Number: Form21_Indicator 09B
Field Name: HSIethnicity_MedicaidNo
Row Name: Number enrolled in Medicaid
Column Name:
Year: 2013

Field Note:
For the tabulation on the number enrolled in Medicaid, the Medicaid data included all infants and children 0-19 years enrolled in Medi-Cal for the October 2011 month of eligibility. The data source is the RASS CINXMOE SAS Dataset created from the MEDS Eligible file with a 12 month reporting lag. The data source is the California Department of Health Care Services, Medical Care Statistics Section.

Total Non-Hispanic category includes persons grouped in the White, African American, American Indian, Asian, Native Hawaiian/ Pacific Islander and More Than One Race categories, as well as those categorized as Other. . Ethnicity Not Reported category includes persons grouped in the Unknown category, with no response or no valid data.

Section Number: Form21_Indicator 09B
Field Name: HSIethnicity_SCHIPNo
Row Name: Number enrolled in SCHIP
Column Name:
Year: 2014

Field Note:
For the tabulation of the number enrolled in SCHIP, the total Non-Hispanic category includes persons grouped in the White, African American, American Indian, Asian, and More Than One Race categories, as well as those categorized as Other within the Other and Unknown category. The table used to collect this information on enrollments changes month by month. The data source is the Managed Risk Medical Insurance Board, HFP Monthly Enrollment Reports, Current enrolled for December 2012. Accessed January 3, 2013 at http://mrmib.ca.gov/MRMIB/HFP/Dec_12/HFPRpt5A.pdf

Section Number: Form21_Indicator 09B
Field Name: HSIethnicity_FoodStampNo
Row Name: Number enrolled in food stamp program
Column Name:
Year: 2013

Field Note:
For the tabulation on the number enrolled in the food stamp program, data represent the number of children ages 0 through 19 in CalFresh food stamp households during FFY 2011, in both public assistance and non-assistance households. No children 19 years of age were reported in the CalFresh survey sample. The count of Total Not Hispanic or Latino includes White Not of Hispanic Origin, Black Not of Hispanic Origin, American Indian/Alaska Native, Asian/Pacific Islander, More Than One Race Reported, and Unknown. Data was requested from the California Department of Social Services, Federal Data Reporting and Analysis Bureau, completed on 3/11/2013.

Section Number: Form21_Indicator 09B
Field Name: HSIethnicity_WICNo
Row Name: Number enrolled in WIC
Column Name:
Year: 2013

Field Note:

For the tabulation on the number enrolled in WIC, the total Not Hispanic or Latino includes White, Black/African American, American Indian/Native Alaskan, Asian, Native Hawaiian/Other Pacific Islander, More Than One Race Reported, and Other and Unknown.

Source: California Department of Public Health; Women, Infants and Children Program; Research and Evaluation Section. Unpublished data, April 2012. Data is for the period from October 2010 to September 2011.

Section Number: Form21_Indicator 09B

Field Name: HSIethnicity_JuvenileCrimeRate

Row Name: Rate (per 100,000) of juvenile crime arrests

Column Name:

Year: 2014

Field Note:

For the tabulation on the rate of juvenile crime arrests, the numerator data include felony and misdemeanor offenses among juveniles age 19 and younger. Data is not available for the More than One Raced Reported category. Total Not Hispanic or Latino includes White, Black/African American, Asian, Native Hawaiian/Other Pacific Islander, and Other.

Numerator data was requested from the State of California, Department of Justice, Bureau of Criminal Information and Analysis, Criminal Justice Statistics Center, Monthly Arrest and Citation Register, 2011. The denominator is from the State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013. Available at: <http://www.dof.ca.gov/research/demographic/reports/projections/P-3/>

Section Number: Form21_Indicator 09B

Field Name: HSIethnicity_DropOutPercent

Row Name: Percentage of high school drop-outs (grades 9 through 12, cohort class 2011)

Column Name:

Year: 2013

Field Note:

For the tabulation on the percentage of high school drop-outs, the total count of Not Hispanic or Latino includes White, Black/African American, American Indian/Native American, Asian, Filipino, Pacific Islander, and two or more races. Total count of Ethnicity Not Reported includes only those whose race/ethnicity was not reported

For the tabulation on the percentage of high school drop-outs, the 4-year adjusted cohort dropout rate is the rate of students that leave the 9-12 instructional system without a high school diploma, GED, or special education certificate of completion and do not remain enrolled after the end of the 4th year. It is calculated by dividing the number of students in the 4-year cohort that dropped out by the end of the 2010-11 school year by the number of first-time grade 9 students in Fall 2007 (starting cohort) plus students who transfer in, minus students who transfer out, emigrate, or die during school years 2007-08, 2008-09, 2009-10, and 2010-11. Due to this change in methodology in calculating the indicator compared to previous years, data currently reported should not be compared with data reported in previous years.

The data source is the California Department of Education, California Longitudinal Pupil Achievement Data System (CALPADS). Cohort Outcome Summary Report by Race/Ethnicity, Cohort Outcome Data for the Class of 2009-2010, Statewide Results. Available at: <http://dq.cde.ca.gov/dataquest/cohortrates/GradRates.aspx?cds=00000000000000&TheYear=2010-11&Agg=T&Topic=Dropouts&RC=State&SubGroup=Ethnic/Racial>. Last accessed on 3/12/13.

Section Number: Form21_Indicator 09B

Field Name: HSIethnicity_FosterCare

Row Name: Number living in foster home care

Column Name:

Year: 2014

Field Note:

For the tabulation on the number living in foster home care, the January 2011 data presented is for a point in time (accessed on 01/22/2013) caseload for children in child welfare supervised foster care ages 0-19 years. It excludes foster care cases placed or supervised by the county probation departments, the state adoptions district offices, the Indian Child Welfare, private adoption agencies, Mental Health, the Kinship Guidance Assistance Program (KinGAP) and out-of-state agencies.

The data source is:

Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Putnam-Hornstein, E., Williams, D., Simon, V., Hamilton, D., Lou, C., Peng, C., Moore, M., King, B., Henry, C., & Nuttbrock, A. (2012). *Child Welfare Services Reports for California*. Retrieved 3/5/2012, from University of California at Berkeley Center for Social Services Research website. URL: http://cssr.berkeley.edu/ucb_childwelfare/PIT.aspx

Health Status Indicator 10

Demographics (Geographic Living Area) Geographic living area for all resident children aged 0 through 19 years old. (Demographics)

Reporting Year: 2011
 Is this data from a State Projection? Yes
 Is this data final or provisional? Final

Geographic Living Area	Total
Living in metropolitan areas	0
Living in urban areas	10,155,381
Living in rural areas	232,059
Living in frontier areas	
Total – all children 0 through 19	10,387,439

Note: The total will be determined by adding reported numbers for urban, rural and frontier areas.

Field Level Notes

Section Number: Form21_Indicator 10

Field Name: Metropolitan

Row Name: Living in metropolitan areas

Column Name:

Year: 2014

Field Note:

The data source is the United States Department of Agriculture, Economic Research Service, Population, Income, Education, and Employment State Fact Sheets: California, Population table. Last updated on February 26, 2013. Available at: <http://www.ers.usda.gov/StateFacts/CA.htm>. Last accessed on March 11, 2013. Data for the population living in metropolitan areas was not provided in the fact sheet.

Section Number: Form21_Indicator 10

Field Name: Urban

Row Name: Living in urban areas

Column Name:

Year: 2014

Field Note:

The data source is the United States Department of Agriculture, Economic Research Service, Population, Income, Education, and Employment State Fact Sheets: California, Population table. Last updated on February 26, 2013. Available at: <http://www.ers.usda.gov/StateFacts/CA.htm>. Last accessed on March 11, 2013.

Urban and rural California population estimates were for year 2011. Urban and rural definitions are based on the Office of Management and Budget June 2003 classification. Estimated number of children living in urban areas was calculated as total population 0-19 multiplied by the percent of children living in urban counties.

Denominator Source:

State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.

Section Number: Form21_Indicator 10

Field Name: Rural

Row Name: Living in rural areas

Column Name:

Year: 2014

Field Note:

The data source is the United States Department of Agriculture, Economic Research Service, Population, Income, Education, and Employment State Fact Sheets: California, Population table. Last updated on February 26, 2013. Available at: <http://www.ers.usda.gov/StateFacts/CA.htm>. Last accessed on March 11, 2013.

Urban and rural California population estimates were for year 2011. Urban and rural definitions are based on the Office of Management and Budget June 2003 classification. Estimated number of children living in rural counties was calculated by multiplying the estimated number of children in the state by the percent of overall state population living in rural counties.

Denominator Source:

State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.

Section Number: Form21_Indicator 10

Field Name: Frontier

Row Name: Living in frontier areas

Column Name:

Year: 20141

Field Note:

The data source is the United States Department of Agriculture, Economic Research Service, Population, Income, Education, and Employment State Fact Sheets: California, Population table. Last updated on February 26, 2013. Available at: <http://www.ers.usda.gov/StateFacts/CA.htm>. Last accessed on March 11, 2013. Data for the population living in frontier areas was not provided in the fact sheet.

Health Status Indicator 11

Demographics (Poverty Levels) Percent of the State population at various levels of the federal poverty level. (Demographics)

Reporting Year: 2011
 Is this data from a State Projection? Yes
 Is this data final or provisional? Final

Poverty Levels	Total
Total Population	37,592,405
Percent Below: 50% of poverty	7.2%
100% of poverty	16.9%
200% of poverty	38.0%

Form Notes

HSI 11 & 12: Source: Current Population Survey, Annual Social and Economic Supplement, 2012, U.S. Census Bureau. Data extracted with online data tool, CPS Table Creator: www.census.gov/hhes/www/cpstc/cps_table_creator.html. Last accessed on March 11, 2013

For the numerator and denominator, the "Persons in Poverty Universe" is used. The poverty status is reported for the survey year (2012), but is based upon family income in the previous year (2011).

Health Status Indicator 12

Demographics (Poverty Levels—Children) Percent of the State population aged 0 through 19 at various levels of the federal poverty level. (Demographics)

Reporting Year: 2011
Is this data from a State Projection? Yes
Is this data final or provisional? Final

Poverty Levels	Total
Children 0 through 19 years old	10,384,643
Percent Below: 50% of poverty	10.1%
100% of poverty	24.6%
200% of poverty	48.5%

Form Notes

HSI 11 & 12: Source: Current Population Survey, Annual Social and Economic Supplement, 2012, U.S. Census Bureau. Data extracted with online data tool, CPS Table Creator: www.census.gov/hhes/www/cpstc/cps_table_creator.html. Last accessed on March 11, 2013.

For the numerator and denominator, the "Persons in Poverty Universe" is used. The poverty status is reported for the survey year (2012), but is based upon family income in the previous year (2011).

Narrative:

The latest data show that the recession had a profound impact on California, particularly families with children. There has been an increase in poverty among children across all federal poverty levels. However, the trend may be shifting among California's poorest children. The percent of children below 50% FPL increased from 8.1 in 2008 to 10.1% in 2011. Those below 100% FPL increased from 20.5% in 2008 to 24.6% in 2011; and, those below 200% FPL increased from 43.3% in 2008 to 48.5% in 2011.

F. Other Program Activities

>MCAH Hotline, MCAH Web Hits and the National Text4baby

Both the State and LHJs have telephone hotlines that provide information regarding maternal, child and adolescent health services and programs. There are several statewide toll free telephone hotlines run by the State of California, including one for MCAH: 1-866-241-0395. **/2014/ The State MCAH toll-free telephone line received 510 calls in FY 2011-12//2014//**The combined number of telephone calls to the local MCAH toll-free lines was 49,748 in FY 2008-09, up from 42,239 in FY 2007-08.

/2014/Local Health Jurisdictions (LHJs) received 66,722 calls to their MCAH toll-free telephone lines and 246,104 MCAH web hits in FY 2011-12. Not all LHJs have the capacity to count web hits, therefore this number is an underestimate//2014//

The MCAH web site received 57,323 hits in 2008/09 /2012/and 29,716 hits in 2009/10. **/2014/ The State MCAH web site received 20,782 visits and 30,561 views in 2011-12//2014//** .Calls to the local MCAH toll-free lines decreased to 24,357 in FY 2009-10, partly due to increased use of local web pages. //2012// Local MCAH web sites have also been accessed by community members. For example, Contra Costa County reported receiving 84,074 hits to their MCAH web site.

Text4baby is a free mobile information service designed to promote maternal and child health. An educational program of the National Healthy Mothers, Healthy Babies Coalition, Text4baby provides pregnant women and new moms with information they need to take care of their health and give their babies the best possible start in life. Of the 42,518 who enrolled in text4baby nationwide as of May 2010, 9.5% (n= 4024) of women were from California.**/2014/According to Text4baby, in 2012 there were approximately 17,660 individuals who signed up for the service. Since Text4baby launch in 2010, California has had 44,940 individuals who have signed up for Text4baby//2014//**.

>Emergency Preparedness

CDPH launched a program to help Californians find local H1N1 and seasonal influenza immunization information using cell phone texting inquiries, Facebook applications, Twitter and Web widgets. CDPH is promoting the campaign through outdoor advertising, public service announcements and social media. CDPH also launched a new television campaign, entitled “Hands”, that lays out the simple facts about H1N1 and encourages vaccination.

MCAH continues to be active in providing updated information about H1N1, perinatal transport and breastfeeding in emergency situations on their website and to LHJs. The information offered is appropriate for pregnant women, parents, clinicians and health officials. Several local MCAH programs participate in collaboratives and have developed activities regarding emergency preparedness for the MCAH population

>Home Visiting Programs

Ten counties in California utilize Nurse Family Partnership (the David Olds home visiting model) to follow high-risk, first-time pregnant women, their children and families. The Olds model is a home visitation model that utilizes public health nurses; other counties utilize a home visitation format with staff ranging from community health workers to registered nurses.

A few counties are applying for federal grants to run the Nurse Family Partnership. Also, a few local Public Health Departments are developing or currently implementing their own home visiting programs to provide assessment of mother and infants, health education, and information and referral for needed services./2012/ MCAH is the designated state entity to apply for and administer HRSA and Administration of Children and Families (ACF) HVP. MCAH engaged stakeholders in selecting 20-30 communities to implement Nurse Family Partnership and HF America HVPs, based on the Federal FY 2010 budget.

>American Indian/ Native Alaskan Health

MCAH provides \$424,000 to the Indian Health Program of the Primary and Rural Health Division of DHCS for improvement of AI/AN MCH outcomes and support the American Indian Infant Health Initiative, which offers home visitation in 5 counties with the greatest AI/AN MCH disparities. Services include case management and lay (Community Health Representative) home visitation that includes health assessment, education, referral and transport. Bi-annual workshops provide professional development for staff and for case review across sites. Collaboration with WIC and Child Protective Services is fostered to improve family outcomes.

Additional resources are available to AI/AN families throughout California. For example, the California Courts recently developed the Statewide Directory of Services for Native American Families. //2012//

>Human Stem Cell Research (HSCR) and Women's Reproductive Health

MCAH created the HSCR Program in 2005 to fulfill legislative mandates through the development of statewide research guidelines, protections for women donating oocytes for research, requirements for HSCR review and approval, and HSCR reporting requirements.

MCAH convened the HSCR Advisory Committee in 2006. In 2007, CDPH approved the statewide guidelines for HSCR submitted by the Advisory Committee. These guidelines were revised in 2008 and 2009 to reflect advancements in the HSCR field. /2013/ The

guidelines were revised in 2011 to maintain consistency with changes in the HSCR field and state regulations. //2013//

The HSCR Program developed reporting forms for research involving human embryonic stem cells and oocyte retrieval in spring 2008. In the first year of data collection, 15 review committees reported on 244 HSCR projects. In the second year of reporting, 18 review committees reported on 303 HSCR projects. /2012/ The third year included reports on 350 HSCR projects. HSCR will submit its second biennial review to the Legislature in Spring 2011. //2012// /2013/ In 2011, 17 review committees reported on 364 HSCR projects. No projects involved women donating oocytes. //2013//

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

/2013/Prenatal screening services are discussed in Performance Measure 01. In 2011, GDSP fully integrated all components of first trimester screening (nuchal translucency ultrasound plus first and second trimester blood screens).//2013// The California Birth Defects Monitoring Program (CBDMP) was established in 1982 to conduct research and surveillance of birth defects and maintain a birth defect registry. /2013/In June 2010, the California legislature approved the use of federal funds for umbilical cord blood banking, and the cord blood program was transferred to the University of California Los Angeles (UCLA).//2013// CBDMP collaborates with GDSP to maintain the Pregnancy Blood Bank, which stores blood samples from GDSP's Prenatal Screening Program. /2013/The bank currently stores more than one million samples from California women.//2013//

>Oral Health Promotion

MCAH recognizes the importance of oral health as being integral to overall health and is responding with a variety of strategies to increase this awareness among its targeted populations. MCAH is contracting with UCSF for a dental hygienist to serve as the MCAH Oral Health Policy Consultant providing technical assistance at both the state and local levels. Guidelines within MCAH programs have been revised to include oral health recommendations for pregnant and postpartum women and their young children. MCAH collaborates with organizations concerned with promoting oral health throughout the state, including formulating recommendations for the newly completed statewide perinatal oral health guidelines.

State budget cuts to the Children's Dental Disease Prevention Program and Medi-Cal adult dental services will be very challenging to MCAH LHJs which provide education and referrals to their clients. MCAH has 18 /2013/19//2013// /2014/ 22//2014//LHJs that have selected oral health as a priority objective. Eleven /2012/ Ten //2012// /2013/11//2013// /2014/Thirteen//2014//of these programs have a minimum of one part-time oral health coordinator/consultant on staff. Another 25 LHJs collaborate on community dental health advisory boards. The boards develop and implement local dental screening and prevention programs and work to increase access by encouraging more dentists to become Denti-Cal providers.

G. Technical Assistance

MCAH requests training and resource materials in the area of capacity assessment, including: 1) Clinical capacity assessment (availability of and access to clinics, maternity beds, neonatal intensive care units, etc.); 2) Clinical workforce assessment at state and county levels (physicians, obstetrician/gynecologists, pediatricians, dentists, nurses, etc.); 3) Public health capacity assessment (epidemiologists, program evaluators, etc.); 4) Integration of needs assessment, capacity assessment, and implementation planning, and; 5) MCAH public health workforce assessment.

MCAH requests guidance in conducting the Home Visitation Program Needs Assessment as mandated by the Maternal, Infant, and Early Childhood Home Visiting Program in the Patient Protection and ACA. Specifically, MCAH requests assistance in identifying the criteria by which MCAH can measure the effectiveness of evidence-based early childhood home visiting models that qualify under the new legislation, guidelines for reporting to fulfill the needs assessment requirements and developing quantifiable measures for setting benchmarks.

MCAH requests training and resource materials in the area of capacity assessment, specifically on : 1) developing process indicators related to direct healthcare services; (2) community level capacity assessment; (3) linking needs analysis with capacity assessment to identify priorities and resource allocation and (4) "train the trainer" on conducting state and community-level capacity assessment 5) internal organizational capacity assessment 6) scope and breadth in assessing systems capacity beyond MCAH services.

MCAH requests assistance in reviving an annual (or biennial) MCAH California Conference. The conferences would be a collaborative effort undertaken by the MCAH, MCAH Action (the statewide organization of local MCAH Directors), and the UCB School of Public Health. Such conferences were held annually in California prior to discontinuation in 2002 due to budget constraints. The conferences were well attended, with approximately 700 participants each. Conference locations alternated between northern and southern California. The conference provided opportunities for participants --from the state, local jurisdictions, academia, and other interested groups --to network and strategize on issues affecting the health of women, children and families in California. Each year the conference had a theme. MCAH encouraged interested parties to submit general or scientific abstracts on current and emerging MCAH issues pertinent to the theme. Programs that addressed the conference theme were recognized.

MCAH has an excellent staff of researchers and analysts for epidemiological analyses and evaluation of Title V programs. However, MCAH requests training for recent hires and junior research staff on several methodological aspects of epidemiological analyses of MCAH and program evaluation. CMS would also benefit from receiving training on these issues, including epidemiological methods, analyses of the cost-effectiveness or budget neutrality of programs, and the analysis of trend data. While it would be desirable

to obtain this training directly through seminars and workshops offered at CDC, HRSA, and other Federal agencies, policies designed to address budget constraints in California prohibit out-of state travel. **/2014/ Reference to Children’s Medical Services (CMS) is being gradually phased out and replaced by Systems of Care Division (SCD)./2014//**

A workshop on epidemiology (e.g., risk ratios, sensitivity, specificity, validation, and bias) and appropriate statistical analyses commonly used in MCAH would be valuable to both MCAH and CMS. Applied examples, including examples of analyses commonly used by comparable state and federal entities, would demonstrate concepts and inform possible areas for enhanced analysis and program development. Many MCAH programs are local; data collected at the state level may be useful for smaller areas, so an overview of small-area and geographic analysis would also enhance current and suggest future analyses.

Technical assistance on how to conduct cost-effectiveness, cost-benefit, and cost avoidance analyses for Title V programs would also be very beneficial for staff. During the current era of budget shortfalls in California, there has been greater scrutiny by decision-makers as to the cost effectiveness and fiscal neutrality of programs run by the MCAH and CMS.

Technical assistance on the steps involved in analyses, parameters to consider, accepted methodologies, and effective presentation of results would supplement staff’s ability to provide this critical information to program managers and administration officials.

Staff would benefit from hands-on training on smoothing techniques to deal with geographic areas (e.g., census tracts) for which there are too few observations to generate statistically stable counts or rates and recommended statistical tests for use with geospatial data, including for smoothed data.

The CDC reports that more than 40 percent of women experience some type of complication during childbirth; many of these complications are preventable. Maternal morbidity is a serious public health problem that can impact maternal, fetal, and infant health and can lead to maternal death. MCAH is working to monitor maternal morbidity. MCAH is developing an MQI project and has contracted with an academic research group to assess variation in maternal outcomes and an evidence-based quality improvement collaborative to analyze the data. MCAH requests assistance in the development of systems for identifying, reviewing, and analyzing maternal morbidity that will serve as a framework for improved maternal standards of care.

MCAH requests assistance in how to obtain youth input into decision-making for the Branch and its adolescent-related programs. Currently, the Branch does not have sufficient manpower to carry out this activity, but would like to include more youth input into our decision-making process

/2012/MCAH requests assistance in the development of systems for identifying, reviewing, and analyzing maternal morbidity and mortality that will serve as a framework

for improved maternal standards of care. Assistance is needed on study design, case selection, medical record review protocols, guidance on whether cases are pregnancy-related or pregnancy-associated, and development of recommendations to reduce morbidity and mortality based on findings.

MCAH requests assistance to translate current evidence regarding contributing factors to racial disparities into Title V programmatic activities and build capacity in addressing the impact of the social determinants of health. Disparities in infant and maternal health outcomes persist and are widening for maternal mortality; thus, MCAH needs to expand current strategies. MCAH is invested in moving to primary prevention and applying the life course theory to interventions, but moving from a programmatic approach to reaching out to influence decision-making in other disciplines is a new and emerging role.

It is essential to communicate the value and make the case for the importance of MCAH programs in contributing to health across the life course. MCAH requests assistance in developing a set of standardized messages that state and local MCAH programs could use. //2012//

//2014/ MCAH requests assistance to raise awareness of Title V program expertise in outreach and enrollment into health services in order to gain state and local support for local MCAH to serve in this capacity and win resources to support implementation of the ACA. //2014//

//2013/ MCAH requests assistance in the area of capacity development related to methodological training for new and junior staff on epidemiological methods and conducting cost-effectiveness analysis, assistance on obtaining youth input, translational research, addressing social determinants of health, methodology development for longitudinal analysis of preconception and interconception health and standardized messaging.

CCS requests assistance from MCHB in adapting the National CSHCN survey to California's CCS population in order to move forward with State Performance Measure 3, The percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey. The national survey results offer some insight into satisfaction, insurance, access of families of CSHCN in California, but does not differentiate between CCS eligible and other CSHCN so that results are not directly applicable to the CCS program. Its length is also limiting. Use of an adapted survey will allow assessment, specific to families and children in the CCS program, of several priority objectives of the Title V needs assessment, including implementation of medical homes, increasing family partnership in decision making, and satisfaction with services;. In addition, an adapted survey would allow the CCS program to monitor family satisfaction as changes are made to the CCS over the next 5 years.

//2013// //2014/ Family Satisfaction Survey has been developed for the 1115 Waiver Counties. CCS is exploring using this survey for the representative sample of CCS clients and families residing in the other counties. //2014//

V. Budget and Expenditures

A. Expenditures

The budget and expenditures for FFY 2012 are presented in Forms 2, 3, 4, and 5.

/2013/ The reductions in federal Title V funding has resulted in programmatic adjustments to reduce expenditures in infrastructure building services which will affect the following:

MCAH Division

MCAH is reducing 6.0 positions and over \$6.8 million in funding expenditure authority for FY 2012/13. Reductions to travel and general expense allocations will limit MCAH's ability to conduct mandatory on-site program reviews, provide technical assistance and respond to information requests from LHJs and MCAH stakeholders. The positions being eliminated are:

≥ Nurse Consultant III (Specialist) – Elimination of this position limits technical assistance capacity to support oversight and effective implementation of newly revised scope of work (SOW) for local MCAH, BIH, and AFLP programs. Nurse Consultant capacity for oversight, development, and long-delayed improvements to the Comprehensive Perinatal Services Program (CPSP) will be reduced by 25 percent. These functions are necessary to ensure CDPH/MCAH compliance with statutory requirements and Title 22 regulations. In addition, the loss of this position will reduce the capacity to develop and implement a health systems framework for coordination and integration of local MCAH, home visiting, and other community programs that make up the local MCAH public health system.

≥ Three Associate Governmental Program Analysts - The elimination of these positions will limit the ability of MCAH to monitor, maintain, and provide technical assistance to LHJs, CBOs, and contractors.

≥ Two Staff Service Analysts - The elimination of these positions will limit the ability of MCAH to monitor, maintain, and provide technical assistance to LHJs, CBOs, and contractors.

≥ Public Health Medical Officer III– The elimination of this position limits the ability of MCAH to address the rising rate of maternal morbidity and mortality, a newly emerged health issue in the last decade.

Primary and Rural Health Division (PRHD)

In FY 2012/13 the PRHD will be reduced by \$373,000 and eliminate 4.0 state positions at DHCS. The PRHD provides training, technical assistance, and limited funding to primary care providers in underserved areas throughout the state to sustain and improve the primary care infrastructure. This assistance enables primary care clinics to plan and evaluate their systems of primary and preventive care delivery to meet the needs of high risk,

underserved populations, including women and children. Targeted clinics include those located in rural areas and clinics that serve migrant farmworkers and American Indians. Additionally, the PRHD supports the implementation of the American Indian Infant Health Initiative (AIIHI). This program provides home visitation services to high-risk pregnant and parenting American Indian families. Services include assessment, counseling, referrals/follow up to medical and social services providers. The following are the positions that will be eliminated:

> Word Processing Technician – Elimination of this position will impact contract oversight and delivery of annual reports. Primary care clinics will be additionally impacted due to delays in Tribal notification of Medi-Cal updates.

> Associate Governmental Program Analyst – Elimination of this position will cause delays in grant execution, limited support to DHCS divisions for Tribal notices, and delays in providing technical assistance and support to Indian health clinics.

> Health Program Specialist I – Elimination of this position will decrease support to community health centers, Federally Qualified Health Clinics, rural health clinics, and other rural health providers for funding applications.

> Nurse Consultant III (Specialist) – Elimination of this position will delay providing clinical technical assistance, limits staff support to mandated Indian health advisory group, and delays development and updates of policy and procedures.

Audits and Investigations (A&I) Division

A & I performs audits on MCAH local contracts to ensure fiscal accountability and that federal requirements are met. A proposed reduction of \$182,000 to A&I will result in a reduction in the number of audits to what has historically been performed.

> APN

Reductions and redirections of the Title V funds resulted in a 25% reduction in the APN for FY 2011/12 and complete elimination by July 2012.

> CDAPP

For FY 2011/12 funding for CDAPP was reduced by 50% to about \$600,000 and the program will be eliminated starting July 2012. A resource and training center was contracted to provide resource materials, educational webinars and maintain the CDAPP website and listings of local CDAPP affiliates.//2013//

B. Budget

Since the enactment of the Omnibus Budget Reconciliation Act 89, California has maintained the availability of Title V funds under both the maintenance of effort and the match requirements. The California Title V agency will continue to do so in the coming year.

The proposed allocation of Title V funds for California for FFY 2011 is \$43,315,317. Preventive and primary services for pregnant women, mothers, and infants are designated to receive \$12,800,106 (29.55 % of the total), preventive and primary services for children to receive \$14,272,848 (32.95 %) and CSHCN to receive \$13,603,489 (31.41%).

/2012/The proposed FFY 2012 allocation is \$42,300,760 Preventive and primary services for pregnant women, mothers, and infants are designated to receive \$13,160,420 (31.11 % of the total), preventive and primary services for children to receive \$13,476,402 (31.86 %) and CSHCN to receive \$13,235,668 (31.29%). //2012//

/2013/The FFY 2013 allocation is \$41,389,219. Services for pregnant women, mothers, and infants are designated to receive \$13,055,182 (31.54 %) services for children to receive \$13,573,945 (32.80 %) and CSHCN to receive \$12,560,334 (30.35%). The required match is \$31,041,914, California's FFY 2013 budget for Title V MCH programs includes \$1,306,322,819 in state funds.//2013//

> State Match/Overmatch

California expects to receive \$43,315,317 in Federal Title V Block Grant funds for FFY 2011. The required match is \$32,486,488. California's FFY 2011 expenditure plan for MCAH programs includes \$1,290,479,684 in state funds. The dramatic increase in California's expenditure plan for FFY 2011 for the provision and coordination of services to the Title V MCAH population is due to the reporting of CSHCN data on actual expenditures. Previously the Electronic Data Systems (EDS) MR 922 report was used to provide the data for these numbers. However, a change to the EDS system for this report changed something in the data compilation and the numbers were not correct as they were grossly understating the expenditure data. Therefore, numbers from previous years' data submission to this year's data submission show a marked increase for the expenditures as the number is projected upon the actual expenditure data from FY 09/10 instead of the MR 922 report. Reporting of expenditure data has been updated and no longer uses the report it used in prior years. //2011//

/2012/ California expects to receive \$42,300,760 in Title V funds for FFY 2012. The required match is \$31,725,5701, California's FFY 2012 budget for Title V MCH programs includes \$1,366,907,980 in state funds.//2012//

>Administrative Costs Limits

In FFY 2011 no more than 10 percent of the Federal Title V MCH Block Grant funds will be used for administrative costs related to each program component. During FFY 2011, California will expend only 6.09 % of Title V funds on administrative costs.

/2012/ In FFY 2012 /2013/and 2013//2013// no more than 10 % of the Title V MCH Block Grant funds will be used for administrative costs and California will expend only 5.74% /2013/ and 5.31%, respectively, //2013// on administrative costs.//2012//

>Definition of Administrative Costs

In this Application, administrative costs are defined as the portion of the Title V dollars used to support staff in the MCAH Division Operations Sections. Funds supporting State program and data staff (but not administrative staff) in MCAH and CMS are considered to be program rather than administrative costs.

Administrative costs include staff and operating costs associated with the administrative support of MCAH. These support functions include, but are not limited to, contract management, accounting, budgeting, personnel, audits and appeals, maintenance of central contract files, and clerical support for these functions.

>"30-30" Minimum Funding Requirement

At least 30 percent of the MCH Title V Block Grant funds will be used for children's preventive and primary care services delivered within a system which promotes family-centered, community-based, coordinated care. At least 30 percent of the Title V Block Grant funds will be used to provide services to CSHCN delivered in a manner which promotes family-centered, community based, coordinated care.

In some cases, the CDPH uses estimates to assess expenditures for both individuals served and the types of services provided. These estimates are based on the target population and program activities authorized in statute, excluding the State budget, and specified in the scope of work for each contractor. Requiring contractors to bill according to actual amounts spent on each type of individual served and by service provided is not possible within current administrative and fiscal policies. Changing State contractual policies would result in undue financial and administrative hardship to local governments and non-profit community-based organizations. This added burden without increased funding would result in many of them not being able to continue to provide needed services to women and children in the state.

//2013/ Since FY 2008/09, LHJ quarterly time surveys were implemented to ensure that the "30-30" minimum funding requirement is met. //2013//

>**Maintenance of State Effort**

CDPH has an ongoing commitment to provide maternal and child health services to women and children within the State of California. This commitment includes continued support to local health jurisdictions, local programs, clinics and Medi-Cal providers for maternal and child health services.

It is the State's intent to ensure that State General Fund contributions to these local programs, which are also funded in part by the Federal Title V Block Grant, be administered by MCAH and CMS.

The State's General Fund contribution for FFY 2011 is \$1,290,479,684 which is \$1,203,320,934 greater than the State's General Fund contribution of \$87,158,750 in base year FFY 1989. /2012/The State's General Fund contribution for FFY 2012 is

\$1,366,907,980 which is \$1,279,749,230 greater than the State's General Fund contribution of \$87,158,750 in base year FFY 1989. //2012//

>Budget Impact

The combined effect of the state's budget deficit and loss of revenues due to the economic downturn resulted in a budget gap of \$26.3 billion for Fiscal Year 2009-10. All California State General Funds (SGF) for MCAH were eliminated effective July 1, 2009, reducing the state and local MCAH Program budget by \$20.3 million in SGF and \$12 million in related matching Federal Title XIX funds.

The loss of SGF to MCAH Programs, BIH, AFLP, CPSP and CBDMP has resulted in deep cuts to local staffing, public health prevention activities, and the numbers of clients served. At the local level, the loss of SGF has reduced or eliminated the capacity of LHJs to provide public health nurse home visiting programs, as well as the LHJs' ability to provide outreach to the community by educating the MCAH population regarding such issues as SIDS, domestic violence, injury prevention, safety promotion measures and accident prevention, preconception care, early prenatal care, STDs and family planning, access to care, oral health, breastfeeding, childhood nutrition, childhood obesity, and guidance and support.

Statewide, the LHJs allocate approximately 3.25% of Public Health Realignment funds to local MCAH programs. In FY 2006-07, total Public Health Realignment funds transferred to counties equaled \$1,538,651,128. In FY 2008-09, total Public Health Realignment funds transferred to counties equaled \$1,372,049,262 and FY 2009-10 will be further reduced to approximately \$1,310,000,000.

Given that the current fiscal year's public health realignment funding distributions are projected to be approximately \$62 million lower than FY 2008-09 distributions, the MCAH reductions in FY 2009-10 can be estimated to be approximately \$2,015,000 in realignment funding and an additional \$705,000 in matching Title XIX across local MCAH, BIH and AFLP programs.

>State MCAH Support

MCAH has lost the ability to leverage SGF to draw down Title XIX matching funds. The loss of \$3.5 million resulted in an additional loss of approximately \$1 million in federal Title XIX matching 188 funds. It reduced capacity at the local level to collect data has impacted the State's ability to document positive program outcomes and identify and address needed changes. State staffing levels were reduced -- vacant positions have not been filled, creating added work burden for remaining State staff. Resources were reduced to coordinate services across LHJs and advocate for vulnerable at-risk MCAH populations. There was an overall reduction in statewide meetings, which are essential to assuring statewide program equality, information sharing, training, and problem solving. There was travel reduction for state staff to audit and monitor budgets and operations and provide crucial technical assistance.

/2012/State General Fund monies have not been reinstated. Title V federal funds were reduced in FFY 2011, which has resulted in a reduction to local allocations for BIH and AFLP. //2012//

>CBDMP and CPSP

Of the \$3.5 million SGF budgeted for State Operations, \$1.6 million was for CBDMP. Reduced funding has caused the program to be drastically restructured. Budget cuts to CPSP has resulted in decreased outreach to promote access to early prenatal care, decreased recruitment and training of new CPSP providers or provision of technical assistance to existing and new CPSP providers. Also, there is reduced monitoring and evaluation of CPSP providers.

>LOCAL MCAH PROGRAMS

The elimination of \$2.1 million in SGF from local MCAH programs resulted in a loss of \$2.1 million in Title XIX federal matching funds. Total local MCAH funds lost as a direct result of the elimination of SGF and the related Title XIX federal match was \$4.2 million statewide in FY 2009-10. For every \$1 of SGF cut, LHJs have experienced an additional \$1 in Title XIX matched funding. Statewide, in addition to the loss of SGF and the related Title XIX match, local funds budgeted were reduced by \$1.9 million in FY 2009-10. Title XIX match to local funds will be affected by the reduction in local funds, and is estimated to be a reduction of approximately \$600,000, based on projected invoices.

/2012/The reduction to Federal Title V allocation to the State did not affect local MCAH program budgets for SFY 2011-12, and there were no shifts in funding from MCAH to other Title V programs. SGF remains at zero, and both state and local agencies continue to operate with less money and staff due to hiring freezes and lack of funds.//2012//

>AFLP

In 2009-2010, \$10.7 million SGF and \$5.1 million related Title XIX were eliminated for AFLP. In the 2009-2010 fiscal year, AFLP reductions resulted in 12,027 fewer clients served -- a 70% reduction in clients served. AFLP agencies experienced staff reductions of 170 full-time equivalent (FTE) statewide. Three AFLP programs -- Riverside, San Bernardino, and Siskiyou Counties -- have been discontinued in FY 2009-10 as a result of their inability to continue activities at the current funding levels.

/2012/Due to a reduction to the Federal Title V allocation to the States in FFY 2011, the total AFLP allocation to local agencies for SFY 2011-12 has been reduced by \$250,000. This will reduce the number of clients served by AFLP agencies and put further stress on local programs, which are reported to be experiencing increasing demands for services due to funding reductions to or elimination of other programs like California's CalLearn Program, which provides related services to the AFLP population. //2012//

/2013/ In FFY 2012, 2 AFLP sites discontinued operations. Funding for AFLP programs will be reduced by \$1,900,000 through reductions to local assistance resulting in 13,435 fewer person-months of service in FFY 2013.//2013//

>Black Infant Health Program (BIH)

The 2009-2010 California budget eliminated \$3.9 million SGF and \$3.7 million related Title XIX to BIH programs statewide. Budget reductions have caused two sites, Riverside and San Bernardino Counties, to close.

/2012/Due to a reduction to the Federal Title V allocation to the State in FFY 2011, the total BIH allocation to local agencies for SFY 2011-12 had been reduced by \$140,000. These reductions add to the difficulties faced by local agencies due to the loss of the SGF in SFY 2009-10 and continued lower revenues from state realignment funds.//2012//

>CMS

CMS has lost 30 positions since the 2007 reorganization of DHS into CDPH and DHCS, which together with operating expense reductions, have resulted in unmet workload and backlogs in all CMS programs including CCS. Backlogs for some CCS eligibility determinations and service authorizations in CMS Branch Regional Offices that support dependent county CCS programs now exceed three months. As county revenues from sales, vehicle licenses, and property taxes have declined, counties have been unable to support baseline levels of services in their public health, public assistance, and safety net health care programs. The State's actions to contain expenditures, including 189 capping allocations of local assistance funds for CCS county administration and the CCS MTP, have exacerbated these challenges. County CCS programs maintain that the reimbursement they receive under these funding caps is inadequate for case management and care coordination, and they are cutting staff by attrition and layoffs. Some providers report that eligibility determination and authorization delays, along with the unavailability of CCS staff to assist them with claiming and reimbursement problems, may force them to stop participating in the CCS program. As with many other essential safety net programs, CCS is having difficulty meeting the needs of the CSHCN population. DHCS is working with CCS stakeholders to redesign the CCS program to more efficiently and effectively provide services to CSHCNs while maintaining access, quality of care, and optimal outcomes.

/2013/ CMS will see a reduction of \$200,000 in administrative costs and \$405,000 will be reduced from HRIF. //2013//

> **Budget Outlook**

All signs point to another tough budget year for California for 2010-2011. The governor had included \$6.9 billion in federal dollars in his January budget plan, but so far the state has received just under \$3 billion. The state was hoping for unexpected gains in state revenues to significantly cut the budget deficit. However, revenues from personal and

corporate taxes fell \$3.6 billion short of what was projected for April 2010 the month when the bulk of revenues are collected. A significant carryover of losses from 2008 to 2009 that brought down revenues from capital gains and weakness in small business income partly explains the shortfall. That means the state's budget deficit, which at the start of 2010 was projected at \$20 billion and dipped to about \$18.6 billion after some midyear actions by the Legislature, could exceed the original estimate. And state legislators have stated that they do not intend to seek higher taxes this year to bridge the gap. This leaves lawmakers and the governor to face decisions such as the wholesale elimination of certain programs. More than ever, California faces the specter of this being the most damaging year for the health of children, the poor and the disabled.

Recent budget actions and proposals have targeted cutting MediCal services, HF and safety-net programs for low-income women, children and those with disabilities. CalWORKS, the state's version of TANF, provides cash assistance for low-income families with children, while helping parents find jobs and overcome barriers to employment. CalWORKS is primarily a children's program: Kids make up more than three out of four recipients (77.9 percent), equivalent to 1.1 million of the more than 1.4 million Californians who are projected to receive CalWORKS cash assistance in 2010-11. Women comprise more than three-quarters (77.7 percent) of all adult recipients, and women make up an even larger share (92.5 percent) of single parents who receive cash assistance. The SSI/SSP Program provides cash assistance to help low-income seniors and people with disabilities meet basic living expenses. More than half (57.3 percent) of SSI/SSP recipients are women, equivalent to approximately 666,500 of the 1.2 million adults who are projected to receive SSI/SSP grants in 2010-11. The In-Home Support Services (IHSS) Program helps low-income seniors and people with disabilities live safely in their own homes, thereby preventing more costly out-of-home care. More than three out of five IHSS recipients (63.1 percent) are women and girls, equivalent to approximately 300,500 who are projected to enroll in IHSS in 2010-11. Women also make up the majority of caregivers that receive IHSS employment. IHSS provides a range of services, including assistance with dressing, bathing, and medications in addition to domestic tasks such as cleaning, shopping, and meal preparation. Women comprise more than three out of five adults enrolled in the major safety-net programs that provide these benefits and services.

Medi-Cal, the state's version of Medicaid, provides comprehensive health coverage to 7.2 million Californians, including reproductive and prenatal care, and is a key component of California's safety net for low-income families. Women comprise nearly two-thirds of adult enrollees in the program. In addition, more than half of women enrolled in the program are in their peak reproductive years, a period where women seek more health services than men. Medi-Cal is also an important source of affordable coverage for unmarried women and their children. Nine out of 10 single parents enrolled in Medi-Cal are women. Because women make up a large share of adult Medi-Cal enrollees, women and their children are disproportionately affected by reductions to the program. State lawmakers made significant cuts to MediCal, CalWORKS, SSI/SSP, and 190 IHSS in 2009. Governor Schwarzenegger's Proposed 2010-11 Budget in January 2010 includes even deeper reductions to these programs to help close the budget gap identified by the

Governor in January.

Nearly one million children and teens in California depend on HF, the state's version of SCHIP, a federal-state partnership for working poor families. HF was launched in 1998 for parents who earn too much to receive Medi-Cal coverage but who are priced out of the private insurance industry. One way for California to keep programs alive, including HF is getting the \$6.9 billion in federal funds. Since California has not received the anticipated federal dollars, the threat to eliminate HF based on the May revise budget proposal is becoming more imminent. These health and safety net programs are not administered by Title V although Title V funding is used to support the maternal and child health needs of populations that utilize these programs. The wholesale elimination of certain programs for children, the poor and the disabled will further exacerbate and create additional challenges for existing Title V administered programs to meet the needs of the vulnerable population it serves.

/2013/ The State's budget shortfall for FY 2012/13 stands at \$15.7 billion.

The State's economic recession hit single women supporting families particularly hard with the largest decline in their average workweek in at least two decades. [54]

Funding for K-12 schools can have an additional \$5.6 billion dollars in cuts by November 2012 if the tax initiative to increase state taxes is not passed.

Continued shortfalls threaten programs and services that California's women and their families depend on. The budget contained proposals for downsizing and achieving efficiencies including reorganization of State government, elimination of some 700 legislative reports and staff furloughs.//2013//

/2014/ The May Revision of the 2013-14 California state budget highlights the planned investments in education and a resolution for a timely state-based Medi-Cal expansion as required by ACA but seeks more than 75% cuts to county safety net funds and would continue cuts to Medi-Cal provider rates and Denti-Cal. It also proposes to shift pregnant women and recent legal immigrants currently in state-funded programs onto private insurance through Covered California but to provide wrap-around coverage for all cost-sharing and benefits not federally funded. It also proposes to shift greater financial responsibility to the counties for CalWORKs , CalWORKs-related Child Care Programs (Stages 1, 2, and 3), and administration costs under CalFresh (formerly known as Food Stamps). The May Revision proposes that consideration be given to balancing county flexibility and appropriate beneficiary protections.

Federal budget cuts or "sequestration" began on March 2013 as an austerity fiscal policy with reductions starting in FY 2013 to FY 2021. It is projected that t California's public health would lose about \$2.6 million in funds to help upgrade its ability to respond to public health threats including infectious diseases, natural disasters, and biological, chemical, nuclear, and radiological events [35]. In addition,

California will lose about \$12.4 million in grants to help prevent and treat substance abuse. Another report estimates that California’s MCH Block grant will be cut by approximately \$3.2 million in FY 2013 due to sequestration [36].//2014//

VI. Reporting Forms- General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets, please refer to Form 16 in the Forms section of the online application.

VII. Glossary

Glossary of Acronyms and Abbreviations

A	AAP-CA	California District of the American Academy of Pediatrics
	ABCD	Assuring Better Child Health and Development
	ACA	Affordable Care Act of 2010
	ACF	Administration of Children and Families
	ACIP	Advisory Committee on Immunization Practices
	ACOG	American Congress of Obstetricians and Gynecologists
	ADP	Alcohol and Drug Program
	AFLP	Adolescent Family Life Program
	AI/AN	American Indian or Alaskan Native
	AIDS	Acquired Immune Deficiency Syndrome
	AIIMI	American Indian Infant Health Initiative
	AIM	Access for Infants and Mothers
	AMCHP	Association of Maternal and Child Health Programs
	ASHWG	Adolescent Sexual Health Work Group
	ASTPHND	Association of State and Territorial Public Health Nutrition Directors
B	BBC	Birth and Beyond California
	BIH	Black Infant Health
	BMI	Body Mass Index
C	CA	State of California
	CAA	Certified Application Assistants (for Medi-Cal & Healthy Families)
	CAHC	California Adolescent Health Collaborative
	CalWORKS	California's cash assistance program for children and families
	Cal-SAFE	California School Age Families Education
	CAN	California Association of Neonatologists

CAPHI	California Asthma Public Health Initiative
CLABSI	Central Line Associated Blood Stream Infection
CBDMP	California Birth Defects Monitoring Program
CBO	Community Based Organization
CCDPPH	Center for Chronic Disease Prevention and Health Promotion
CCG	Community Challenge Grant
CCHA	California Children's Hospital Association
CCLHO	California Conference of Local Health Officers
CCS	California Children's Services
CCSTWG	California Children's Services technical workgroups
CDAPP	California Diabetes and Pregnancy Program
CDC	Centers for Disease Control and Prevention
CCDDP	California Children's Dental Disease Prevention Program
CDE	California Department of Education
CDPH	California Department of Public Health
CDRT	Child Death Review Team
CFH	Center For Family Health
CFHC	California Family Health Council
CHDP	Child Health and Disability Prevention
CHSA	California Health and Human Services Agency
CHI	Children's Health Initiatives
CHIIP	California Health Incentives Improvement Project
CHIS	California Health Interview Survey
CHP	California Highway Patrol
CHVP	California Home Visiting Program
CIPP	Childhood Injury Prevention Program
CIPPP	Center for Injury Prevention Policy and Practice
CLABSI	Central Line Associated Blood Stream Infections
CLPP	Childhood Lead Poisoning Prevention program
CME	Continuing Medical Education
CMQCC	California Maternal Quality Care Collaborative
CMS	Children's Medical Services
CPeTS	California Perinatal Transport Systems
CPQCC	California Perinatal Quality Care Collaborative
CPSP	Comprehensive Perinatal Services Program
CPS	Child Passenger Safety
CRISS	Children's Regional Integrated Service Systems
CSCC	Children's Specialty Care Coalition
CSHCN	Children with Special Health Care Needs
CSS	California Student Survey
CSTS	California Student Tobacco Survey
CSUS	California State University, Sacramento
CT	Chlamydia trachomatis
CTCP	California Tobacco Control Program
CWA	California WIC Association

	CYSHCN	Children and Youth with Special Health Care Needs
D	DDS	Department of Developmental Services
	DHCS	Department of Health Care Services
	DHF	Dental Health Foundation
	DMH	Department of Mental Health
	DMS	Data Management Service
	DSS	Department of Social Services
E	EAPD	Epidemiology, Assessment and Program Development
	ECCS	Early Childhood Comprehensive Systems
	ELL	English Language Learner
	EPSDT	Early and Periodic Screening, Diagnosis and Treatment
F	Family PACT	Family Planning, Access, Care & Treatment
	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
	FISC	Functional Improvement Score
	FMCO	Fiscal Management and Contract Operations
	FPL	Federal Poverty Level
	FQHC	Federally Qualified Health Clinic
	FRC	Family Resource Center
	FVCA	Family Voices of California
	FY	State Fiscal Year (July 1 - June 30)
G	GDSP	Genetic Disease Screening Program
	GHPP	Genetically Handicapped Persons Program
	GIS	Geographic Information System
H	HBV	Hepatitis B vaccine
	HBEX	Health Benefit Exchange
	HCC	Hearing Coordination Center
	hCG	human chorionic gonadotropin
	HCP	Hearing Conservation Program
	HCPFC	P.55 mentioned once
	HCPFCF	Health Care Program for Children in Foster Care
	HF	Healthy Families -- California's State Children's Health Insurance Program
	HeAPA	Health-e-App Public Access
	HIV	Human Immunodeficiency Virus
	HRIF	High Risk Infant Follow-up
	HRSA	Health Resources and Services Administration
	HSCI	Health Status Capacity Indicator

	HSCR	Human Stem Cell Research
	HSI	Health Status Indicator
	HV	Home Visiting Program
I	I&E	Information and Education Program
	ICD	International Classification of Diseases
	ICPC	Interconception Care Project of California
	IHI	Institute for Healthcare Improvement
	IPODR	Improved Perinatal Outcome Data Reports
	ITS	Information Technology Section
	IZB	Immunization Branch, CDPH
K	KASA	Kids as Self Advocates
L	L.A.	Los Angeles
	LAMH	Local Assistance to Maternal Health
	LAPSNC	Los Angeles Partnership for Special Health Care Needs Children
	LBW	Low Birth weight (<2500 grams)
	LHDMP	Local Health Department Maternal Child and Adolescent Health Program
	LHJ	Local Health Jurisdiction
M	MCAH	Maternal, Child, and Adolescent Health
	MCHB	Maternal and Child Health Bureau (Federal Agency)
	MCMC	Medi-Cal Managed Care
	MEDS	Medi-Cal Eligibility Data System
	MHF	Maternal Health Framework
	MHSA	Mental Health Services Act
	MIG	Medicaid Infrastructure Grant
	MIHA	Maternal and Infant Health Assessment
	MIS	Management Information Services
	MOD	March of Dimes
	mPINC	Maternity Practices in Infant Nutrition and Care Survey
	MQI	Maternal Quality Improvement
	MRMIB	Managed Risk Medical Insurance Board
	MTP	Medical Therapy Program
N	NBS	Newborn Screening
	NCHS	National Center for Health Statistics
	NH/PI	Native Hawaiian or Other Pacific Islander
	NHSP	Newborn Hearing Screening Program
	NICU	Neonatal Intensive Care Unit
	NICHQ	National Initiative for Children's Healthcare Quality
	NPM	National Performance Measure
	NQI	National Quality Improvement
	NT	Nuchal Translucency

	NTD	Neural Tube Defect
O	OFP	Office of Family Planning
	OHAC	Oral Health Access Council
	OHC	Other Health Coverage
	OHU	Oral Health Unit
	OOH	Office of Oral Health
	OPG	Obesity Prevention Group
	OSHPD	Office of Statewide Health Planning and Development
	OTech	Office of Technology Services
	OTS	Office of Traffic Safety
	OVR	Office of Vital Records
P	PAF	Pregnancy Assistance Fund
	PAIS	Program Allocation, Integrity and Support
	PAMR	Pregnancy-Related and Pregnancy-Associated Mortality Review
	PAOPP	Physical Activity and Obesity Prevention Program
	PCC	Pediatric Critical Care
	PCP	Primary Care Physician
	PDD	Patient Discharge Data
	PDS	Program Development Section
	PedNSS	Pediatric Nutrition Surveillance System
	PPC	Pediatric Palliative Care
	PHCC	Preconception Health Council of California
	PHHI	Preconception Health and Healthcare Initiative
	PHL	Parent Health Liaison
	PHN	Public Health Nurse
	PICU	Pediatric intensive care unit
	PKU	Phenylketonuria
	PPC	Pediatric Palliative Care Waiver Program
	PPE	Preconception Peer Educators
	PQIP	Perinatal Quality Improvement Panel
	PRAMS	Pregnancy Risk Assessment Monitoring System
	PRISM	Pediatric Risk of Mortality
	PSA	Public Service Announcement
	PSS	Program Support Section
	PSU	Provider Services Unit
	PYD	Positive Youth Development
Q	QCI	Quality of Care Initiative
	QI	Quality Improvement
R	RCA	Regional Cooperative Agreements
	RFAs	Requests for Applications
	RFP	Request for Proposal

	RLP	Reproductive Life Planning
	ROS	Regional Operations Section
	RPPC	Regional Perinatal Programs of California
S	SAC	Safe and Active Communities
	SCCs	Special Care Centers
	SCD	Systems of Care Division
	SCHIP	State Children's Health Insurance Program
	SCOTS	Statewide Coalition on Traffic Safety
	SDSU	San Diego State University
	SIDS	Sudden Infant Death Syndrome
	SIT	State Interagency Team
	SPM	State Performance Measure
	SPS	Statewide Programs Section
	SSC	State Screening Collaborative
	STD	Sexually Transmitted Disease
T	TA	Technical Assistance
	TANF	Temporary Assistance to Needy Families
	TWG	technical workgroups
U	UCB	University of California, Berkeley
	UCEDD	University Center for Excellence in Developmental Disabilities
	UCLA	University of California, Los Angeles
	UCSF	University of California, San Francisco
V	VFC	Vaccines for Children
	VLBW	Very Low Birth weight (<1500 grams)
W	WIC	Women, Infants, and Children Supplemental Nutrition Program
	WHO	World Health Organization
Y	YRBS	Youth Risk Behavior Survey
	YSHCN	Youth with Special Health Care Needs

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