SECTION 3 – SCOPE OF WORK AND PERFORMANCE MEASURES

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

Mission: Assuring the health of California's children.

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

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

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

CMS Goals

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

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

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

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

CMS Program Components – Scope of Work

The day-to-day operations of the CCS, CHDP, and HCPCFC programs have been outlined in "Program Components" with associated activities. These program components are the basic required activities that must be performed to meet federal and state requirements. The program components and activities are within the Scope of Work.

I. Program Planning and Administration

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

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

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

    b. Identify and evaluate mutual activities and areas of implementation. Participate as Local Program Administrators in arranging for the development of special services as necessary, e.g., Orthodontic screening, medical therapy conferences at the Medical Therapy Unit, Primary Care, Foster Care resources and dental care.

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

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

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

4. Evaluate program outcome data to strategically plan and implement for more effective use of program resources.

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

1. Expend funds according to allocations.

2. Develop budget revisions as necessary.

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

4. Prepare and submit expenditure reports as appropriate and as requested by CMS.

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

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

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

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

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

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

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

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

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

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

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

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

G. Develop an MOU, for implementing responsibilities in the HCPCFC program, among the local CHDP program, local Child Welfare Agency of the County SSS, and the Juvenile Probation Department according to the outline provided by CMS.

H. Develop and maintain an IAA between:

1. CMS and the local Head Start program,

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

3. CMS and the Early Start program.

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

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

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

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

a. Dissemination of CMS information.

b. Participation in CMS services among eligible children.

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

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

e. Participation in school reporting requirements.

CHDP Program Letter No. 05-01, documents changes brought about by Assembly Bill 2855, Chapter 895, Statutes of 2004, that included amendments to the Health and Safety Code section 124100. The amended section no longer requires every public school district and private school in California to report data on the number of children receiving health screening examinations at school entry. Therefore, public school districts and private schools are NOT required to submit the CHDP Annual School Report (PM 272) to the CHDP Program within the local health department and there will be no reimbursement provided. Private schools and public school districts may continue to gather and share this information at their discretion.

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

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

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

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

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

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

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

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

L. Establish a process in counties/cities for CMS programs to participate in the Maternal Child and Adolescent Health (MCAH) Title V planning process.

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

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

1. Facilitate CMS provider application process.

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

3. Provide on-going information, assistance, resources, and support necessary to ensure quality program implementation including, but not limited to, Provider Notices sent by CMS.

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

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

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

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

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

1. Receive or initiate referrals among:

a. CCS,

b. CHDP,

c. HCPCFC/Child Welfare Services (CWS),

d. Outside agencies/individuals,

e. Managed Care Plans, and

f. Health care providers.

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

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

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

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

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

1. Referrals,

2. Health status,

3. Care coordination/administrative case management activities,

4. Services utilization,

5. Informing activities,

6. Documentation, and

7. Reports.

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

1. Develop measures to gauge quality of care coordination/administrative case management that includes:

    a. Timely services delivery,

    b. Completeness and accuracy of documentation,

    c. Effective interdisciplinary/interagency collaboration,

    d. Culturally and linguistically competent care,

    e. Family centered care,

    f. Service delivery outcomes, and

    g. Access to a medical home.

IV. Outreach and Education

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

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

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

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

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

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

V. Using and Reporting Performance Measures in CMS Programs

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

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

Accountability is determined in by:

A. Having budget and expenditure figures;

B. Measuring the progress towards successful implementation and achievement of individual performance measures; and ultimately,

C. Having a positive impact on the desired outcomes of the program. These outcome measures are part of the CMS goals. If program activities are effective and successful, the CMS goals and outcomes will be accomplished.

While improvement in outcome measures is the long-term goal, more immediate success may be demonstrated through performance measures that are short-term, incremental, intermediate, and/or precursors for the outcome measures. Performance measures reflect program specific measures which are to be reported separately.

The following performance measures were selected by state staff with local program input to represent the focus of CMS programs. Data is to be reported annually for each performance measure.

VI. Directions for Completing the Report of Performance Measures

Reporting on the CMS Performance Measures is a Scope of Work requirement.

The following outlines the annual reporting requirements of the Performance Measures. One original and one copy of the CMS Report of Performance Measures are to be sent to the local program's CMS Regional Administrative Consultant by November 30th.

A. CCS, CHDP, and HCPCFC programs under joint administrations submit a single joint performance report to CMS.

B. Performance Measures should be reported in the appropriate format identified for each Performance Measure. Include a short narrative description of the process used to define a percentage for the Performance Measure or to achieve the score presented.

C. Monitoring of the Performance Measures and their completion will be conducted on an annual basis.

D. The Annual Report of the Performance Measures consists of the following required elements:

1. Report the Results of the Performance Measures using the report forms provided.

2. **Narrative**: The narrative should outline the methods that each program implemented for data collection and any unique issues related to the measure, (e.g., sampling methodology, information used to validate the data to ensure measures are correctly tracked). In addition, the narrative should include collaborative relationships with other departments, agencies and organizations, (e.g., meeting frequency, signed MOU, and identified CHDP liaison). **The total narrative length is not to exceed three pages**.

3. Describe plans to enhance or change interventions and to monitor activities based on review of this data.

4. Describe plans to share the results of data collection with primary care providers, community, and public health agencies.

5. Note any requests for additional information and provide the requested information/response to the Regional Nurse Consultant and/or Administrative Analyst.

6. Performance Measures require the denominator to be divided by the numerator to determine the percentage. Once the percentage is determined, complete the Performance Measure Profile template located on pages 12 and 13 of this Section. The P.M. Profile form must be submitted with the Performance Measures and Narrative.

7. Note that the reporting cycles for CCS and CHDP/HCPCFC differ. Correct information for the appropriate fiscal year should be recorded.

Performance Measure Profile

Performance Measure Number	2012-13		2013-14		2014-15		2015-16		2016-17	
	MC	N-MC	MC	N-MC	MC	N-MC	MC	N-MC	MC	N-MC
CHDP 1										
2										
3										
4 Average for all three providers	BMI		BMI		BMI		BMI		BMI	
	Dental		Dental		Dental		Dental		Dental	
	Lead		Lead		Lead		Lead		Lead	
5										
6 (Optional)										
E (Optional)										
G (Optional)										
HCPCFC 1										
2	Health		Health		Health		Health		Health	
	Dental		Dental		Dental		Dental		Dental	

Performance Measure Profile – Continued

	2008-09		2009-10		2010-11		2011-12		2012-13	
CCS										
1										
2	MED		MED		MED		MED		MED	
	RES		RES		RES		RES		RES	
	FIN		FIN		FIN		FIN		FIN	
3 (A)										
3 (B)										
4	CCS		CCS		CCS		CCS		CCS	
	MTP		MTP		MTP		MTP		MTP	
5										

Performance Measure Profile – Example

Performance Measure Number	2012-13		2013-14		2014-15		2015-16		2016-17	
CHDP 1	MC	N-MC	MC	N-MC	MC	N-MC	MC	N-MC	MC	N-MC
	51%	50%	75%	100%						
2	100%		100%							
3	50%		75%							
4 Average for all three providers	BMI	10%	BMI	31%	BMI		BMI		BMI	
	Dental	8%	Dental	15%	Dental		Dental		Dental	
	Lead	11%	Lead	20%	Lead		Lead		Lead	
5	Hispanic Children 12-14 yrs. of age 27% (>95th% Critical Prevalence		African American Children 5-8 yrs. of age 30% (>95th% Critical Prevalence)							
6 (Optional)	55% of children referred for dental tx received care		75% of children referred for dental tx received care							
E (Optional)										
G (Optional)										
HCPCFC 1	75%		95%							
2	Health	85%	Health	87%	Health		Health		Health	
	Dental	60%	Dental	65%	Dental		Dental		Dental	

Performance Measure Profile Example – Continued

CCS	2008-09		2009-10		2010-11		2011-12		2012-13	
1	90%		92%							
2	MED	75%	MED	100%	MED		MED		MED	
	RES	100%	RES	90%	RES		RES		RES	
	FIN	100%	FIN	100%	FIN		FIN		FIN	
3 (A)	65%			100%						
3 (B)	75%			100%						
4	CCS	100%	CCS	90%	CCS		CCS		CCS	
	MTP	100%	MTP	95%	MTP		MTP		MTP	
5	50%		75%							

CHDP Performance Measure 1 - Care Coordination

The degree to which the local CHDP program provides effective care coordination to CHDP eligible children.

Definition: CHDP health assessments may reveal condition(s) requiring follow-up care for diagnosis and treatment. Effective CHDP care coordination is measured by determining the percentage of health condition(s), coded 4 or 5, where follow-up care is initiated[1] within 120 days of local program receipt of the PM 160.

Numerator: Number of conditions, coded 4 or 5, where the follow-up care was initiated within 120 days of receipt of the PM 160.

Denominator: Total number of conditions, coded 4 or 5, on a PM 160, excluding children lost to contact.

Data Source: Local program tracking system.

Reporting Form:

Element	**Number of conditions coded 4 or 5 where follow-up care was initiated** (Numerator)	**Total number of conditions coded 4 or 5, excluding children lost to contact** (Denominator)	**Percent (%) of conditions where follow-up care was initiated within 120 days**
Conditions found on children eligible for fee-for-service Medi-Cal that required follow-up care			
Conditions found on children eligible for State-funded CHDP services only (Aid code 8Y) that required follow-up care			

[1] Centers for Medicare and Medicaid Services, Publication #45, the State Medicaid Manual, Chapter 5 EPSDT, Section 5310 A http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html

CHDP Performance Measure 2 - New Provider Orientation

The percentage of new CHDP providers with evidence of quality improvement monitoring by the local CHDP program through a New Provider Orientation.

Definition: The number of new CHDP providers (i.e., M.D., D.O., N.P., P.A.) added within the past fiscal year who were oriented by the local program staff.

Numerator: The number of new CHDP providers who completed an orientation within the past fiscal year.

Denominator: The number of new CHDP providers in the county or city (local program) added within the past fiscal year.

Data Source: Local program tracking system.

Reporting Form:

Number of New Providers who Completed Orientation (Numerator)	
Number of New Providers (Denominator)	
Percent (%) of New Providers Oriented	

Optional Local Program Data Tracking Form:

Provider	Provider Location	Date of Orientation	Number of Licensed Staff in Attendance	Number of Non-Licensed Staff in Attendance
1.				
2.				
3.				
4.				

CHDP Performance Measure 3 - Provider Site Recertification

The percentage of CHDP provider sites (excludes newly enrolled providers) who have completed recertification within the past fiscal year. Provider site visits may occur for other reasons. These can be documented for workload activities. The purpose of this performance measure is to ensure that all providers are recertified at least once every three (3) years. This performance measure is a benchmark to ensure that providers are recertified using the Facility and Medical Review Tools. These tools ensure that providers maintain CHDP standards for health assessments.

Definition: An office visit which includes a medical record review and a facility review or Critical Element Review with a Managed Care Plan.

Numerator: The number of CHDP provider sites who have completed the Recertification within the past fiscal year using the facility review tool and medical record review tool.

Denominator: The number of active CHDP provider sites in the county/city due for recertification within the fiscal year.

Data Source: Local program tracking system.

Reporting Form:

Number of Completed Site Recertifications (Numerator)	
Number of Active CHDP Provider Sites Due for Recertification (Denominator)	
Percent (%) with Completed Recertifications	

Optional Workload Data Tracking Form:
(Other reasons for a provider site visit by local program. This identifies workload.)

Other reasons for provider site visits:	**Number of Visits**
1. Provider change in location or practice	
2. Problem resolution such as, but not limited to, billing issues, parental complaints, facility review and/or other issues.[2]	
3. Medical record review.	
4. Office visits for CHDP updates or in-service activities	
5. Other Please Specify:	

[2] **CHDP Provider Manual: Program, Eligibility, Billing and Policy**. California Department of Health Care Services, Child Health & Disability Prevention (CHDP) Program. See website for current updates.
Local Program Guidance Manual Chapter 10: Problem Resolution and/or Provider Disenrollment. California Department of Health Care Services, Child Health & Disability Prevention (CHDP) Program, May 2005.
Both references available at: http://www.dhcs.ca.gov/formsandpubs/publications/Pages/CHDPPubs.aspx#dgmp.

CHDP Performance Measure 4 - Desktop Review: Dental, Lead

Within the past fiscal year, identify the percentage of PM 160s with documentation indicating compliance with the CHDP Periodicity Schedule and Health Assessment Guidelines. Local programs may choose to evaluate the same provider sites over the 5-year Performance Measure cycle, or select different provider sites each year.

Definition: A targeted desktop review for three high volume providers within the county/city by determining the percent of PM 160s that have documentation for:

- Referral to a dentist at 1 year exam (12-14 months of age)
- Lead testing or a referral for the test at 1 year exam (12-14 months of age)

Numerator: The number of PM 160 elements recorded correctly per selected providers for the specific ages.

Denominator: The total number of PM 160s reviewed per selected providers for the specific ages.

Data Source: Local program tracking system.

Reporting Form:

	Dental Referral			Lead Test or a Referral		
Provider	Number of PM 160s w/ Dental at 1 year exam (Numerator)	Total PM 160s Reviewed (Denominator)	Percent (%) Compliance	Number of PM160s w/ Lead Test or Referral at 1 year exam (Numerator)	Total PM 160s Reviewed (Denominator)	Percent (%) Compliance
1.						
2.						
3.						

CHDP Performance Measure 5 – Desktop Review: BMI

Within the past fiscal year, identify the percentage of PM 160s with documentation indicating compliance with the CHDP Periodicity Schedule and Health Assessment Guidelines. Local programs may choose to evaluate the same provider sites over the five-year Performance Measure cycle, or select different provider sites each year.

Definition: A targeted desktop review for three (3) high volume providers within the county/city by determining the percent of PM 160s that have documentation for:

- Body Mass Index (BMI) Percentile for ages two (2) years and over.
- If BMI Percentile is abnormal, the description of weight status category[3] and/or a related diagnosis are listed in the Comments Section.

BMI percentile	Weight status category
< 5th %ile	Underweight
85th - 94th %ile	Overweight
95th - 98th %ile	Obese
≥ 99th %ile	Obesity (*severe*)

Numerator: The number of PM 160s BMI-related elements correctly documented for ages two (2) years and over.

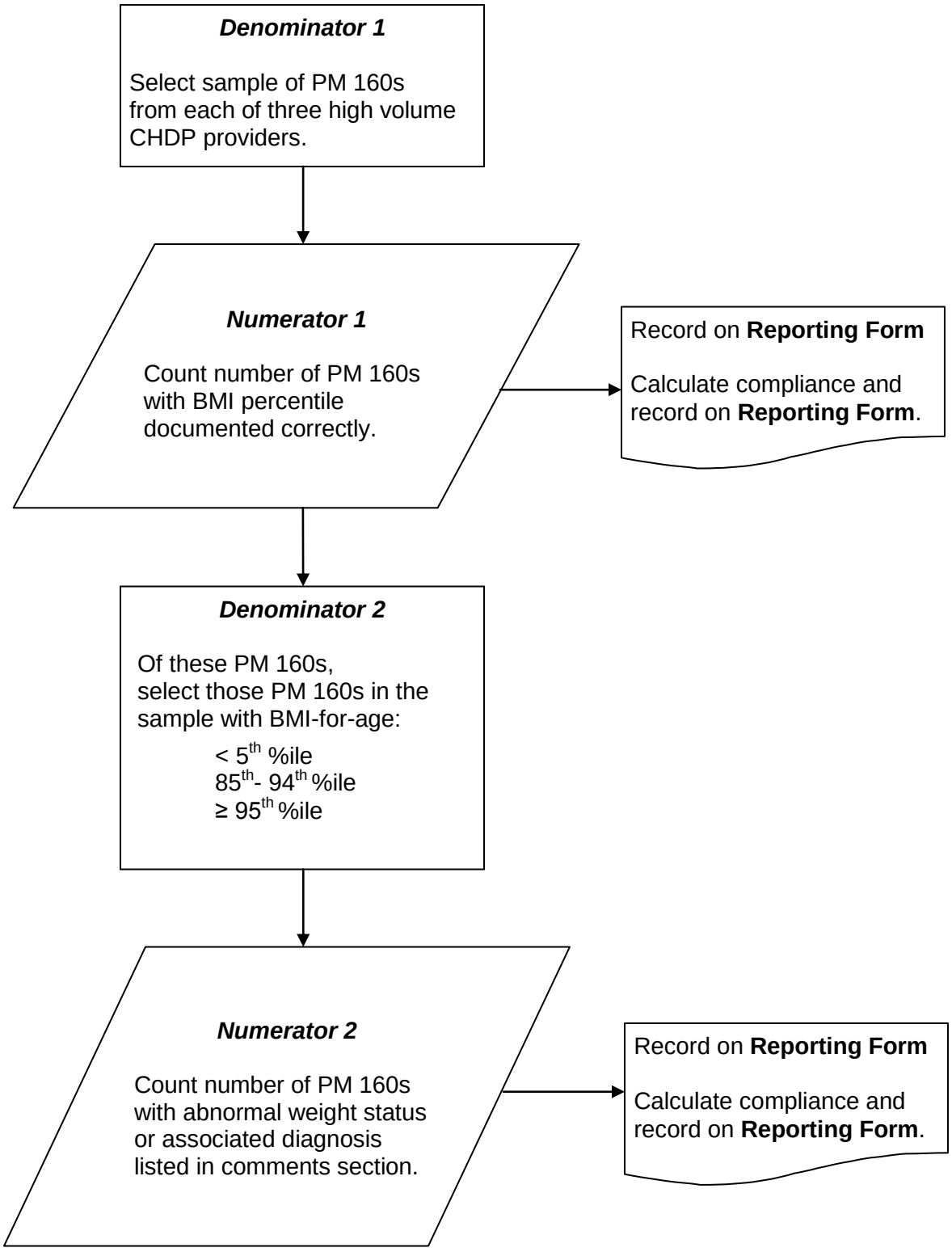
Denominator: The total number of PM 160s reviewed per selected providers for ages two (2) years and over.

Data Source: Local program tracking system.

[3] **CHDP Provider Information Notice No.: 07-13:** Childhood Obesity Implementation Guide from the Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity- 2007. http://www.dhcs.ca.gov/services/chdp/Documents/Letters/chdppin0713.pdf

Reporting Form for Performance Measure 5 – Desktop Review: BMI

BMI Desktop Review Flow Diagram:



Reporting Form for Performance Measure 5 – Desktop Review: BMI

Provider	**BMI percentile recorded on PM 160s for children ages 2 (two) and older**			**If BMI percentile is < 5 %, 85 - 94 %, or ≥ 95 %, abnormal weight status category and/or related diagnosis listed in Comments Section**		
	Number of PM 160s with BMI %ile recorded (Numerator)	Number of PM 160s reviewed (Denominator)	Percent (%) Compliance	Number of PM 160s with abnormal weight status category/ diagnosis in Comments (Numerator)	Number of PM 160s with abnormal weight status reviewed for, diagnosis and follow-up (Denominator)	Percent (%) Compliance
1.						
2.						
3.						

CHDP Performance Measure 6 - County/City Use of Childhood Obesity Data

1.	**Childhood obesity data shared with CHDP Providers to inform about overweight and obesity prevalence rates:** *(If yes, underline all that apply)*	**YES**	**NO**
	Presentations, in-services, trainings		
	Newsletters, media outreach, reports		
	Provide educational and resource materials related to healthy eating/active living		
2.	**Childhood obesity data shared to support local assistance grants and implementation of multi-sector policy strategies to create healthy eating and active living community environments (Goal 3, California Obesity Prevention Plan 2010):** *(If yes, underline all that apply)*		
	Academic: Universities, Academic Institutions, Educators and Researchers Other (*Please specify)*:		
	Community Coalitions/Committees: Health Advisory Committee, Health Collaboratives/Coalitions Other (*Please specify)*:		
	Community Planning: City Planners, County Land Use Staff, Built Environmental Groups Other (*Please specify):*		
	Community Programs: Faith-based Groups. YMCA/YWCA, After School programs, Parks and Recreation programs, Child Care, University Cooperative Extension Other (*Please specify)*:		
	Health Care: Managed Care Health Plans and Insurers, Hospitals, CCS Program/Special Care Centers, Medical Provider Groups, Medical Societies, Health Associations Other (*Please specify)*:		
	Policy Makers: County Board of Supervisors, City Councils, Community Planners, Legislators Other (*Please specify)*:		
	Projects or Funding Entities: First Five Commission, Public and Private Foundations/Endowments/Grants Other (*Please specify)*:		
	Public Health Programs: WIC, Foster Care, MCAH, Nutrition Network Funded Projects, Health Officers, Epidemiologists, Program Directors Other (*Please specify)*:		
	Schools: School Health Nurses, School Health Coordinators, County Office of Education, Elementary, Junior High and High Schools, Head Start, other preschool programs, student groups and parent groups Other (*Please specify*):		

CHDP Performance Measure E - School Entry Exams - OPTIONAL -

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

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

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

A. Certificate, or

B. Waiver.

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

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

Reporting Form: Local program tracking system

Number of Children with Certificates (PM 171 A) (Numerator)	
Total Number of Enrolled in Public and Private Schools (Denominator)	
Total Percent of Children with Certificates	

Number of Children with Waivers (PM 171 B) (Numerator)	
Total Number of Enrolled in Public and Private Schools (Denominator)	
Total Percent of Children with Waivers	

	Percent (%) Compliance
Total Number of Certificates + Total Number of Waivers / **Total Number of Enrolled Students**	

OPTIONAL CHDP Performance Measure G – Childhood Overweight and Obesity

Review and Use of Local Childhood Overweight and Obesity Data

Identification of the prevalence rate of children with overweight and obesity in a "critical group" according to a defined data source and description of local program use of these data results in health care and community venues.

Definition: "Critical group" is the age and/or race/ethnic group with the highest prevalence rate of overweight and obesity, as indicated by Body Mass Index (BMI)-for-Age ≥ 85th percentile in data source. This supports Goal 4 of the California Obesity Prevention Plan (2010)[4], "Create and implement a statewide tracking and evaluation system."

Local CHDP programs use child overweight and obesity data with other agencies and organizations for the purposes of informing and promoting appropriate community and healthcare responses to the prevalence of child overweight and obesity. This supports Goal 3 of the California Obesity Prevention Plan (2010), "Healthy Community Environment."

Data Source: Most current Pediatric Nutrition Surveillance System (PedNSS)[5] or other similar data report determined by State Children's Medical Services. If using PedNSS, refer to this table: Annual Report, County/City Specific Data, Growth Indicators by Race/Ethnicity and Age. Values are obtained by referring to the columns BMI-for-Age 85th < 95th percentile and ≥ 95th percentile of the table. Please attach a copy of this table with your submission.

Reporting Form*:

Overweight and Obesity Prevalence Rates by Critical Age Group

for _____ County/City

Critical Group	Overweight Prevalence Rate Percent BMI-for-Age 85 < 95 %	Obesity Prevalence Rate Percent BMI-for-Age ≥ 95	Combined Overweight and Obesity Prevalence Rate Percent BMI-for-Age ≥ 85 %

* When the number of records for any age category or race/ethnic group is less than 100, PedNSS does not provide a prevalence rate. Counties that have fewer than 100 records in specific age categories may report on:

1. Broad age categories (children < 5 years or children 5 to < 20 years) or
2. Combine their overweight and obesity prevalence rates or
3. Refer to a nearby local program or statewide prevalence rates.

[4] http://www.cdph.ca.gov/programs/COPP/Pages/CaliforniaObesityPreventionPlan.aspx
[5] http://www.dhcs.ca.gov/services/chdp/Pages/CountySurveillanceData.aspx

VII. CHDP Optional Performance Measures

Clinical preventive services for CHDP eligible children and youth are expected to be delivered in accordance with the CMS/CHDP Health Assessment Guidelines. The delivery of those services is documented on the Confidential Screening/Billing Report (PM 160). Examples of evidence-based performance of these services include focused monitoring for presence of completed fields on the PM 160 for the following:

A. Number and percent of children two years old fully immunized.

B. Number and percent of children of appropriate age given a WIC referral.

C. Number and percent of CHDP health assessments PM 160 coded 4 or 5 for dental, where the follow-up appointment was kept.

D. Number of providers returning PM 160s within 30 days.

Other optional performance measures not associated with the PM 160:

E. The percent of children entering first grade with a health exam certificate or waiver. (See sample "Reporting Form" for details.)

F. Percent of local CHDP provider sites that have transitioned to the World Health Organization (WHO) Growth Standards (updated growth charts) for Infants and Children Birth to 24 Months. See website: http://www.cdc.gov/growthcharts/

G. Review and use of local childhood overweight and obesity data (See sample Performance Measure G for details).

HCPCFC Performance Measure 1 - Care Coordination

The degree to which the local HCPCFC provides effective care coordination to CHDP eligible children.

Definition: CHDP health assessments may reveal condition(s) requiring follow-up care for diagnosis and treatment. Effective HCPCFC care coordination is measured by determining the percentage of health condition(s) coded 4 or 5 where follow-up care is initiated within 120 days of local program receipt of the PM 160.

Numerator: Number of conditions coded 4 or 5 where the follow up care was initiated within 120 days of receipt of the PM 160.

Denominator: Total number of conditions coded 4 or 5 on a PM 160, excluding children lost to contact.

Reporting Form:

Number of conditions coded 4 or 5 where the follow-up care was initiated within 120 days of receipt of the PM 160. (Numerator)	
Total number of conditions coded 4 or 5 on a PM 160, excluding cases lost to no contact. (Denominator)	
Percent of conditions coded 4 or 5 where the client received follow-up care within 120 days of receipt of the PM 160.	

Data Source: Child Welfare Services Case Management System (CWS/CMS), and county specific data for Probation Department

HCPCFC Performance Measure 2 - Health and Dental Exams for Children in Out-of-Home Placement

The degree to which the local HCPCFC program ensures access to health and dental care services for eligible children according to the CHDP periodicity schedule.

Definition: This measure is based on characteristics that demonstrate the degree to which the PHN in the HCPCFC facilitates access to health and dental services as evidenced by documentation of a health and dental exam in the Health Education Passport.

Numerator 1: Number of children in out-of-home placement with a preventive health exam, according to the CHDP periodicity schedule documented in the Health and Education Passport, and

Numerator 2: Number of children in out-of-home placement with a preventive dental exam, according to the CHDP dental periodicity schedule documented in the Health and Education Passport.

Denominator: Number of children in out-of-home placement during the previous fiscal year supervised by Child Welfare Services or Probation Department.

Reporting Form:

Element	**Number of Children With Exams** (Numerator)	**Number of Children** (Denominator)	**Percent of Children with Exams**
Number of children in out-of-home placement with a preventive health exam according to the CHDP periodicity schedule documented in the Health and Education Passport. (Numerator)			
Number of children in out-of-home placement with a preventive dental exam according to the CHDP dental periodicity schedule documented in the Health and Education Passport.			

Data Source/Issue: Child Welfare Services Case Management System (CWS/CMS), and county specific data for Probation Department.

CCS Performance Measures

The degree to which local CCS programs provide effective administrative case management to eligible CCS children; the local programs will evaluate and rate **each** of the five (5) components as individual indicators of program effectiveness.

The five components for review are:

1. Medical Home
2. Determination of CCS Eligibility
3. Special Care Center,
4. Transition Planning
5. Family Parts/PP0

CCS Performance Measure 1 – Medical Home

Children enrolled in the CCS Program will have documented Medical homes/primary care providers. The goal is to have 100% compliance.

Definition: Children in the CCS program will have a designated primary care physician and/or a physician who provides a medical home.

Numerator: The total number of children with a completed field with identification of a primary care physician and/or a physician that provides a medical home.

Denominator: The total number of children in the local CCS county program.

Data Source: Sample of 100 charts or 10% of caseload if caseload under 1,000.

Reporting Form:

Number of children with a primary care physician/ Medical Home **(Numerator)**	**Number of children in the local CCS program** **(Denominator)**	**Percentage of compliance**

* Note: If county percentage of compliance is under 80%, counties need to submit with the annual report a plan for how they will work to improve this result.

CCS Performance Measure 2 – Determination of CCS Program Eligibility

Children referred to CCS have their program eligibility determined within the prescribed guidelines per Title 22, California Code of Regulations, Section 42000, and according to CMS policy. Counties will measure the following:

Numerators:

a. Medical eligibility within five working days of receipt of all medical documentation necessary to determine whether a CCS-eligible condition exists.

b. Residential eligibility within 30 days of receipt of documentation needed to make the determination.

c. Financial eligibility within 30 days of receipt of documentation to make the determination.

Denominator: Number of CCS unduplicated new referrals to the CCS program assigned a pending status in the last fiscal year.

Data Source: 10% of the county CCS cases or 100 cases (which ever number is less).

Reporting Form:

MEDICAL ELIGIBILTY	Number of referrals determined medically eligible within 5 days (Numerator)		Number of new unduplicated referrals (Denominator)		Percentage of compliance
Medical eligibility determined within 5 days of receipt of all necessary documentation					
PROGRAM ELIGIBILITY	Number of cases determined eligible within 30 days of receipt of documentation needed to make the determination (Numerator)		Number of new unduplicated referrals (Denominator)		Percentage of compliance
Financial eligibility determined within 30 days	FSMC /HF	CCS only	FSMC /HF	CCS only	
Residential eligibility determined within 30 days					

CCS Performance Measure 3 (A & B) – Special Care Center

This Performance Measure is evaluated in two parts.

Part A: **Annual Team Report**

Definition: This performance measure is based on the CCS requirement for an annual team report for each child enrolled in CCS whose condition requires Special Care Center services and has received an authorization to a Special Care Center. County CCS programs will evaluate this measure by the presence of an annual team conference report in the child's medical file.

Numerator: Number of children that received a Special Care Center authorization and were seen at least annually at the appropriate Special Care Center as evidenced by documentation and completion of the interdisciplinary team report.

Denominator: Number of children enrolled in CCS whose condition as listed in categories defined in Numbered Letter 01-0108 requires CCS Special Care Center services and has received an authorization to a Special Care Center.

Data source: 10% of the county CCS cases authorized to SCC or 100 cases (which ever number is less).

Part B: **Referral of a Child to SCC**

Definition: This measure is based on the CCS requirement that certain CCS eligible medical conditions require a referral to a CCS Special Care Center for ongoing coordination of services.

Numerator: Number of children in CCS, with medical conditions in the categories as listed in Numbered Letter 01-0108 requiring a Special Care Center Authorization, who actually received an authorization for services.

Denominator: Number of children enrolled in CCS, with medical conditions, requiring Special Care Center Authorizations.

Data source: Counties shall identify and use four or five specific diagnosis categories (cardiac, pulmonary, etc) as listed in the Special Care Center Numbered Letter 01-0108 as it relates to the SCC(s) identified for your client population. The county shall identify one or more diagnostic codes and use the diagnosis codes indicated for the SCC categories selected for this PM.

Reporting Form - Part A:

Category selected (cardiac, pulmonary, etc.)	**Number of children with annual team report in client's medical records** (Numerator)	**Number of children with SCC authorization** (Denominator)	**Percentage of compliance**

Reporting Form - Part B:

Category selected (cardiac, pulmonary etc.)	**Number of children with authorization to SCC** (Numerator)	**Number of children with eligible medical conditions that require an authorization to a SCC** (Denominator)	**Diagnostic Code Chosen**	**Percentage of compliance**

*** Counties may select four (4) to five (5) specific medical conditions as outlined in the SCC NL to use as the basis for clients that should have a referral to a CCS SCC.**

CCS Performance Measure 4 – Transition Planning

Definition: Children, 14 years and older who are expected to have chronic health conditions that will extend past the twenty-first birthday will have documentation of a biannual review for long term transition planning to adulthood.

Numerator: Number of CCS charts for clients 14, 16, 18, or 20 years containing the presence of a Transition Planning Checklist completed by CCS program staff within the past 12 months for children aged 14 years and over whom requires long term transition planning.

Denominators:

a. Number of CCS charts reviewed of clients 14, 16, 18, and 20 years in (10% of children aged 14 and over) whose medical record indicates a condition that requires a transition plan.

b. Number of MTP charts reviewed of clients 14, 16, 18, and 20 years in (10% of children aged 14 and over) whose medical record indicates a condition that requires a transition plan.

Data Source: Chart Audit, Completion of Transition Planning Checklist.

* Due to caseload numbers in Los Angeles County, LA County should work with the State to select an appropriate number of clients to be included in their sample size.

Transition Planning Checklist

Transition Documentation	YES	NO	Comments
1. Client has an identified need for long-term transition planning.			
2. Transition planning noted in child's medical record.			
3. Transition planning noted in SCC reports.			
4. Vocational Rehab noted in child's reports.			
5. Adult provider discussed or identified for children 17 years of age or older.			
6. Transition planning noted in SELPA for those children that are in the MTP.			

* Note: Not all of the items in the Checklist will be applicable for each chart review.

Reporting Form:

Number of CCS charts reviewed	Number with transition planning	Percentage of compliance
Number of MTP charts reviewed	Number with transition planning	Percentage of compliance

CCS Performance Measure 5 – Family Participation

The degree to which the CCS Program demonstrates family participation.

Definition: This measure is evaluated based on each of the following four (4) specific criteria that documents family participation in the CCS program. Counties need to indicate the score based on the level of implementation.

Checklist documenting family participation in the CCS program.	**Yes**	**No**	**Comments**
1. Family members are offered an opportunity to provide feedback regarding their satisfaction with the services received through the CCS program by participation in such areas as surveys, group discussions, or individual consultation.			
2. Family members participate on advisory committees or task forces and are offered training, mentoring and reimbursement when appropriate.			
3. Family members are participants of the CCS Special Care Center services provided to their child through family participation in SCC team meeting and/or transition planning.			
4. Family advocates, either as private individuals or as part of an agency advocating family centered care, which have experience with children with special health care needs, are contracted or consultants to the CCS program for their expertise.			

Reporting Form:

Criteria	**Performing (25% for each criteria)**	**Not Performing**
1.		
2.		
3.		
4.		
Total	_____**%**	