



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

This PDF was produced by the National Center for Education in Maternal and Child Health under its cooperative agreement (MCU-119301) with the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.



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1.4 Overview of the State

Demography:

California is the most populous State in the nation with a total population of 34,336,000 residents as of January 1, 2000¹. The State's population comprises 12 percent of the nation's total; one of every eight of the nation's residents lives in California. Since 1990, the population has increased by 13.7 percent, with an additional 4.1 million people now residing in California. The annual growth rate from January 1, 1999 to January 1, 2000 was 1.7 percent, adding 570,000 people. State population projections suggest continuing growth over the next decade with approximately 40 million residents projected for 2010².

The 1998-99 population growth resulted primarily from a natural increase (54.9 percent of the annual growth). In 1999, the total number of births in the State, 525,097, increased for the first time since the 1990 peak of 611,666³. Deaths at 227,795 also increased to their largest value in the 1990s. Net migration at 244,698 accounted for 45.1 percent of the total growth. The number of migrants to the State exceeded the number leaving for the fourth year. The strong State economy over the past five years has contributed to significant migration from other areas of the country as well as other regions of the world. By the year 2008, births are projected to rise by 71,000 to 596,038⁴ for a nearly 13.5 percent increase.

In 1998, California's population included 10,319,517 infants and children aged 0 through 19 years. Of those, 550,947 were infants less than one year of age, 7,512,327 were children aged 1 through 14 years, and 2,256,243 were adolescents aged 15-19 years of age. There were 7,302,860 women of childbearing age, 15-44 years old. California's population of infants, children, adolescents, and women of childbearing age is projected to reach 17 million in 2000⁵.

The number of Children with Special Health Care Needs (CSHCN) requiring services is increasing. Children with eligible medical conditions enrolled in California Children's Services (CCS), the designated Title V Children with Special Health Care Needs program, rose from 122,642 to 140,129 between 1997 and 1999 (a 14.3 percent increase). The number of children receiving physical and occupational therapy services through the CCS Medical Therapy Program has increased by 36 percent over the past nine years⁶.

California has a proportionally large and rapidly expanding adolescent population. It is estimated that from 1995 to 2005, the number of youth aged 10-19 residing in California will grow by 34 percent, compared to a 13 percent increase nationally. This will result in over one and a half million more adolescents living in California—from 4.4 million in 1995 to 6.0 million in 2005⁷. This growth will have an impact on the need for adolescent health services.

Racial and Ethnic Diversity

California is one of the most ethnically diverse states in the nation. By July 1997, 48 percent of California's population was either Hispanic (29.2 percent), Asian or Pacific Islander (10.9 percent), Black (7.0 percent), or Native American (0.6 percent). Current estimates suggest that, by the year 2002, California will be comprised of a "majority of minorities"; no single ethnic or racial group will comprise a majority of the State's population⁸.

In 1997, California had the largest percent of foreign-born residents of any state; nearly 25 percent of the State's population was born outside the U.S, compared with approximately ten percent nationwide⁹. Thirty-three percent of California residents speak a language other than English in the home, compared with 14 percent nationwide. More than one-third of school-age children speak a language other than English at home. Spanish is the most widely spoken language after English. Languages of the Southeast Asian and Pacific Islander populations also contribute to the State's linguistic diversity. Ethnic diversity will continue to be a defining characteristic of the State's population in the 21st century. This diversity will present continuing challenges and opportunities to the design of health services that are culturally accessible and relevant to the needs of the various population groups.

Table 1: Population Distribution by Race and Ethnicity

Year	1990 No. (%)	1999 (projected) No. (%)	2000 (projected) No. (%)	2010 (projected) No. (%)
Total Population	29,942,397	34,072,478	34,653,395	39,957,616
White Non-Hispanic	17,131,831 (57.2)	17,339,690 (50.9)	17,421,511 (50.3)	17,901,991 (44.8)
Hispanic	7,774,789 (26.0)	10,352,763 (30.4)	10,688,752 (30.8)	13,964,050 (34.9)
Asian and Pacific Islander	2,745,781 (9.2)	3,856,288 (11.3)	3,999,427 (11.5)	5,313,750 (13.3)
Black	2,105,207 (7.0)	2,320,916 (6.8)	2,337,935 (6.7)	2,540,500 (6.4)
Native American	184,789 (0.6)	202,821 (0.6)	205,770 (0.6)	237,325 (0.6)

County Population Projections with Racial/Ethnic Detail, Estimated July 1, 1990-96, Projections for 1997-2040. California Department of Finance, December, 1998.

California's youth, already among the most ethnically diverse in the nation, will become even more diverse. The number of Latino youth, aged 10 to 19 years, will grow from 1.6 to 2.6 million (a 47 percent increase); African-American youth will grow from 349,860 to 452,300 (a 29 percent increase); and the number of white youth will increase from 1.9 million to 2.3 million (a 17 percent increase)⁷.

The State's cultural diversity places added demands on the health care system in relation to both access to and quality of care. For example, in 1998, approximately one-third of the mandatory eligibles in Medi-Cal managed care spoke a language other than English¹⁰. To improve access to Medi-Cal services, all Medi-Cal managed care materials are to be made available in ten threshold languages. These include: Spanish, Chinese, Vietnamese, Cambodian, Hmong, Laotian, Korean, Russian, Farsi, and Tagalog. Approximately 28 percent of the Healthy Families applications received by May 2000 were in one of these ten threshold languages¹¹.

Geography

California's 34 million residents are distributed over 58 counties that range in size from the smallest, Alpine, with a population of 1,180 in January 1999, to Los Angeles, with a population of 9.7 million¹². The State's population is predominantly urban with over 92 percent of the State's residents living in urban areas. In 1999, eight counties had populations exceeding one million. Nine of the 58 counties were home to over 70 percent

of the total population. The three most populous counties, Los Angeles, San Diego, and Orange, are located in the southern part of the State. These three adjacent counties comprise over 45 percent of the population; almost 30 percent live in Los Angeles County alone.

The State's geography also contributes to access to care problems. Twenty percent of the State's population lives in the Central Valley and eastern California. The granite mountains of the eastern border may be impassable because of weather conditions during a portion of the year. Flooding of the State's rivers can contribute to limited access at some times of the year. Technological developments have made possible the expansion of systems of telemedicine with the potential of increasing access to high quality medical care in these more isolated areas. One example is the collaborative activity of the Maternal and Child Health Branch, the Sierra Foundation, and the University of California Davis School of Medicine to assist the Plumas County Hospital Obstetric Service to develop the first obstetric telemedicine project. The project will improve the quality of obstetrical services available to the county's largely rural population.

The demography of California presents challenges to improving access to health care. The 2.5 million rural residents, while comprising a small portion of the State's population, often require unique responses to their health care needs. Rural residents are generally older, poorer, and have fewer health resources than their urban counterparts. Given the provider shortages that are common in many rural areas, some rural clients drive over one hundred miles to access care. Given the dispersion of the rural population, trained providers confront financial difficulties in maintaining a viable practice for small client populations. In addition, they experience the difficulties of isolation from professional support and the specialty services their clients may require.

To assure that needed health service programs reach throughout the State, the Maternal and Child Health (MCH) and Children's Medical Services (CMS) Branches, which comprise the California Title V agency, interface with 58 county and 3 municipal health departments. Title V allocations support the local MCH programs and the local Maternal, Child, and Adolescent Directors. While each of the counties has a CCS program, the State CCS program, within the CMS Branch, directly shares case management activities for CSHCN with 28 of the counties, termed "dependent" counties.

Economy

California has participated in the nation's economic recovery in the second half of the 1990s. Unemployment rates are at a thirty-year low, having fallen below five percent by the end of 1999. Nevertheless, notable disparities in economic development are found among counties. Marked differences are found when comparing

Silicon Valley, the hub of computer technology developments, and the more rural counties working to attract new industries. A large portion of children in the State live in poverty. In 1999, 46.7 percent of the State's 0-19 year olds were living below 200 percent of the Federal Poverty Level (FPL), 23.8 percent were below 100 percent, and some 9.7 percent were living below 50 percent FPL¹³.

A portion of California's low-income families experiences insecurity about the ability to meet the basic needs of their children. In 1997, approximately 18.5 percent of California's children lived in low income families where parents were "not confident" they could get their child needed medical care; this figure compared with 14.2 percent nationwide. Of those California children, 14.4 percent had no usual source of health care according to their parents. In the same year, 12.2 percent of California's children living in low-income families were in fair or poor health, compared with the national average of 8.2 percent. Among low-income Californians in 1997, 59 percent reported that they either experienced food shortages or they worry about running out of food before they can afford to buy more¹⁴. In times of prosperity, additional resources are more likely to be made available to address the health needs of the under-served if those needs remain in the public forum. The Title V agency plays a central role in identifying, responding to, and creating an awareness of those needs.

Private Sector Participation in Health Services

The private sector is the principal provider of California's health services, including services for low-income populations. In programs such as the Child Health and Disability Prevention (CHDP), Comprehensive Perinatal Services (CPSP), and Family Planning Access Care and Treatment (Family P.A.C.T.), services are offered by a broad network of providers in private practice, community health centers, and other private non-profit clinics. The historic mainstreaming of Medi-Cal clients to private providers of care has continued with the expansion of Medi-Cal managed care. By July 1998, over 45 percent of Medi-Cal enrollees were in a managed care plan¹⁵. Programs of the MCH and CMS Branches work with Medi-Cal in providing technical assistance, as well as setting standards and monitoring the utilization and quality of care. These programs impact on large numbers of the California population; CHDP provided health assessments and screenings to over 2 million infants, children and adolescents in Fiscal Year (FY) 1998¹⁶.

California's version of the State Children's Health Insurance Program, Healthy Families, also relies on the private sector delivery of health services to low-income working populations. Healthy Families provides health insurance coverage to children in families with incomes up to 250 percent of the FPL who are above Medi-Cal eligibility limits. As of June 2000, there were 293,342 children enrolled in Healthy Families¹⁷.

Health care services for CSHCN are an example of cooperation and coordination between private and State health care providers. The CCS program assures access to health care for eligible children with most serious or chronic medical conditions. CCS case manages the services provided for the CCS eligible condition for CSHCN, who in large part receive their health services from private practitioners and institutions. CCS also provides case management as a Fee-For-Service carve-out for health plan beneficiaries in the Medi-Cal Managed Care and Healthy Families populations.

Private foundations play a significant role in meeting the health needs of women, infants, children, and CSHCN by working in partnership with State and local government, and local communities. The David and Lucille Packard Foundation has provided grants for the School Health Connections program in the Maternal and Child Health Branch and the California Perinatal Quality Care Collaborative. The first supports school outreach activities to expand Medi-Cal enrollment. The second supports data analysis and prenatal quality care initiatives. Private foundations also promote innovative community health initiatives and applied research that explores the State's current and emerging health care issues.

Major State Initiatives

A State ballot initiative, Proposition 10, the Children and Families First Act, was implemented in 1998, imposing an additional surtax on cigarette sales. Proposition 10 will result in increased revenues of about \$690 million in 1999-00, with slightly declining amounts annually thereafter. The price increase is also expected to contribute to reducing smoking among California's youth. The tax revenue is being distributed to County Commissions (80 percent) and the State Children and Families Commission (20 percent) to develop programs to promote early childhood development. In light of the large numbers of young children who are in child care, one focus of the Proposition 10 activities will be on the improvement of child care services. A second priority area will be the improvement and expansion of home visiting services to provide support and training to parents and other caregivers.

The Title V program will coordinate its prenatal smoking cessation and prevention activities with the California Children and Families programs. Prenatal and postnatal education on the risks of maternal smoking during pregnancy and secondhand smoke to the mother and the newborn is a component of all Title V programs, including the Adolescent Family Life and the Black Infant Health Programs as well as CHDP. MCH and CMS work with other departments of the Health and Human Services Agency to identify best practices on home visiting, case management, family-centered care, and family resource centers which are

pertinent to priorities of the California Children and Families initiative. Local MCH programs work directly with their County Children and Families Commissions in the planning of activities.

Expanding the enrollment of low-income children in Medi-Cal is a priority in California. Medi-Cal enrollment declined following welfare reform's delinkage of cash assistance and Medicaid enrollment. As enrollment in the CalWORKs program, California's cash assistance program for children and families, has declined, so has Medi-Cal enrollment. The percent of California's children 0-18 years of age who enrolled in Medi-Cal fell from 25 percent in 1995 to 20 percent in 1998. Job-based insurance coverage increased by one percent, while the percent of uninsured increased by four percent in the corresponding period¹⁸. The State budget for FY2000-2001 allocates significant resources to Medi-Cal and Healthy Families outreach activities to expand enrollment of the eligible population. The budget for FY2000-2001 also includes initiatives to further simplify the Medi-Cal application process.

The Title V administrator is a member of the senior management of the Department of Health Services and has ongoing activities within the California Health and Human Services Agency. In this capacity, the Title V Director participates in identifying, planning and implementing State policies.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

The Maternal and Child Health (MCH) Branch and the Children's Medical Services (CMS) Branch comprise the Title V agency in California. The California Children's Services (CCS) program within CMS is the designated Title V program for Children with Special Health Care Needs (CSHCN). All California residents who are pregnant women, mothers, infants, children including CSHCN, and adolescents comprise the Title V population.

1.5.1.1 Organizational Structure

Please see Organizational Charts in Other Supporting Documents, Section 5.3.

MCH and CMS are located in the California State health agency, the Department of Health Services (DHS). DHS is one of 13 departments within the California Health and Human Services Agency. Mr. Grantland Johnson is the Secretary for Health and Human Services, which is a cabinet-level position reporting directly to Governor Gray Davis. The DHS Director is Diana Bontá, RN. DrPH.

The MCH and CMS Branches are in the Primary Care and Family Health (PCFH) Division of the DHS. The other Branches in PCFH are: Office of Family Planning; Women, Infants and Children (WIC) Supplemental Nutrition; Genetic Disease; and Primary and Rural Health Care Systems. The Deputy Director of PCFH is Tameron Mitchell, RD, MPH. The Acting Chief of the MCH Branch is Gilberto Chavez, MD, MPH and the Chief of the CMS Branch is Maridee A. Gregory, MD. The MCH and CMS Branches have joint responsibility for carrying out the Title V functions. Details of the organization of the MCH and CMS Branches are provided in Section 1.5.1.3.

DHS is designated to administer the MCH program by the California Health and Safety Code Div. 106, Part 2, Chapter 1, Article 1 Sections beginning with 123225. The CCS program is authorized by the Health and Safety Code Division 106, Part 2, Chapter 3, Article 5, Sections 123800-123995. The Genetically Handicapped Persons Program, 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 125125-125180. The Child Health and Disability Prevention 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.

1.5.1.2 Program Capacity

The programs of the MCH and CMS Branches of DHS have been developed to address the three core public health functions: needs assessment of the population; development of program policies to address the needs and improve health outcomes; and assurance of the availability of accessible and appropriate high-quality services. Assuring cultural competence and access to services in a community-based setting are both important principles of DHS policy development.

◆ Preventive and primary care services for pregnant women, mothers and infants

California has eliminated most financial barriers for reproductive and prenatal services for low-income women and preventive and primary services for infants. Medi-Cal eligibility for prenatal coverage includes all pregnant women with incomes below 200 percent of the Federal Poverty Level. A property disregard program expands eligibility. As of 1998, a mail-in prenatal application procedure was adopted to facilitate enrollment. Presumptive eligibility facilitates early enrollment in prenatal care, while the Medi-Cal application is being processed. Medi-Cal prenatal coverage is provided for full-scope prenatal, delivery, and postpartum medical services. An expanded service package is funded through the Comprehensive Perinatal

Services Program that is available to high-risk Medi-Cal eligible women. In 1998, Medi-Cal covered the prenatal care and delivery costs for 40 percent of all women who delivered a live-born infant in California¹⁹.

The Access for Infants and Mothers (AIM) Program provides State-subsidized third party insurance at low cost to pregnant women and infants between 200-300 percent of the FPL, if they are uninsured or otherwise meet eligibility requirements for AIM maternity benefits. Annually, AIM serves approximately 4,000 moderate-income women²⁰. In addition, the MCH Branch has a memorandum of understanding with the Genetic Disease Branch to conduct alpha fetoprotein screening of pregnant women to identify neural tube and other defects. The combination of Medi-Cal, AIM and private health insurance results in near universal health insurance coverage for prenatal and maternity care in California. In 1998, approximately three percent of the women who delivered live-born infants in the State did not have a third party source of health coverage for prenatal or delivery services¹⁹.

Non-financial barriers to early and continuous prenatal care use still exist. The fact that 18 percent of women who delivered live-born infants in California in 1998 started care after the first trimester is indicative of the continuing challenges. Issues of transportation, child care, cultural and linguistic needs, awareness of publicly funded insurance coverage, and a differing perception of the need for early and continuous care are all likely to contribute to inadequate utilization. The enabling and population-based prenatal care programs supported by the Title V program address these barriers.

Medi-Cal and AIM also provide health insurance coverage for a comprehensive service package for infants. Medi-Cal reaches infants under one year living in households with incomes below 200 percent of FPL. In FY 1998-99, the average monthly enrollment in Medi-Cal for infants less than one year of age was 187,214. The total number of infants enrolled at some point during the year was 417,710²¹. AIM provides continuing coverage for the first two years of life for infants of mothers enrolled during the prenatal period. The Healthy Families Program has expanded insurance coverage to infants by enrolling uninsured infants who live in households with incomes between 200-250 percent of FPL. As of June 2000, 2,056 infants less than one year were enrolled in Healthy Families.

A number of newborn screening programs are conducted in California. The Genetic Disease Branch of DHS provides newborn screening for primary hypothyroidism, phenylketonuria, galactosemia and several hemoglobinopathies to approximately 99 percent of the newborn population. A newborn hearing screening program is being instituted through CMS. By the end of 2002, this program will assure neonatal hearing

screening for all infants born in CCS approved hospitals (approximately 70 percent of all births). This program is also creating a framework that would serve as a model for further expansion of hearing screening to all newborns in the State.

Individual hospitals are now receiving training in hearing screening. The State has been divided into five geographic service areas for infant tracking and follow-up. Three hearing coordination centers have been chosen that will provide technical assistance to hospitals in the service regions, carry out infant tracking and follow-up, and assure performance of screening and additional testing as needed. Several hospitals are already screening all inborn newborns and others will be incrementally added to the program over the next two years. In addition, high-risk infants, who have received care in CCS-approved Neonatal Intensive Care Units, are currently required to receive hearing screening before hospital discharge.

State and local MCH programs work collaboratively with the Medi-Cal, A.I.M. and Healthy Families Programs, as well as with local health plans to assure the accessibility and availability of quality health care services for pregnant women, mothers, and infants. A memorandum of understanding (MOU) has been signed between the Medi-Cal agency and the MCH and CMS Branches, as the Title V agency, on Standards and Quality of Care for programs serving women and children.

Access to family planning services has been expanded by the Family Planning Access, Care and Treatment (Family P.A.C.T.) program, which was introduced in FY 1996-97 by the Office of Family Planning. The program promotes access to comprehensive family planning services to low-income men and women who are not otherwise eligible for Medi-Cal and have no other source of family planning coverage. Family P.A.C.T. makes available comprehensive family planning services, including contraceptive methods, screening for sexually transmitted infections, and breast and cervical cancer to all women and men in California with incomes at or below 200 percent of FPL. In 1997, after eight months of operation, approximately 1,800 providers and more than 600,000 clients were enrolled in Family P.A.C.T. The program is expected to increase client enrollment by 60 percent over California's prior family planning program²².

Extensive preventive, screening and basic health services are provided to infants under a year of age by the Child Health and Disability Program (described under Preventive and Primary Care for Children, below). In FY 1997-98, 550,596 infants received services through this program.

◆ *Preventive and Primary Care for Children*

The Medi-Cal and Healthy Families Programs (HFP) provide financial access to a comprehensive package of primary and preventive services, including dental care, for California's low-income children. Medi-Cal covers children ages 1 through 5 at 133 percent of FPL, children and adolescents ages 6 up to 19 at 100 percent of FPL, and young adults 19 up to 21 years at 86-92 percent of FPL. In 1998, California expanded Medi-Cal eligibility in three ways: 1) accelerated coverage for all children 6-19 under 100 percent of FPL; 2) adopted a resource disregard for children in the FPL program; and 3) approved one month of HFP coverage under the Medi-Cal program to allow children whose families become ineligible for Medi-Cal enough time to become enrolled in HFP. An estimated additional 40,000 children beyond the normal projected growth, have been enrolled in the Federal Poverty Level programs²³. In October 1998, the Medi-Cal eligible population included 2.5 million children and adolescents 1-19 years of age²⁴. The number of children served over a year was actually greater, since beneficiaries move on and off the eligibility list.

Healthy Families provides insurance coverage for preventive and primary care to children from 0 through 18 years of age who are uninsured and living in households with incomes up to 250 percent of FPL. Monthly premiums and copayments for certain types of visits and prescriptions are required. As of June 5th, 2000, 293,342 children and youth 0-18 years of age were enrolled in the Healthy Families Program¹⁷. The MCH and CMS Branches support outreach and enrollment initiatives for both the Medi-Cal and HFP at the State and local levels.

The CMS Branch administers the screening and preventive component of the Federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. In California this screening and prevention component is called the Child Health and Disability Prevention (CHDP) Program. CHDP assures preventive services, including health assessments, immunizations, screening tests, dental screening, and referral for further diagnosis and treatment for Medi-Cal funded children up to 21 years of age. There is also a State funded component that extends these same services to children up to 19 years of age from families with incomes up to 200 percent of the FPL. In FY 1997-98 approximately 2.3 million children received health services through CHDP, with 54 percent funded by Medi-Cal and 46 percent funded through State-only sources. Of the Medi-Cal beneficiaries, approximately two thirds were reported by Fee-For-Service Medi-Cal and one third by Medi-Cal managed care plans.

Local CHDP Programs are located in all 58 counties and 3 local health departments. Each local program maintains a network of health care providers, who perform the health care assessments, provide prevention services, offer technical assistance and see that problems identified during screenings receive appropriate diagnostic and health care follow-up. CHDP programs also perform quality assurance activities and assist

families with functions such as medical appointment scheduling and obtaining transportation for health care. Each CHDP Program provides outreach and education to families, providers in their network, and other agencies. CHDP serves as a gateway to the Medi-Cal and Healthy Families Programs, by identifying potentially eligible children and by informing families of available health care options.

Efforts are underway through the county and local health programs to improve health care and health care access for foster children. In cooperation with the Department of Social Services, additional funds have been allocated to local programs to fund public health nurses to coordinate health care services for children in foster care (The Health Care Program for Children in Foster Care).

A new Children's Asthma Program is currently being developed as a collaborative activity between branches within the DHS, including the Chronic Disease Prevention Branch and CMS. The program targets children up to age 5 years and will increase medical provider knowledge and community awareness about asthma symptoms and treatments. The aim is to identify children with asthma and assure early, appropriate monitoring and treatment, to decrease the need for hospitalization and decrease asthma morbidity and mortality.

◆ *Services for Children with Special Health Care Needs*

The CMS Branch administers the CCS program that provides case management and payment of services for CSHCN who meet the program's medical, residential, and financial eligibility criteria. The program authorizes medical and dental services related to the CCS eligible condition. Additionally, it establishes standards for providers, hospitals, and special care centers for the delivery of care in tertiary medical settings and in local communities, and provides physical and occupational therapy and medical case conference services at selected public school sites for children with specific medically eligible conditions. The program is available for children whose family incomes are less than \$40,000 State adjusted gross income per year, or at any income if the family's out-of-pocket medical expenses for the child are projected to be 20 percent or more of the family's annual income. The school therapy program has no financial eligibility requirements.

The CCS program is financed by Federal, State, and county funds. Thirty counties directly administer their own CCS program and are designated as independent counties. The remaining 28 counties, designated as dependent counties, share the administrative and case management activities with CMS Branch Regional Offices located in Northern and Southern California. The CCS program is responsible for case managing the CCS eligible condition for Medi-Cal beneficiaries (even if the child is enrolled in a managed care plan)

according to the California Code of Regulations, Title 22, Section 51013, and authorizes Medi-Cal reimbursement for medical and dental services related to the CCS condition, including EPSDT supplemental services. CCS also case manages the CCS eligible condition for children enrolled in Healthy Families.

The CMS administrative claims for FY 1998-99 show a CCS caseload of 140,129 CSHCN. Of these children, approximately 74 percent had Medi-Cal coverage and 3 percent were estimated to be enrolled in Healthy Families. Overall 96 percent of CSHCN enrolled in CCS have some form of health insurance. The CHDP program, through periodic health assessments, continues to identify CSHCN and serves as a referral source to CCS and for enrollment in Healthy Families and Medi-Cal, where eligible.

The CMS Branch has two programs that address the needs of high risk infants. The first allows infants that are discharged from CCS approved Neonatal Intensive Care Units (NICUs) to be followed in the individual NICU follow-up clinics. Three multidisciplinary outpatient hospital visits are authorized by CCS during the first two years of life, to identify problems, institute referrals and monitor outcomes. Visits include a comprehensive history and physical examination, developmental testing, and ophthalmologic, audiologic and family psychosocial evaluations. Children are evaluated at 4-6 months, 9-12 months, and 18-24 months corrected age. If a child is diagnosed with a CCS-eligible medical condition, and other eligibility criteria are met, he/she is then enrolled in the treatment and case management part of the CCS program. If a developmental disability is identified, the child is referred to the Early Start program, for children 0 to 3 years (Infants with Disabilities Act [IDEA] Part C [formerly part H]).

The second program, the High Risk Infant Follow-up Program, has used a network of community based contractors to provide home-based services to high risk infants from NICUs and their families. Services have been provided to infants up to three years of age. This year, the Title V funded High Risk Infant Follow-up Program has been restructured into the Medically Vulnerable Infant Program (MVIP). The new program is intended to increase the focus on medically fragile infants. Infants will be eligible for the MVIP program, if they have required medical care in a CCS approval Neonatal Intensive Care Unit, are at risk of developing a CCS eligible condition, and were premature or had a defined, serious neonatal health problem. The contractors will provide needed home visiting services, assessments, monitoring, interventions, referrals, and parental counseling and education, up through the third birthday. The goals of the MVIP program are to reduce preventable sequelae, secondary illness, hospitalizations and developmental disabilities or delays. Services are to be home based, family centered, and culturally appropriate. Applications have been submitted for the MVIP contracts and selection of geographically varied, quality contractors is being finalized.

The CCS program also provides for screening and monitoring of infants, children, and adolescents under the age of 21 who are at risk for Human Immunodeficiency Virus (HIV) infection. These children are eligible for screening, diagnostic evaluation or medical monitoring, and follow-up services regardless of family income. If found to be HIV positive and other eligibility criteria are met, they are enrolled in the treatment and case management part of the CCS program.

The Genetically Handicapped Persons Program (GHPP) provides case management and funding for medically necessary services for people with certain genetic conditions including cystic fibrosis, hemophilia, sickle cell disease, and neurologic and metabolic diseases. Most GHPP clients served in this program are adults. However, approximately 10 percent of the program enrollment are children under 21 years of age. The GHPP will serve eligible children with higher family incomes that make them ineligible for the CCS program.

- ◆ Rehabilitation services to SSI beneficiaries under the age of 16

SSI beneficiaries with a CCS medically eligible diagnosis, who meet the CCS residential eligibility criteria, are served by the CCS program. These children have Medi-Cal coverage and CCS funds any medically necessary services that are not benefits of Medi-Cal or EPSDT Supplemental Services. Additionally, if physical and/or occupational therapy are needed, they can be provided in the CCS Medical Therapy program. Children on SSI who have mental or developmental conditions are served by the Departments of Mental Health, Developmental Services, and Education.

- ◆ Provide and promote family-centered, community-based coordinated care for CSHCN

The CMS Branch recognizes the critical need to work toward a more integrated, family-centered service system for CSHCN. This is especially true given the many levels of healthcare workers and health organizations involved in providing medical services to CSHCN. A major goal, expressed in the last CMS Strategic Plan, is to develop partnerships with families, service providers in the community, local healthcare agencies and health care plans, in order to improve and promote family-centered, coordinated systems of care.

Special Care Centers and hospitals that treat CSHCN and wish to become CCS-approved must meet specific criteria for approval. One of the criteria used in evaluation involves family-centered care. During the center review, the following are considered: the level of parental involvement in treatment decision making; sharing of reports with families; the degree of parent/patient involvement in advisory committees

that set policies and procedures; and availability of healthy sibling and parent visiting. Following the review of the Special Care Center, the CMS Branch sends a follow-up report to the facility with family-centered care recommendations.

To promote the adoption of family-centered policies and services within the CCS program, the CMS Branch, in collaboration with the University of Southern California - University Affiliated Program, received funding from the Federal MCH Bureau that allowed hiring of a parent consultant to work on site in the CMS Branch over most of the past year. The duties of the parent consultant included reviewing needs assessment documents; contributing to the development of case management standards; collaborating with a variety of agency personnel, parent groups, and managed care organizations; and facilitating the development of workshops on family-centered care. In addition, a series of trainings were conducted, directed towards county and State CCS staff and other agencies serving CSHCN, on family centered care and interagency coordination. Due to family responsibilities the parent consultant has now left CMS. Since grant funding is also temporary, an alternative source of funding is being sought in order to create a more permanent parent consultant position.

1.5.1.3 Other Capacity

The staffing and responsibilities of the MCH and CMS Branches are discussed in this section.

Maternal and Child Health Branch

Since February 2000, Dr. Gilberto Chavez has been serving as the Acting MCH Branch Chief. Dr. Chavez is a Pediatrician with training in Epidemiology and Preventive Medicine. He is also an Assistant Clinical Professor at the University of California at Davis School of Medicine and a Lecturer at the School of Public Health, University of California at Berkeley. Dr. Chavez serves as a Temporary Advisor to the World Health Organization and consults regularly on MCH issues and epidemiology around the world. Dr. Chavez has received numerous honors and awards within the state and at the national level. In addition, he has authored and co-authored over 50 scientific articles in peer-reviewed journals, reports, and book chapters. Prior to his appointment as Acting MCH Director, Dr. Chavez served as Chief of the Epidemiology and Evaluation Section in the MCH Branch. He has also served as a Medical Officer with CDC's Division of Reproductive Health and as an EIS Officer with CDC's Division of Birth Defects and Developmental Disabilities.

The MCH Branch has primary responsibility for Title V activities. Its focus is on the development and strengthening of systems of care for women, infants, and youth, and support for local maternal and child health programs. The Branch has over 300 contracts with public and private non-profit agencies that participate in the core public health assessment and monitoring population-based functions as well as the provision of enabling services at the community level.

The MCH Branch is divided into five sections:

1. *Program Policy Section*-develops and maintains policies related to MCH programs and issues.
2. *Epidemiology and Evaluation Section*-conducts needs assessments, program evaluations, and surveillance functions.
3. *Domestic Violence Section*-assures that services are provided to families affected by domestic violence.
4. *School Health Connections*- works to create a statewide infrastructure for coordinated school health.
5. *Operations*-ensures compliance with all policies and maintains contracts and provider payments consistent with legislative priorities and regulations.

Program Policy Section: This section is under the leadership of Dr. Terrence Smith, Public Health Medical Officer (PHMO) III, who is Board Certified in both Family Medicine and Public Health and Preventive Medicine. The section is comprised of four units and two medical officers: Perinatal Health (A & B), Child and Adolescent Health and Title V and Youth Services.

Perinatal Health units are supervised by Nurse Consultant Supervisors and have 17 staff members. This office coordinates the implementation of standards of care for pregnant women under the Comprehensive Perinatal Services Program (CPSP), Regional Perinatal Programs of California (RPPC), Fetal Infant Mortality Review (FIMR), Sudden Infant Death Syndrome (SIDS) program, California Diabetes and Pregnancy Program (CDAPP), and the Black Infant Health (BIH) program.

The Child and Adolescent Health Unit is supervised by a Nurse Consultant Supervisor III and has 12 staff members. The office is responsible for the Adolescent Family Life Program (AFLP) which also includes the Sibling Pregnancy Prevention Component. Program consultants from all three units develop standards and provide consultation and technical assistance to the 61 local MCH jurisdictions, community-based organizations, school districts, hospital-based programs, and schools of nursing and public health.

Dr. Robert Bates (PHMO III) serves as the MCH State Adolescent Health Coordinator. He has been a California County Health Officer for 14 years and has a special interest in childhood injury prevention issues. His work includes expanded efforts in injury prevention, with a focus on decreasing adolescent homicide and suicide rates, and motor vehicle and drowning deaths, as well as efforts within MCH in improving the oral health of California's children. A second public health medical officer position will serve as liaison to local maternal and child health program medical officers, and provide technical assistance to the largest county health departments.

The Title V and Youth Services Unit is supervised by a Health Program Manager I and includes five staff. Responsibilities of this unit include the Youth Pilot Program and coordination on program issues related to meeting performance and outcome measures. The majority of staff in the Program Policy Section are located at the headquarters in Sacramento with some work based in the Regional office located in the city of Berkeley.

Epidemiology and Evaluation Section: This section is currently headed by Don Taylor, an epidemiologist who was named Acting Chief in March 2000. Prior to his appointment he had worked as a research scientist and epidemiologist in the Section since 1993.

The section is organized into three units: the Office of Special Projects (OSP) conducts independent epidemiological research and evaluation projects on emerging MCH issues, the Office of Program Data and Evaluation (OPDE) develops, maintains, and analyzes program-related databases, and the Office of Epidemiology and Surveillance (OEAS) develops and analyzes population-based data resources.

The OSP is managed directly by the Section Chief. The two staff in this group use innovative methodological techniques such as small area analysis to support community level analysis of such core MCH issues as teenage births, prenatal care utilization, and low birthweight. Work from this unit is used to support localized surveillance as well as programmatic targeting of MCH resources.

The OPDE is managed by a Research Manager II. The 7 staff in this group provide program information to State and local agency planners for monitoring MCH program implementation, evaluating program effectiveness, and for policy development. OPDE currently provides support for the following five programs: AFLP, BIH, CDAPP, BWSP (Battered Women's Shelter Program), and FIMR.

The OEAS is under a Research Manager II. The 10 research staff provide population-based data to support California's application for Federal Title V Grant Funds. They also provide assessment and surveillance information for use in program related research, program policy planning, allocation of resources at program,

regional, and county levels, and evaluation. OEAS currently supports the California Title V needs assessment, surveillance and reporting; the MCH component of the Women's Health Survey; SIDS surveillance; the California Birth/Death Cohort file; the Maternal and Child Health Hospital Surveillance (*Perinatal Profiles*) activities; RPPC data-related activities, and the Improved Perinatal Outcome Data Reports (IPODR) system.

Domestic Violence Section:

This section is headed by Mrs. Carol Motylewski-Link, a Health Program Manager II, with 25 years of experience in the public health arena. She holds a Masters in Public Health degree from California State University, Northridge and worked in a local health department for 17 years prior to joining the Department of Health Services. Her nine years with DHS include work in the Tobacco Control Section and in the Domestic Violence Section of MCH. She manages the administration, implementation and evaluation of the Battered Women Shelter Program (BWSP).

The section has a staff of seven, who work with the BWSP and the statewide technical assistance and training project (Safe Network). The MCH Branch operates 128 domestic violence grants: 85 for shelter-based services, 27 for prevention services, 6 for statewide teen relationship abuse assessment and training, and 10 for statewide technical assistance and training. Staff in this section work closely with domestic violence constituents to ensure that necessary and appropriate services are provided, facilities are safe, and grants are properly administered. All staff except one work from MCH headquarters in Sacramento, with the remaining member stationed in Berkeley.

School Health Connections:

This section is headed by Nancy Gelbard, MS, RD, a Health Program Specialist II, who works as a member of a cross-departmental team with the California Department of Education. Prior to her position with School Health Connections, Ms. Gelbard worked for twenty-four years in the field of public health in a broad range of settings. For the past 10 years, she has worked at the Department of Health Services in chronic disease prevention/control and maternal and child health.

School Health Connections (SHC) is working to create a statewide infrastructure for coordinated school health. The SHC goal is to improve the health status and academic achievement of California's children and youth by taking advantage of the pivotal position of schools in reaching children and families. SHC combines, in an integrated and systematic manner, health education, health promotion, disease prevention and access to health-

related services. The Section has a total of five staff; two positions are funded through a school health infrastructure grant from the Centers for Disease Control and Prevention. The other three staff are supported by a David and Lucile Packard grant. The Packard grant was designed to increase outreach and enrollment in Healthy Families and Medi-Cal through expanded involvement with schools. DHS School Health Connections staff work closely with their counter parts at the Department of Education.

Operations Section:

Operations Section: Les Newman is the Chief of the Operations Section for the MCH Branch. In this capacity, Mr. Newman plans, organizes, coordinates, directs, supervises, and evaluates the ongoing operation of all administrative functions necessary for MCH. Prior to coming to MCH, Mr. Newman spent over 20 years working in leadership positions in California government, the last 10 years in management. In Mr. Newman's last several positions he has played a leadership role in nationally recognized public-private health insurance programs. Recently, he was the Benefit and Quality Monitoring Manager for California's Healthy Families Program. Mr. Newman has also held several key positions in California's Medi-Cal Program, including supervisory positions in the Medi-Cal Eligibility Branch. Mr. Newman holds a B.A in Political Science from the State University of New York and took post graduate course work in Public Administration at Pennsylvania State University.

The section is divided into three units: the Contract Management and Policy Unit (11 staff), the Contract and Fiscal Management Unit (10 staff), and the Office Support Unit (6 staff). The Operations Section assumes all of the administrative functions for the branch, including: legislative liaisons, managing over 300 contracts, auditing functions, maintaining the infrastructure needs of the branch, and working with Department of

Finance and other control agencies. In addition, the section does budget-related work, fiscal forecasting, contract development, as well as providing technical assistance to the contractors. The Operations Section has assisted with the implementation efforts outside MCH including the large community

Children's Medical Services Branch

In 1992, the CMS Branch was created by integrating the Child Health and Disability Prevention and California Children's Services Branches of the Department of Health Services. Maridee A. Gregory, M.D. implemented the merger of the two Branches and has been Branch Chief since that time.

Dr. Gregory is a board-certified Pediatrician who received her M.D. from Indiana University School of Medicine. Dr. Gregory has served as a staff pediatrician in Hawaii; Assistant Professor of Pediatrics at Loma Linda University School of Medicine; Health Officer of Humboldt-Del Norte County Health Department; and Director of CHDP and MCH for the Riverside County Health Department. She has been with the Department of Health Services since 1981, serving in the capacity of Chief of the Maternal and Child Health Branch, Acting Deputy Directory of Public Health, Chief of the California Children's Services Branch, and currently as Chief of the Children's Medical Services Branch.

Dr. Gregory is assisted in her administrative duties by Elisabeth H. Lyman, Assistant Branch Chief. Ms. Lyman has been with the Department of Health Services since 1978, and in that time has served in a variety of policy and administrative positions in Medi-Cal, Vital Statistics, and WIC as well as in the CMS Branch. From 1990 to 1993, she served as Chief of the Family Health Division. Ms. Lyman has a M.P.H. in Medical Care Organization from the University of Michigan. Ms. Lyman is currently functioning as the full time project manager for the mission critical, CMS Net/ Enhancement 47 data development and linkage project.

The CMS Branch is organized into four sections:

Program Standards and Quality Assurance (PSQA) Section: With a vacancy in the PSQA Section Chief Position, Acting Section Chief responsibilities are currently being shared by Karlette Winters, M.D. and Valerie Charlton, M.D., M.P.H. Dr. Winters is specialty certified in Pediatrics and Ophthalmology and Dr. Charlton is specialty and subspecialty certified in Pediatrics and Neonatal- Perinatal Medicine.

The PSQA section has 19 staff who are responsible for the development and implementation of: program policy for both the CHDP and CCS programs; development and promulgation of regulations, policies and procedures for both programs; development and implementation of the Newborn Hearing Screening program; development of provider standards for CHDP and CCS; development of policies and procedures to implement Medi-Cal managed care, the Healthy Families Program, the Health Care Program for Children in Foster Care and the Children's Asthma Program, as well as maintenance of an ongoing role in these programs; provision of pediatric consultation to the Medi-Cal program in the development of policies and procedures for EPSDT benefits and Supplemental Services; and provision of pediatric consultation to other DHS programs. The PSQA section also performs the review and approval of all requests for organ transplants for children funded by CCS and Medi-Cal and provides consultation to the Medi-Cal program for the review of other requests for services.

Program Operations Section (POS): Jean Whittiker, P.H.N., M.S., is the Chief of the Program Operations Section. She graduated from Fresno State College with a B.S.N. and a P.H.N. certificate, and received a Masters in Science in Health Care Management from California State University, Los Angeles. Ms. Whittiker began her public health career as a Public Health Nurse for the Pomona Health District, Los Angeles Department of Public Health. While with the Los Angeles County Health Department, she was responsible for the daily operation of the Pomona Health District office which provided preventive health care, public health services, and primary ambulatory care for pediatric and adult patients. In 1980, Ms. Whittiker joined CCS as a regional nurse consultant, and in 1993 transferred to Sacramento to become the statewide nurse consultant for the PSQA Section. In 1996 she was appointed to the position of Chief of the Program Operations Section.

The POS is responsible for planning, implementing, and monitoring the CCS, CHDP, and Genetically Handicapped Person's Program programs. Professional staff provide pediatric medical expertise and consultation in the disciplines of medicine, nursing, physical and occupational therapy, dentistry, nutrition, audiology, public health social work, and serve a health education role with respect to providers, State and local agencies, and the public. There are 45 permanent positions in this section, divided between the central office in Sacramento and the regional offices. The prior system, using three regional offices (in Sacramento, San Francisco, and Los Angeles) has been reorganized into a two region, Northern and Southern California, structure. Each regional office has a Public Health Medical Officer III (Medical Director) and provides direct case management services for CCS-eligible children in dependent counties, consultation to the independent CCS programs regarding medical management, and consultation to local CHDP programs regarding program operations. The POS is assuming primary responsibility for implementation of the Health Care Program for Children in Foster Care.

Program Case Management Section: The Program Case Management Section manages the GHPP and the Children's HIV programs and carries out most of the dependent county case management for the Northern California region. The section has 48.5 permanent positions, distributed in three units: medical case management; administrative case management; and provider services and will be headed by a Health Program Manager II (still to be named). The section is currently under the direct supervision of Dr. Gregory.

Program Support Section (PSS): The PSS is under the direction of Irvin B. White, Staff Services Manager II. Mr. White received his B.A. degree in Political Science from the University of California at Berkeley. From 1968 to 1972, he served in the U.S. Navy as a Hospital Corpsman. He has been with the Department of Health Services and Emergency Medical Services Authority for 15 years in a variety of administrative and policy

positions, including the Chief of Child Health Promotion Section in the MCH Branch, prior to becoming the Chief of the Program Support Section in the CMS Branch.

The PSS has 25.5 permanent staff who are organized into five units with responsibility for the development, implementation, and evaluation of the following Branch operations: Administration (fiscal, personnel, contracting, purchasing, business service); Information Systems Development; Information Systems Support (with information systems including automation, information technologies systems and CMS Net); Data Analysis, Research and Evaluation; and Clerical Support (typing, word processing, graphics and copying).

1.5.2 State Agency Coordination

DHS is one of thirteen entities within the Health and Human Services Agency. The other Departments are; (i) Alcohol and Drug Programs, (ii) Mental Health, (iii) Developmental Services, (iv) Emergency Medical Services Authority, (v) Aging, (vi) Rehabilitation, (vii) Social Services, (viii) Office of Statewide Health Planning and Development, (ix) Managed Risk Medical Insurance Board (Healthy Families), (x) Employment Development, (xi) Health and Welfare Data Center, and (xii) Community Services and Development.

DHS encompasses a number of Divisions with responsibilities that are relevant to Title V activities and which coordinate with the programs of the MCH and CMS Branches within the PCFH Division. These include: the Office of Women's Health; Medical Care Services (Medi-Cal); Prevention Services (site of Immunization and Childhood Lead Poisoning Prevention Branches); Health Information and Strategic Planning; and the Office of Multicultural Health. Organizational relationships within the PCFH Division are discussed in Section 1.5.1.1, Organizational Structure. PCFH, MCH, and CMS Branch schematic charts are also provided, in Section 5.3, Other Supporting Documents.

Inter and intra agency collaboration is vital for meeting the needs of all children and particularly CSHCN. Local CHDP programs operate in 58 counties and three city, local health departments and local CCS programs are in 58 counties. The CMS Branch works with other agencies in the State to improve health care and service delivery. For example, CMS represents the DHS on the Interagency Coordinating Council (ICC) for Early Start. The Department of Developmental Services is the lead agency for the Early Start program and other ICC members include the Departments of Education, Mental Health, and Alcohol and Drug. CMS has numerous other collaborative relationships with State and local public health agencies, in both the public and private sectors, as well as working relationships with organizations such as local foundations, medical professional associations, and children's advocacy groups. For further discussion of CMS Branch collaboration, see Section 3.1.2.5., Infrastructure Building Services, and Section 4.2, Other Program Activities.

II. REQUIREMENTS FOR THE ANNUAL REPORT

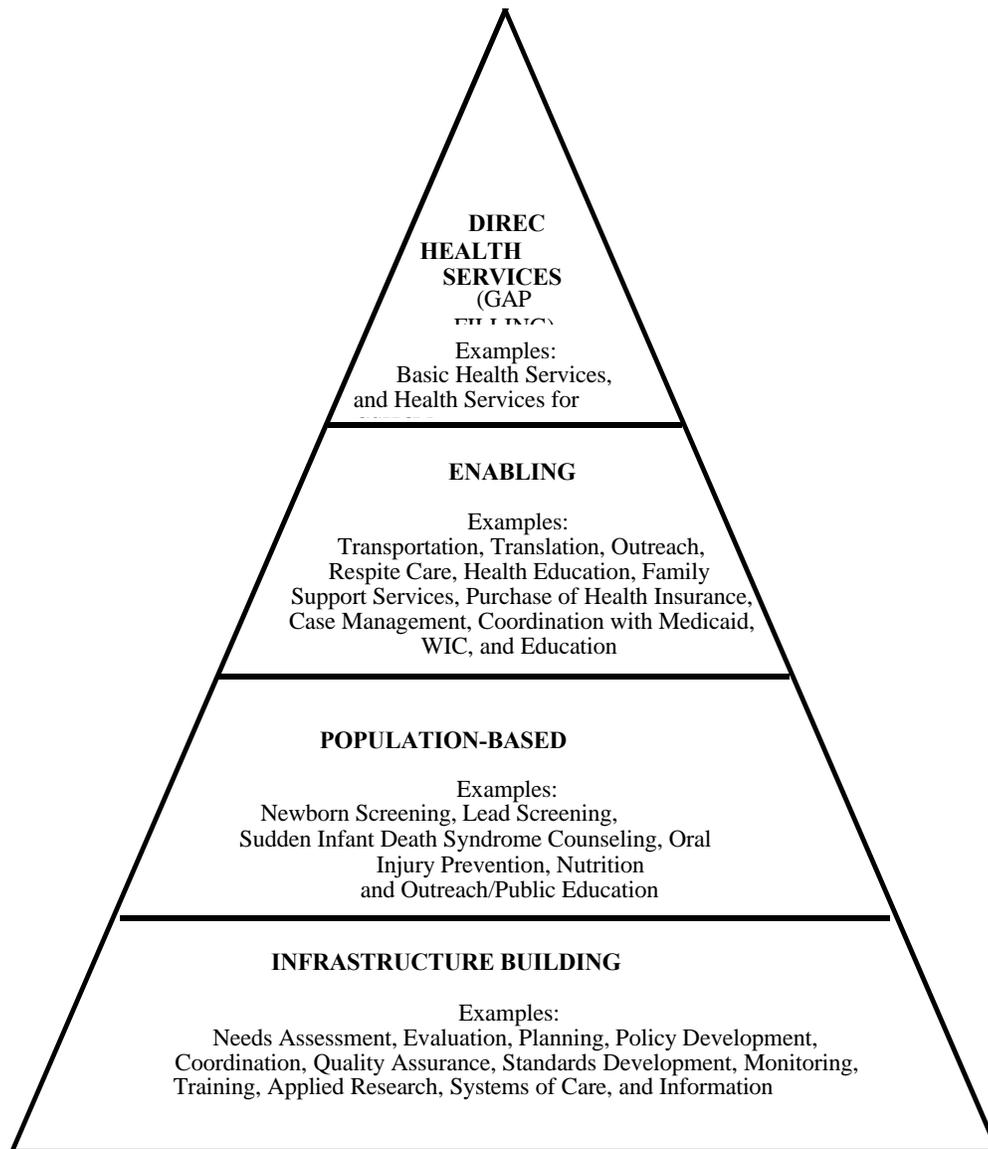
2.1 Annual Expenditures

The budgeted and expended funds for FFY 2001 are presented on Forms 2, 3, 4, and 5. Funds are listed by source (Forms 2 and 3), by population group served (Form 4), and by type of services (Form 5). Funds reported for FFY 2001 are presented using the methodology from the Federal MCH Bureau's most recent guidance.

Significant year to year budget variations that appear on Forms 3,4, and 5 are attributable to the new process of including and displaying all funding sources for services for the MCH population. The total budgeted amount in FFY 1997 did not reflect all the budgeted Title XIX funds available, while the FFY1999, 2000, and 2001 budgets reflect the total Title XIX and Title XXI funds budgeted for Title V related services. These changes are reflected on all applicable forms (Forms 2, 3, 4, and 5).

Figure 2

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



2.2 Annual Number of Individuals Served

Please see details in Forms 6, 7, 8, and 9 and corresponding Notes.

2.3 State Summary Profile

Please see details in Form 10.

2.4 Progress on Annual Performance Measures

Please see Form 11 and corresponding Notes.

This section describes California's progress on the 25 Performance Measures, 18 of which are federally mandated, and 7 of which were selected by the State. The information is presented according to the four levels of the pyramid: direct health care services, enabling services, population-based services, and infrastructure building services. Within each of these levels, the information is presented by population group, first for pregnant women, mothers and infants, then for children, and finally for CSHCN. The Performance Measures are listed on Figure 4 (Performance Measures Summary Sheet). Overall the annual objectives were achieved for 13 of 25 measures and progress toward the targets was achieved for five additional measures.

Direct Health Care Services

◆ *Preventive and primary care services for pregnant women, mothers, and infants*

There are no Federal or State Performance Measures for direct health care services targeting the population group pregnant women, mothers and infants.

◆ *Preventive and Primary Care Services for Children*

State Performance Measure 1 addresses the utilization of preventive medical exams by children whose family income is below 200 percent of the FPL. This Performance Measure evaluates low-income children's access to preventive medical care, health assessments, and basic services. Child Health and Disability Prevention data is used to calculate this measure, and data for FY 1998-99 was not completely analyzed as of this writing. The latest available information, program data from FY 1997-98, showed that 40.2 percent of eligible children

received at least one preventive medical exam. This was basically unchanged from 1996-97, but did not meet the annual objective of 42.0 percent set for 1998. However, more children are moving into managed care and the number of children receiving preventive EPSDT examinations through Medi-Cal Managed Care appears to be underreported in CHDP data. This problem is being evaluated. In addition, CHDP currently does not include annual examinations for children over age 3 years in the State-funded component of the program. Annual CHDP preventive services would, therefore, not be anticipated in State-funded children over 3 years, who comprise approximately 24 percent of the total CHDP participants. Since enrollment into Healthy Families started in July 1998, no Healthy Families data has been included in this measure so far. Since outreach efforts are underway to enroll eligible children in Healthy Families, and consideration is being given to increasing the periodicity for CHDP assessments, the target objectives for *SPM 1* over the next five years have been chosen to show a steady anticipated increase in the number of children receiving preventive examinations.

◆ *Preventive and Primary Care Services for Children with Special Health Care Needs*

Direct health care services for the CSHCN population are addressed in ***Federal Performance Measures 1 and 2***. The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program, *FPM 1*, is being assessed using Medi-Cal files for SSI/SSP persons age 15 and under who received services that were approved by the CCS program and resulted in a claim paid by Medi-Cal. In FFY 1999, 28.5 percent of children receiving SSI/SSP met this criteria, exceeding our target of 27.0 percent for 1999. It should be noted that not all SSI children have conditions eligible for CCS. Children with purely mental health or developmental disabilities are served by other State departments. However, since performance on this outcome measure exceeded expectations, the target objectives set previously have been increased and additional, steadily rising objectives have been set through 2005.

Federal Performance Measure 2, the degree to which the State CSHCN program provides or pays for specialty and subspecialty services not otherwise accessible or affordable to its clients, including care coordination, is evaluated based on CCS program standards. The measure is scored based on provision of the 9 services listed on the attachment for *FPM 2*. This Performance Measure continues to be completely fulfilled by CCS with a score of 9 out of 9 possible points. Objectives for future years maintain this standard for CSHCN services.

Enabling Services

◆ *Preventive and primary care services for pregnant women, mothers, and infants*

The only measure that directly addresses enabling services for these population groups is the ***proposed State Performance Measure 9***, which examines the prevalence of self-reported intimate partner physical abuse among women eighteen years of age and older. (See Section 3.4.2.2.) Since this measure was not included in prior applications, progress is not assessed. Nonetheless, enabling services are provided for these groups under programs such as the Black Infant Health (BIH) Program, the Adolescent Family Life Program (AFLP), and the CHDP program.

◆ *Preventive and primary care services for children*

There are no Federal or State Performance measures for enabling services that specifically target children. However, *SPM 1* (discussed above), has an access to care/ enabling component.

◆ *Preventive and Primary Care Services for Children with Special Health Care Needs*

Enabling services for CSHCN are addressed in ***Federal Performance Measure 3*** and ***State Performance Measure 2***. ***Federal Performance Measure 3***, the percent of CSHCN in the State who have a “medical home”, is measured using the automated CCS information system (CMS Net) that is currently on-line in 45 counties. The statewide estimate of this Performance Measure, based on the subset of State information available in 1999 on CMS Net, indicated that 32.2 percent of children in CCS had a “medical home”. This is considerably improved from the 1997 performance of 19.3 percent but below the estimate derived in 1998. The reason for the discrepancy in the data from the past two years is unclear. However, the current assessment is derived using all the active cases in CMS Net and defining medical home as the listing of a primary care provider in the case file. Since many of the children in CCS are receiving services in intensive care nurseries or Special Care Centers, they either may not yet have a been linked to a primary care provider or may not use a primary care provider for their medical home. How best to define medical home in these cases is under discussion. Objectives for 2000-2005 for this performance measure have been chosen, incorporating this year's value, methodology, and the current definition of medical home.

State Performance Measure 2, the percent of CCS children with Acute Lymphoid Leukemia, Spina Bifida, and Cleft Palate who were referred to Special Care Centers showed that 79.2 percent of CCS children with these

conditions were authorized to receive multidisciplinary services at Special Care Centers in 1998. This performance was slightly short of the target of 80.0 percent for that year but was an increase from the rate of 77.3 percent in 1997. No new information is available on this State performance measure. Since the number of children with these conditions has been decreasing (see discussion in Section 3.1.2.1., Needs Assessment, Health Status of CSHCN), *SPM 2* will be removed as a performance tool in future applications.

Population-Based Services

◆ *Preventive and primary care services for pregnant women, mothers, and infants*

Federal Performance Measures 4, 6, 9, 10 and State Performance Measure 6 all relate to population-based services for pregnant women, mothers and infants. Newborn screening for genetic metabolic and hematologic disorders, ***Federal Performance Measure 4***, has been in effect in California for many years. In 1998, 98.8 percent of newborns were screened, a figure very close to the 1998 (99.0 percent) objective. Given the near universal newborn genetic screening coverage for California, significant changes in this measure are not expected over time. (Please also see Form 6.)

Decreasing the birth rate among adolescents, ***Federal Performance Measure 6***, is one of California's highest health priorities. Between 1987 and 1994, the birth rate among 15-17 year olds rose from 34 to 45 births per 1,000 women. By 1998, this rate had fallen to 32.6 per 1,000 15-17 year old women. The 1998 target of 35.6 births per 1,000 women aged 15-17 was met. Past and projected declines in the teen birth rate reflect the extensive State leadership and investment in teen pregnancy prevention activities such as the Community Challenge Grants, Partnership for Responsible Parenting campaign, Adolescent Sibling Pregnancy Prevention Program (ASPPP), Teen Smart, and expanded access to comprehensive family planning services (Family P.A.C.T.). Further decreases in teen birth rates are projected based on the continued State involvement in prevention activities.

Increasing the proportion of mothers who breastfeed their infants continues to be a Title V priority for the period 2001-2005. Progress is monitored in ***Federal Performance Measure 9***. In California, the measure examines the percent of women who report intending to exclusively breastfeed their infant upon hospital discharge. Exclusive breastfeeding is defined as the infant receiving breast milk, and no other fluids or solids, with the exception of vitamins, minerals, water, juice, or cultural feeds given infrequently. The 1998 annual objective of 42.3 percent of women intending to exclusively breastfeed upon hospital discharge was achieved. Modest progress has been seen from 1996-1998, with an increase from 41.8 percent to 43.5 percent.

Based on the DHS strategic plan for breastfeeding promotion, MCH has focused its breastfeeding activities on increasing public awareness and education, changing hospital practices, and promoting increased collaboration among breastfeeding advocates. These efforts are carried out through the Regional Perinatal Programs and several prenatal programs such as the Adolescent Family Life and California Diabetes Prevention Programs. It is predicted that these efforts will result in increased breastfeeding rates.

The percent of newborns who have been screened for hearing impairment before hospital discharge, ***Federal Performance Measure 10***, is anticipated to rise dramatically over the next few years, as indicated in the target objectives. This is because of the new hearing screening program being implemented by the CMS Branch. Hospitals are beginning to initiate hearing screening and the 1998 data used for *FPM 10* is based on births at the hospitals doing universal newborn hearing screening in 1998. The percent of infants receiving hearing screening, 9.4 percent, was slightly below the projected target for 1998. However, the indicator measure is an underestimate since all infants treated in CCS approved intensive care units also receive hearing screening before discharge (and are not included in the calculated measure). The current goal is to have all CCS approved hospitals performing newborn hearing screening, on all inborn infants, by the end of 2002. This would mean that 70 percent of California newborns will be screened by 2003. Data to address the measure will be collected in future years through the Newborn Hearing Screening program tracking system.

The incidence of neural tube defects among fetal deaths and live births, ***State Performance Measure 6***, is determined from the California Birth Defects Monitoring Program (CBDMP) Registry. The rate of neural tube defects (NTDs) fell from 6.9 to 5.3 per 10,000 fetal deaths and live births from 1996 to 97, after rising in the previous year. The 1997 annual objective of 4.2 NTDs per 10,000 live births and fetal deaths was not met. Nevertheless, the rate of neural tube defects has shown a statistically significant downward trend from 1990-97, with a decline from 8.0 to 5.3 per 10,000 live births and fetal deaths.

The Title V agency has undertaken a number of outreach activities to increase awareness and stimulate preconceptional folic acid use, as described in Section 4.1. (Program Activities Related to Performance Measures). The prenatal and preconceptional use of folic acid and multivitamin supplements is being monitored in the Maternal and Infant Health Assessment (MIHA). MIHA data will help identify populations with lower probabilities of supplementation. CMS, through CHDP and CCS, is able to identify families with a prior infant with neural tube defects to target educational and preventive efforts. Based on these activities and other relevant State programs, the rate of neural tubes defects is expected to decline in the next five years.

◆ *Preventive and Primary Care Services for Children*

Several Performance Measures assess population-based services for children. These include measures related to: immunizations, ***Federal Performance Measure 5***; the use of dental sealants, ***Federal Performance Measure 7***; deaths resulting from injury, ***Federal Performance Measure 8 and State Performance Measures 3, 4 and 5***; and adolescent suicide, ***Federal Performance Measure 16***.

According to the National Immunization Survey (NIS) data from July 1997 through June 1998, 75.9 percent of children in California, aged 19-35 months, had completed the 4:3:1:3 series, ***Federal Performance Measure 5***. This series consists of four or more doses of diphtheria and tetanus toxoids and pertussis vaccine/diphtheria and tetanus toxoid (DPT/DT); three or more doses of poliovirus vaccine; one or more doses of measles-containing vaccine (MCV); and three or more doses of *Haemophilus influenzae* type b vaccine (Hib). The percent coverage for 1997/98, 75.9 percent, fell just below the 1998 objective of 76.0 percent and has shown no statistically significant change over the time period 1995-98, when the 4:3:1:3 has been monitored. Efforts are currently underway to increase immunization rates through raising provider and public awareness. CMS, Medi-Cal, the Immunization Branch and managed care plans are collaborating on an immunization improvement project that is related to Federal Government Performance and Results Act (GPRA) reporting on immunization.

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, ***Federal Performance Measure 7***. In 1998, 17.6 percent of third graders had a protective sealant. The 1998 objective (10.6 percent) was achieved. Comparable data on sealants is unavailable for the period 1996-98 because of a change in the methodology of analysis. Consequently, the time trend can not be assessed with the available data. Further expansion of Healthy Families and Medi-Cal enrollment, which provide coverage of dental services, is expected to contribute to increased access to preventive dental services in the period from 2001-2005.

The number of youth who die or suffer disabilities caused by intentional and unintentional injuries is a major public health problem. Unintentional injuries are the leading cause of death among children 1-14 years of age. Three State Performance Measures examine sentinel injuries. These are: pool drowning among 1-4 year olds, ***State Performance Measure 3***; homicides among 15-19 year olds, ***State Performance Measure 4***; and motor vehicle deaths among 15-19 year olds, ***State Performance Measure 5***. These three supplement ***Federal Performance Measure 8***, motor vehicle deaths among 0-14 year olds. Efforts to prevent injuries include collaboration with several State agencies addressing injury mortality and morbidity, and participation in and sponsorship of the annual statewide injury conference.

Motor vehicle accidents are the leading cause of death among children 0-14 years of age. A review of the motor vehicle death rates in this age group from 1990-1998 suggests a statistically significant downward trend. In 1990, there were 5.4 deaths per 100,000 0-14 year olds compared with 2.8 in 1998. The 1998 annual objective of 2.9 deaths per 100,000 was met. Increased enforcement of drinking and driving laws and passenger restraint laws, along with public education campaigns regarding the risks of drinking while driving, and road safety improvements have contributed to this notable progress.

As with younger children, the rate of motor vehicle deaths among 15-19 year olds, *State Performance Measure 5*, showed a significant downward trend from 1990-98, falling from 27.3 to 17.2 per 100,000 15-19 year olds. From 1997 -98, the rate continued to decline from 18.0 to 17.2 deaths per 100,000. The objective of 17.5 deaths per 100,000 was reached. Despite this progress, motor vehicle accidents remain the leading cause of death among teenagers and young adults, aged 15-19 years. Continued declines are expected in the rates of motor vehicle deaths for both age groups. Among adolescents, the introduction of a graduated driving license is expected to further reduce motor vehicle-related deaths.

The rate of pool drowning among 1-4 year olds, *State Performance Measure 3*, remained virtually unchanged from 2.05 deaths per 100,000 children 1-4 years of age, in 1997, to 2.06 in 1998. The annual objective of 1.8 deaths per 100,000 was not met. Nevertheless, over the past nine years, a statistically significant downtrend trend has been observed. Further improvements are expected with the ongoing efforts of the California Drowning Prevention Network, the training of local Building Code Officials, and the passage of new pool safety legislation (AB3305).

Since 1994, progress has been achieved in reducing the adolescent homicide rate, *State Performance Measure 4*. The rate was virtually halved from 1994 to 1998 when it fell from 34.4 deaths per 100,000 15-19 year olds to 17.1. Most recently, the rate of homicide deaths per 100,000 adolescents aged 15-19 years fell from 20.4 in 1997 to 17.1 in 1998. The 1998 objective of 20.9 per 100,000 was achieved. The trend in the rate from 1990-98 showed only borderline statistical significance since the decline did not start until 1995. Based on recent figures and the State's passage of strict gun control legislation, further improvements are projected for the period of 2001-2005.

The rate of suicide deaths among youth aged 15-19, *Federal Performance Measure 16*, continued to decline from 7.1 suicide deaths per 100,000 youth 15-19 years old in 1997 to 6.3 deaths in 1998. The 1998 objective of 8.5 deaths per 100,000 was achieved. Over the period of 1990-98, a statistically significant downward trend has been observed in the adolescent suicide rate, which fell from 9.2 to 6.3 deaths per 100,000 youth 15-19 years

old. Continued improvement is projected for the period of 2001-2005. The Department of Mental Health and the California Liaisons for Adolescent Suicide Prevention (CLASP) will continue to develop strategies for coordinating efforts to address the problem of adolescent suicide.

◆ *Children with Special Health Care Needs*

There are no specific Federal or State Performance Measures for population-based services for CSHCN, though children born with neural tube defects (*SPM 6*) are CSHCN.

Infrastructure Building Services

◆ *Preventive and primary care services for pregnant women, mothers, and infants*

Infrastructure services for pregnant women, mothers and infants address the issues of very low birthweight (VLBW) infants, assuring that VLBW infants, those weighing less than 2,500 grams, are delivered at facilities for high risk deliveries and neonates, and early entry into prenatal care for all pregnant women.

The percent of VLBW infants born to resident women in California, ***Federal Performance Measure 15***, has remained relatively stable since 1989. The figure fluctuated between 1.0 and 1.2 from 1989 to 1998. From 1997 to 98, the rate increased slightly from 1.1 VLBW newborns per 1,000 live births in 1997 to 1.2 in 1998. Consequently, the 1998 annual objective, which reflected maintenance of the 1997 figure, was not achieved. An analysis of the percent of VLBW infants among singleton births, ***Health Status Indicator 5B***, reveals a stable figure of 0.9 VLBW newborns per 1,000 live births from 1997-1998. The increasing use of assisted reproductive technologies can increase the incidence of multiple births and the percent of very low birthweight infants.

California continues to strive to reduce the percent of VLBW newborns through increasing entry into prenatal care during the first trimester of pregnancy, assuring the delivery of newborns of high-risk women in appropriate facilities, and quality improvements in perinatal hospital services. Nevertheless, until the causes of preterm birth are better understood, new interventions developed, and the use of reproductive technologies stabilizes, a decline in the overall percent of VLBW infants is not likely to be observed.

By 1998, 64.6 percent of California's VLBW newborns were delivered in facilities for high-risk deliveries, ***Federal Performance Measure 17***. The annual objective of 60.6 percent was achieved. The 1998 figure is

based on data from hospitals designated by the CCS program as Regional or Community NICU facilities. However, not all facilities providing care for VLBW infants seek certification by CCS. California's efforts to improve access to the appropriate level of facility include; encouraging all hospitals functioning as high-risk facilities to seek CCS designation, developing collaborative hospital relationships through the CCS program, and outreach and education by the Regional Perinatal Programs to encourage appropriate referrals. In light of these continuing activities, further improvement is expected in this measure over the period of FFY 2001-2005.

Improving access to first trimester prenatal care, ***Federal Performance Measure 18***, has been a long-term MCH priority. In 1998, 82.4 percent of women entered prenatal care in the first trimester, meeting the annual objective of 82.1 percent. The marked reduction in the disparity between Medi-Cal and non-Medi-Cal insured women, ***Core Health Status Indicator 6 C***, is also noteworthy. The absolute difference between the two groups in relation to first trimester entry into care was 29 percent in 1989, and fell to 15 percent in 1998. Continued improvement is anticipated based on the education and outreach efforts by the State and the local MCH jurisdictions, including the activities of such Title V programs as the Regional Perinatal, Black Infant Health, and Adolescent Family Life Programs.

◆ *Preventive and Primary Care Services for Children*

Infrastructure building services for children are examined in ***Federal Performance Measures 12 and 13***. These measures address health insurance coverage for children and service utilization by Medicaid eligible children.

Data from the Health Insurance Policy Program UCB/UCLA provide an estimate of the percent of children who are uninsured, ***Federal Performance Measure 12***. In 1998, this figure increased to 21.0 percent from the 1997 level of 18.3 percent. Consequently, the 1998 objective was not reached. In future years, gradual reductions in the percent of uninsured children are anticipated because of California's commitment to the expansion of the Healthy Families Program and the enrollment of Medi-Cal eligible children in the Medi-Cal program. The California budget for FY 2000-2001 eliminates the Quarterly Status Report to contribute to increased continuity of Medi-Cal coverage.

The percent of potentially Medicaid eligible children receiving services paid by the Medicaid program, ***Federal Performance Measure 13***, is based in part on data from a new data system being developed by the State. In 1998, 54.2 percent of the potentially Medicaid eligible received a service paid for by Medicaid. The objective for 1998, 60.0 percent, was not achieved. Since data from prior years were based on a different data source,

earlier figures are not comparable. Based on the outreach activities undertaken by the State to expand enrollment of the Medi-Cal eligibles, increases in the percent of eligibles who receive a service are anticipated in the period from FY2001-2005.

◆ *Children with Special Health Care Needs*

A number of activities in infrastructure building are included for CSHCN. The related Federal Performance Measures are the percent of CSHCN in the State CSHCN program with a source of insurance for primary and specialty care, ***Federal Performance Measure 11***, and family participation in the CSHCN program, ***Federal Performance Measure 14***. In addition, California chose an infrastructure building service for CSHCN as ***State Performance Measure 7***, the percent of CCS enrolled children registered in CMS Net.

The percentage of CCS children with a source of insurance, ***Federal Performance Measure 11***, including Medi-Cal, was 96.0 percent in 1999, which met the targeted objective. This high objective was set last year because of better than expected performance in 1998 and high levels of insurance coverage have been maintained. CCS coordinates efforts with Medi-Cal and Healthy Families and further increases in health insurance for CSHCN have been set as the goals for 2000-2005.

Family participation in the CSHCN program, ***Federal Performance Measure 14***, achieved a score of 14 out of 18 for 1999, exceeding State goals. The scoring is detailed in the attachment to this measure. There has been a steady increase in *FPM 14* over the past 3 years. The presence of a parent consultant in the CMS Branch staff in 1999 increased parent/family participation in CSHCN programs and policy activities. The objective for 2000-2005 is to build on this progress and continue to encourage and increase family involvement.

State Performance Measure 7, the percent of CCS enrolled children registered in CMS Net, was developed in response to the identified need to facilitate case management and coordination of care. In 1999, this measure increased to 18.5 percent. However, the increase did not achieve the 1999 target of 50 percent of active CCS cases on CMS Net. Other data based activities, such as Y2K updates and standardization of information, temporarily slowed progress on CMS Net. However, 45 counties have started using CMS Net and an enrollment goal of 100 percent participation is now targeted for 2003.

2.5. Progress on Outcome Measures

See Form 12 and corresponding Notes.

The infant mortality rate (IMR), *Outcome Measure 1*, fell from 5.9 to 5.7 deaths per 1,000 live births from 1997 to 98. Despite this decline, the annual objective of 5.6 deaths per 1,000 live births was not achieved. A statistically significant downward trend in the IMR has been observed in the period from 1989-98, when the rate fell from 8.5 to 5.7 deaths per 1,000 live births.

A large number of Title V programs address the problem of infant deaths. Prenatal interventions such as Adolescent Family Life, Black Infant Health, Comprehensive Perinatal Services, the Fetal and Infant Mortality Review, the Genetic Screening Program, injury prevention initiatives and the SIDS Prevention Program are all critical components of the effort to reduce the IMR. A significant portion of infant deaths is related to preterm births. The underlying causes of preterm delivery are still not fully understood. Based on the trend over the last decade and the Title V agency's continuing support of a wide array of activities to improve infant health, a further decline in the IMR is projected for the period 2001-2005.

The ratio of the black to white infant mortality rates, *Outcome Measure 2*, increased from 1997 to 1998, from 2.4 to 2.7. The 1998 objective of a ratio of 2.5 was not achieved. It is important to note that the black IMR has been declining over the past ten years along with the white IMR. With both falling, the disparity has not changed. In order to reduce the racial disparity in the IMR, MCH will continue the Black Infant Health projects (BIH) in each of the local areas in the state where the majority of black infants are born. A recent evaluation of the BIH showed the program to be effective in reducing the rates of very low birthweight and immature births among African-American women participating in the program. Because of its effectiveness and the persisting black-white gap, the state budget for the fiscal year 2000-2001 recently signed by Governor Davis, included a \$4 million augmentation for the BIH. This augmentation doubles the size of the program and will allow us to provide services to an additional 3,000 African-American families. The SIDS Reduction Campaign will also continue to focus its efforts on the black community. MCH will work with the Federal Healthy Start sites to assist in insuring the availability of substance abuse treatment programs for pregnant women. The Fetal Infant Mortality Reviews will examine the risk factors for preterm births for all African American births in the BIH project area. MCH will conduct analyses of new survey data and large databases such as Maternal and Infant Health Assessment (MIHA) and WIC's Integrated Statewide Information System, to identify risk factors associated with the racial disparities in birth outcomes. These analyses will guide future interventions wherever possible.

The neonatal mortality rate, *Outcome Measure 3*, the number of deaths under 28 days of life per 1,000 live births, was 3.8 deaths per 1,000 live births in 1998, compared with 3.9 deaths in 1997. The 1998 annual

objective of 3.7 deaths per 1,000 live births was not achieved. A statistically significant downtrend trend in the neonatal mortality rate was observed in the period from 1989-98. However, the rate has been relatively stable since 1995. Low birthweight and preterm birth are major contributors to neonatal deaths. Assuring pregnant women access to the appropriate level of health care through the Regional Perinatal Programs, and prenatal programs like the CPSP, BIH, and AFLP can help further reduce neonatal deaths. Title V supported interventions to reduce the prevalence of prenatal smoking and substance abuse can also have an impact on the neonatal death rate. To some extent, the potential impact of new reproductive technologies as well as the impact of some birth defects on the neonatal mortality rate extends beyond the scope of the Title V programs.

The postneonatal mortality rate, ***Outcome Measure 4***, the number of infant deaths from 28 days to one year of age per 1,000 live births, was 2.0 in 1997 compared with 1.9 in 1998. The 1998 annual objective, 1.9 deaths per 1,000 live births, was achieved. A significant decline has been observed in the postneonatal mortality rate over the period of 1989-98, when the rate fell from 3.3 to 1.9 deaths per 1,000 live births. The Title V supported SIDS Reduction Program has contributed to this decline. Other important interventions include AFLP and BIH. Targeting of the SIDS messages and expansion of the AFLP and BIH along with increased health insurance coverage under the Healthy Families Program and the development of early childhood interventions through local Proposition 10 initiatives can contribute to further reductions in the postneonatal mortality rate.

The perinatal mortality rate, ***Outcome Measure 5***, the number of fetal deaths after 20 weeks of gestation and infants deaths prior to seven days of life per 1,000 live births and fetal deaths, was 8.9 in 1998 compared with 8.8 in 1997. Since a continuing decline was projected, the 1998 objective was not met. The perinatal mortality rate has shown a significant decline over the 1989-98 period, falling from 10.8 to 8.9 deaths per 1,000 live births and fetal deaths. Low birthweight and preterm delivery contribute to perinatal mortality. Increasing access to appropriate prenatal care and reducing prenatal smoking and substance abuse through the programs mentioned above should help further reduce perinatal mortality. As noted in relation to neonatal mortality, the future impact of new reproductive technologies and some birth defects extends beyond the scope of the Title V programs.

Major improvements have been achieved in relation to reducing the child death rate, the number of deaths per 100,000 children aged 1-14 years, ***Outcome Measure 6***. From 1997-1998, the child death rate declined from 20.2 to 18.9 deaths per 100,000. The 1998 annual objective, 20.2 deaths per 100,000 children was achieved. A significant downward trend has been observed in the period from 1990-98 when the child mortality rate declined by one-third from 30.2 to 18.9 deaths per 100,000 1-14 year olds. Reductions in injury related child deaths, particularly motor vehicle related mortality, contributed to the overall decline. Continuing work with

the California Center for Childhood Injury Prevention and the Epidemiology and Prevention for Injury Control (EPIC) Branch of DHS along with other State and local agencies are expected to contribute to further future reductions in the child mortality rate.

The maternal mortality rate, *State Outcome Measure 1*, declined in 1998 to 6.5 maternal deaths per 100,000 live births from 8.6 in 1997. Nevertheless, the 1998 objective of 5.6 deaths was not achieved. The maternal mortality rate has fluctuated considerably from 1989-98. No time trend is evident over that period. The random fluctuation observed in the maternal mortality rate is not uncommon when measuring rare events such as maternal deaths. The Regional Perinatal Programs will continue to improve access to the level of prenatal and delivery services appropriate to the woman's prenatal needs. Reducing the rate will depend on the identification of those factors contributing to the deaths and developing effective interventions to address those factors. In Los Angeles County, a review of maternal deaths will be implemented that will build on the FIMR model. Modest progress is expected in the reduction of maternal deaths in the period FFY 2001-2005.

III. REQUIREMENTS FOR THE APPLICATION [Section 505]

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

The California needs assessment has involved a two-year process conducted both within the Title V agency and, externally, in collaboration with local health departments, other State agencies and programs, health care providers, community groups, health care consumers and families. The methodology adopted for the development of the 2001-2005 needs assessment included the following major processes:

- *Data collection and quantitative analysis of the trends in health status and health care access indicators, and programmatic data on direct health care services to the populations served by Title V.*

A comprehensive review of the health status of women, infants, children, adolescents, and CSHCN was conducted. This included an assessment of the magnitude of specific health problems or measures of access to care and an analysis of recent and projected trends in the relevant measures. Data sources from various California government departments, academic institutions, federal agencies, and health care programs and providers were analyzed by State Title V staff in collaboration with other agencies. The review process highlighted those health needs for which significant progress has been achieved as well as those areas where annual objectives were not met. The process also uncovered new areas requiring further evaluation and possible intervention.

- *Collaboration with county-level agencies in the preparation and review of local needs assessments and plans.*

The California Title V agency facilitated a process whereby the local health jurisdiction in each of California's 58 counties and the three municipalities with health departments prepared a community health assessment and MCH plan. This process was noteworthy for the extensive coordination between State and local activities as part of the Title V assessment. The health jurisdictions worked with a broad range of local stakeholders, which included community and advocacy groups and health care providers, in conducting their assessments and defining the local priorities. At the end of the process, each jurisdiction developed a plan that included objectives and a scope of work upon which to base future program planning and development. To further support the

statewide needs assessment, local agencies providing direct health care services to children and working with CSHCN were surveyed by CMS to identify areas of major unmet health care needs.

- *Collaboration with a broad base of stakeholders throughout the State in the identification of priority issues and recommended intervention strategies.*

Interviews were conducted by CMS with external stakeholders representing children's hospitals, physicians, academic institutions, medical professional organizations, and parent representatives to incorporate multiple perspectives on current issues and problems in the delivery of health services to Title V populations. Individuals serving as liaisons between the Title V agency and other government programs were also interviewed to provide insight into issues of coordination between programs such as Healthy Families and service delivery to CSHCN. Information was gathered from a survey of health care providers, carried out by CMS for a specific health program, and from a parent directed survey, conducted by a parent group for CSHCN (Family Voices). Reports based on information gathered by other agencies were also used, such as the May 2000 California Senate Office of Research Report on California's system for caring for CSHCN and the April 1999 California State Auditor's report on protecting California's children from lead poisoning.

A Title V planning meeting was attended by over fifty representatives of local health jurisdictions, legislative staff, the Department of Finance, the Health and Human Services Agency, other State and Federal agencies, community and private agencies, consumers, advocacy organizations, professional organizations, and academic institutions. The main purposes of the meeting were to draw on the knowledge and experience of the group to identify the needs of the Title V populations and potential resources to meet these needs. As background to these discussions, MCH and CMS staff reviewed health performance and outcome measures and trends for mothers, infants, children, and CSHCN. Proposed new Federal Health Status Indicators were also presented.

- *Participation in strategic planning with other organizations to address critical needs of the Title V population.*

The Title V agency participated in the development of the adolescent health strategic plan, the Dental Health Initiative, the school health plan, the health care program for children in foster care, and the children's asthma program. Participation in these planning processes provided an in-depth understanding of the extent of child and adolescent health needs in California. The MCH Branch supported the preparation of the Adolescent Health Strategic Plan, "Investing in Adolescent Health: A Social Imperative for California's Future", as part of an effort to establish a consensus and develop and implement policies that support adolescent health. The MCH Branch also participated as an active member of the CDHI Advisory Committee which developed the policy

recommendations for the oral health plan, *The Oral Health of California's Children: Halting a Neglected Epidemic*". The Department of Health Services and the Department of Education developed the School Health Report, as part of a joint effort to further the development of the infrastructure needed for coordinated school health activities. The CMS Branch worked with the Department of Social Services to develop a program that utilizes public health nurses to oversee health care services for children in foster care and with the Chronic Disease Branch to develop the new asthma program that will increase awareness about asthma and early intervention for young children.

- *Public input and document review*

The FY2001 preliminary report and application was circulated to encourage broad-based input in planning for the next five years. Input relating to the new needs assessment was also solicited by CMS at the time of circulation of the FFY 2000 report and application.

The main strengths of the needs assessment process include the involvement of a broad range of stakeholders and the reliance on a combination of quantitative and qualitative analytic methodologies to validate the significance of the health needs of the Title V population. An additional strength was the vital role of the local health departments, in collaboration with local representatives, in the identification of local needs and the preparation of local needs assessments. Their ongoing participation increased the input from the representatives of local agencies and community groups.

Limitations of the needs assessment process must also be acknowledged. Given the size and diversity of California, the Title V agency faces a challenge in representing the needs of the diverse population groups who are Title V stakeholders. While statewide data include all populations, and efforts have been made to invite consumer input, not all population groups have actively participated in the process. A further limitation of the quantitative review relates to some reliance on data files collected for administrative purposes.

3.1.2 Needs Assessment Content

3.1.2.1. Overview of the Maternal and Child Health Population's Health Status

The information presented in the following sections contributed to the identification of the Title V priorities. The health status of California's population of pregnant women, mothers, infants, children, and CSHCN is analyzed in terms of the major indicators of mortality and morbidity and the prevalence of selected risk factors. Health

status is described in the overview in relation to the specific Title V populations. Health care access is assessed in relation to measures of insurance coverage and utilization of preventive, primary, and specialty care services. Issues of access are described under the appropriate level of the pyramid and in reference to the specific Title V population. Where data are relevant to specific Federal and State Performance (*FPM and SPM*), Outcome Measures (*FOM and SOM*), and Core and Developmental Health Status Indicators (*HSI and DHSI*), the measure is noted.

◆ ***Health Status of Pregnant Women, Mothers, Infants***

Infant Mortality

One indicator of the progress achieved in improving the health status of California's infants is the reduction of deaths during infancy. California's infant mortality rate (IMR) (*FOM 1*) in 1998 was 5.7 deaths per 1,000 live births. The IMR declined by one-third from 1989-98, falling from 8.5 to 5.7 deaths per 1,000 live births. The Healthy People 2000 Objective of 7.0 deaths per 1,000 live births has been achieved and the State is well on its way toward meeting the Healthy People 2010 Objective of 4.5 deaths per 1,000 live births.

California's neonatal mortality rate (*FOM 3*) in 1998 was 3.8 deaths during the first 28 days of life per 1,000 live births. The State's overall neonatal mortality rate has decreased by 27 percent, from 5.2 per 1,000 live births in 1989 to 3.8 per 1,000 in 1998. California has achieved the Healthy People 2000 objective of 4.5 deaths per 1,000 live births and is making progress toward the Healthy People 2010 Objective of 2.9 neonatal deaths per 1,000 live births.

In 1998, California's postneonatal mortality rate (*FOM 4*) was 1.9 deaths among infants 28-364 days old per 1,000 live births. The postneonatal mortality rate decreased from 3.3 per 1,000 live births in 1989 to 1.9 per thousand live births in 1998, representing a 42 percent decline. The 1998 rate is below the 2.5 postneonatal deaths per 1,000 live births set as the Healthy People 2000 Objective. The relevant 2010 Objective is 1.5 postneonatal deaths per 1,000 live births.

California's perinatal mortality rate (*FOM 5*) was 8.9 deaths per 1,000 live births and fetal deaths in 1998, having declined by 18 percent from 10.8 in 1989. Perinatal mortality measures neonatal deaths under seven days and fetal deaths of at least 20 weeks of gestation. Differences in the definition of the measure preclude comparison with the Healthy People objectives.

Low Birthweight

The percent of California's live born infants who were low birthweight (LBW), less than 2,500 grams (*HSI 4A*), was 6.2 percent in 1998. This figure was higher than the Healthy People 2000 and 2010 Objective of 5.0 percent. The percent of low birthweight infants increased slightly from 6.1 percent in 1989 to 6.2 percent in 1998. While this upward trend over time was statistically significant, when the analysis is restricted to LBW among singleton births (*HSI 4B*), no increasing trend is observed. The percent of LBW among singletons remained at 4.9 percent from 1996-98. Since the increase in multiple births associated with the use of reproductive technologies is likely to affect the percent of LBW infants, stratification by plurality is appropriate in analyzing the LBW problem and developing appropriate interventions. Reducing the LBW rate remains one of the major challenges for the State. Further identification of the causes of preterm births can contribute to achieving this goal.

In 1998, 1.2 percent of live born infants were very low birthweight (VLBW) (*HSI 5 A*). The percent increased from 1.1 percent in 1989. A modest but statistically significant upward trend was observed from 1989-98. As noted in relation to the percent of LBW newborns, when the analysis is restricted to VLBW among singletons, the time trend is no longer statistically significant. The percent of VLBW among live-born singletons has remained at 0.9 percent from 1994 to 1998.

Racial and Ethnic Disparities

The notable progress achieved in the overall reduction of infant deaths does not diminish the importance of the persistent racial and ethnic disparities (*FOM 2*) in perinatal health status. Of greatest concern is the marked disparity in risk among African-American newborns. In 1998, 13.7 black infants died in their first year of life for every 1,000 live births. The comparable figure for white infants was 5.1 deaths per 1,000 live births. While the IMR is falling among black as well as white infants, the gap has not narrowed. From 1989-98, the ratio of the black/white IMR did not exhibit any statistically significant trend.

The 1998 neonatal, postneonatal, and perinatal mortality rates for African American infants were between two and three times the corresponding rates for whites. The percent of low birth infants was also twice as high among African American newborns (11.7 percent) compared with the percent among white infants (5.8 percent). California's Black Infant Health Program and the SIDS program are designed to address the needs of pregnant black women and their newborns to improve perinatal health status.

Racial and ethnic disparities in infant health status are observed in relation to a number of health problems in addition to infant mortality. Examples include the higher rate of neural tube defects among Latina women and the teen birth rate among African American and Latina adolescents. These disparities are discussed below in relation to the specific problem.

Teen Pregnancy

California has achieved a significant decline in the birth rate among females aged 15 to 17 years old (*FPM6*). Increasing awareness of the risks associated with sexual activity, an increased State investment in pregnancy prevention programs for teens, greater availability of contraceptives, and more aggressive enforcement of statutory rape may have contributed to this decline. In 1998, the rate of births was 32.6 per 1,000 15-17 year-olds. The rate fell by 30 percent from a high of 46.5 births per 1,000 in 1991. Despite this notable progress, in 1998, there were 21,630 births to 15-17 year-olds.

Racial and ethnic disparities in the teen birth rate persist despite the marked declines that have occurred across racial and ethnic groups in recent years. Compared with the 1998 rate of 13.0 teen births per 1,000 teens aged 15-17 years among white non-Latina adolescents, the rate among Latina adolescents was 61.9 per 1,000, and among African American teens, 41.4 per 1,000. The continued reduction of the teen birth rate among all population groups remains a priority for California's Department of Health Services and the Title V agency.

Breastfeeding

The low prevalence of exclusive post-partum breastfeeding (*FPM 9*) in California despite the immunological, nutritional, and psychological benefits breastfeeding provides the infant and mother, highlights the importance of this issue. In 1998, 43.5 percent of mothers with a live birth in California intended to exclusively breastfeed at hospital discharge. The 1999 Maternal and Infant Health Assessment (MIHA), a survey of women who delivered live born infants in California in 1999, provides information on breastfeeding rates that include exclusive and mixed feeding. According to the 1999 MIHA, when exclusive breastfeeding and mixed feeding are combined, 87.5 percent of the women who delivered a live-born infant in the State in 1999 breastfed after delivery, and 58.8 percent continued to breastfeed when the infant was two months old. MIHA data will be analyzed to identify populations at risk for failure to initiate breastfeeding, early adoption of mixed feeding practices, and early breastfeeding cessation. The survey will also be used to gain a better understanding of the reasons for these practices. Over the last five years, California has implemented a breastfeeding initiative to

increase the breastfeeding rate through heightened public awareness and education, changing hospital practices, and increased collaboration among breastfeeding advocates.

AIDS

Women continue to be the fastest growing population with AIDS in California. As of January 1, 1998, there were a total of 7,367 AIDS cases among women 25-44 years of age, and 553 cases among children less than 13 years of age. It is estimated that in 1996 there were 9,300 to 12,900 women living with HIV/AIDS in California. AIDS affects women and children of color disproportionately. Among women, African Americans had the highest percentage, 36.9 percent of all cases reported, followed by whites, 36.2 percent and Latinas, 23.6 percent. African American children had the highest rate of pediatric AIDS (3.06 cases per 100,000 population per year, 1988-97)²⁵. The most frequent source of infection for children was from perinatal transmission from the mother. The mother's infection was most often from injection drug use or through heterosexual exposure to an injection drug user. Three local health jurisdictions identified the reduction of HIV infection in women of childbearing age as a priority for their MCH programs. The majority of local Perinatal Service Coordinators are working with perinatal health care providers and their staff to assist women in receiving appropriate HIV information and screening tests during the prenatal period.

Birth Defects

The prevention of birth defects as well as screening and early intervention for children who are born with these conditions can prevent disability and child mortality. Based on registry data that covers eleven counties representing half of the State's births, the rate of neural tube defects (NTDs) in California declined from 8.0 per 10,000 live births plus fetal deaths in 1990 to 5.3 in 1997 (*SPM 6*). Of particular concern is the fact that the risk for NTDs is more than twice as high among infants of Mexican-born mothers and fathers when compared with infants of white mothers and fathers. A heightened risk has not been observed among infants of U.S.-born parents of Mexican descent²⁶. Further research is needed to identify the causes of this disparity.

Current estimates suggest that approximately 50 percent of pregnancies affected with NTDs could be prevented with adequate consumption of folic acid from one month before conception through the first three months of pregnancy²⁷. According to the 1999 MIHA results, only 26.5 percent of women who delivered a live born infant in the State in 1999 took multivitamins or folic acid on a daily basis just before they became pregnant. Approximately one fourth of the women did not take multivitamins or folic acid on a daily basis after learning of

their pregnancy. The MCH and Genetic Disease Branches promote increased consumption of folic acid among women of childbearing age and disseminate the findings of the registries to local MCH programs. MCH programs such as the Adolescent Family Life Program (AFLP) and the California Diabetes and Pregnancy Program (CDAPP) have integrated messages about the importance of folic acid consumption in their health education.

Domestic Violence

Domestic violence is a major public health problem affecting a large number of women and their families. Domestic violence is the leading cause of injury to women ages 15-44 in the U.S. In California, 196,832 incidents of domestic violence were reported to law enforcement, and 56,892 domestic violence arrests were made in 1998. The 1998 California Women's Health Survey (CWHS) provides information on the prevalence of intimate partner physical abuse, with the severity ranging from being pushed to being threatened with a gun or knife. The 1998 CWHS findings indicate that approximately 6.0 percent of the women over 18 in California reported being victims of intimate partner physical domestic violence (IPP-DV) during the past 12 months (*proposed SPM 8*). Younger women were more likely to report being victims of IPP-DV than older women. Approximately 71 percent of IPP-DV victims have children younger than 18 at home; 42.9 percent have children aged 1-5 in their households. MCH supports domestic violence shelters and a wide range of enabling services for victims in addition to numerous prevention programs, including those that address teen relationship abuse assessment and training.

Substance Abuse

Alcohol and illicit drug use present significant threats to the health of the mother, infant, and child. While recent statewide data on the severity of the problem of perinatal substance abuse are not available, data from the 1999 California MIHA indicate that approximately 20 percent of mothers whose infants were born in the State reported having consumed alcohol, and 11.5 percent reported smoking during their most recent pregnancy. Further progress is needed to reach the Healthy People 2010 Objectives of six percent of pregnant women consuming alcohol and two percent smoking. Information from local agencies and hospitals suggests that trends in illicit substance use among pregnant women are more difficult to monitor because users are better able to avoid hospital-based testing. Case studies from FIMR show that perinatal substance abuse is related to instances of failure to thrive and child neglect. Consequently, the problem has been highlighted by the inclusion of perinatal substance abuse as a program priority for the three federally-funded Healthy Start programs, and in California, many county needs assessments identified substance abuse as a local priority.

Maternal Mortality

Maternal deaths have devastating long-term effects on the children and families of the deceased. Maternal deaths should be considered sentinel events; for every woman who dies of maternal complications, many more experience serious complications of pregnancy and are hospitalized for conditions related to pregnancy. The maternal mortality rate (*SOM 1*), the number of pregnancy-related deaths, declined in 1998 to 6.5 maternal deaths per 100,000 live births from 8.6 in 1997. The maternal mortality rate has fluctuated considerably from 1989-98. Random fluctuation is not uncommon when measuring rare events such as maternal deaths.

The Regional Perinatal Programs, FIMR, and other Title V programs will continue to improve access to the level of prenatal and delivery services appropriate to each woman's needs. Incorporation of maternal mortality case reviews in the Los Angeles FIMR project in 1996 provided valuable information on the risk factors and services needed to reduce maternal death²⁸. More recently, the MCH Branch has begun to work collaboratively with the UCLA School of Public Health, to develop a set of maternal quality of care indicators in order to address the high rate of complications during pregnancy and the problem of maternal mortality.

◆ *Health Status of Children and Adolescents*

Childhood Mortality

Childhood mortality rates provide critical indicators of the health status of California's children and youth as well as the overall effectiveness of relevant public health interventions. From 1990 to 1998, the leading causes of death among children aged 1 to 14 years were injuries (regardless of intent), congenital anomalies, and malignant neoplasms. When the age group is restricted to the 5-14 year-olds, homicides replace congenital anomalies as a leading cause of mortality. The rate of mortality among children aged 1 to 14 years (*FOM 6*) in California decreased by more than one-third from 1990-98, declining from 30.3 to 18.9 deaths per 100,000 children.

Racial and Ethnic Disparities

Racial and ethnic disparities are observed in relation to a number of measures of child health status. In 1998, the child mortality rate among African Americans, 34.1 deaths per 100,000 children aged 1-14 years, was approximately twice as high as the rate among white children, 16.5 deaths per 100,000. The adolescent homicide death rate also reveals significant racial and ethnic disparities. In 1998, the homicide death rate per

100,000 adolescents aged 15- 19 years was over nine times greater among African Americans, 48.2 homicide deaths per 100,000, when compared with whites, 4.9 deaths per 100,000. A heightened risk of mortality from homicide was also observed among Latino and Asian and Pacific Islander adolescents compared with whites.

Adolescent suicide death rates also reveal racial and ethnic disparities. In 1998, the suicide death rate was approximately 45 percent higher among white teens at 7.8 suicide deaths among teens aged 15-19 years, compared with Latino adolescents, for whom the rate was 5.4 suicide deaths per 100,000.

Childhood Injury Deaths

Public health interventions to reduce injury-related child deaths can have a major impact on lowering the child mortality rate. The death rate resulting from unintentional injuries among children 1-14 years of age (*DHSI 1A*) was 6.2 per 100,000 in 1998. This represents a nearly 50 percent decline from the 12.1 rate in 1990. Despite this considerable decline, injuries remain the leading cause of death among children 1-14 years of age.

In California, drowning is the leading cause of death among children 1-4 years of age (*SPM 3*). Bathtubs, swimming pools, and spas pose a special threat to young children. Children who survive near drowning often have severe brain damage, requiring permanent hospitalization in state-operated developmental centers. Drowning deaths and permanent brain damage from near drowning to children can be reduced through appropriate public health action. The rate of swimming pool related drowning deaths among children aged 1 through 4 years decreased from 3.3 deaths per 100,000 in 1990 to 2.1 in 1998. There has been a significant downward trend over that period.

Motor vehicle crashes are the leading cause of death among California's children and youth 1-19 years of age. A large portion of motor vehicle-related deaths is preventable. Among younger children, the failure to use proper child restraints is a major contributing factor. Among both children and adolescents, alcohol consumption by the driver is another cause of motor vehicle accident deaths. An additional risk for adolescents is the lack of driving experience. In 1998, the California motor vehicle fatality rate was 2.8 deaths per 100,000 children 0-14 years of age (*FPM 8*), having declined by nearly 50 percent since 1990 when the rate was 5.4. Among adolescents 15-19 years old, the 1998 motor vehicle death rate was 17.2 deaths per 100,000 adolescents (*SPM 5*), 37 percent below the 1990 rate, 27.3 percent. Despite this progress, over 600 infants and youth from 0-20 years of age lost their lives in motor vehicle-related accidents in 1998.

Homicide

Homicide is the second leading cause of death among California's teenagers, aged 15-19 years. It is the leading cause of death among adolescent African Americans and Latinos. While it is illegal for minors to buy guns, firearms are obtained from older friends, unknowing parents, and illicit street sales. Societal acceptance of the portrayal of gun violence in the media and popular entertainment may contribute to youths' perception of gun violence as one way of resolving conflict and personal frustrations. In California, significant gains have been achieved in reducing the adolescent homicide rate (*SPM 4*) from 25.7 deaths per 100,000 youth 15-19 years old in 1990 to 17.1 in 1998. Despite these gains, there were 386 homicide deaths among 15-19 year olds in 1998.

Suicide

Suicide is the third leading cause of death among adolescents and young adults in California. Life's transition from teenager to adult can be extremely stressful because of peer pressure and problems of self-esteem. Many teens experience significant changes beyond their control, such as divorce of their parents and relocation to a new community. Biological factors also contribute to the mood disorders that are associated with adolescent suicide. Substance abuse can also play a role in the problem of adolescent suicide. In California, the 1998 suicide rate was 6.3 deaths per 100,000 youths aged 15 to 19 years (*FPM 16*). This represents a 32 percent decline from the rate of 9.2 in 1990, and a statistically significant declining trend.

Youth Smoking

California has made progress in reducing the prevalence of adult smoking while youth smoking prevalence has remained relatively stable since 1994. In 1998, 10.7 percent of 12-17 year-olds reported having smoked at least one cigarette in the past 30 days. Racial and ethnic differences have been observed in the prevalence of youth smoking. Whites have had the highest rates, followed by Hispanics, Asians, and African Americans. Some differences by age group have been observed. Since 1994, the smoking prevalence in the 14-15 and 16-17 age groups has declined; the prevalence has increased in the 12-13 age group. The State has restricted cigarette advertising that is targeted to youth by limiting the sites where advertisements may be located, increased enforcement of laws that prohibit the sale of tobacco products to youth, and the implementation of a nationally regarded public education campaigns designed to reach children and adolescents. The campaigns utilize the advertising and marketing strategies of the tobacco sellers. Maintaining the focus on tobacco

prevention among youth is necessary to counter the impact of tobacco advertising. The imposition of the surtax on cigarettes resulting from the passage of Proposition 10 should have a significant impact on reducing youth smoking.

Alcohol and Illicit Drug Use

Data from the 1997-98 California Student Substance Abuse Survey indicate that alcohol is the most popular drug among California's youth. Approximately 47 percent of students in 11th grade and 22 percent of those in 7th grade reported drinking alcohol in the past thirty days. Binge drinking, the consumption of five drinks in a row, in the past two weeks, was reported by 10 percent of the 7th graders and 26 percent of 11th graders²⁹. Alcohol is the most common co-factor in motor vehicle accidents and injuries. The inappropriate use of alcohol by youth is associated with risk-taking behavior and poor school performance.

Illicit drugs also pose significant health risks to the adolescent population. The California Student Substance Abuse Survey of 1997-98 data indicate that 11 percent of 7th graders reported use of marijuana in the past six months. That figure rose to 33 percent among 9th graders, and 42 percent among 11th graders. The ready availability of alcohol and illicit drugs among adolescents influences their use and adult attitudes toward youth drug use range from permissive to punitive. Programs and services for youth involved in drug use are unavailable in many areas.

Overweight and Obesity

The prevalence of overweight in California's children is higher than the national average and is increasing annually. Sedentary activity, as measured by hours of television viewing, is also increasing. Among low-income children served in the Child Health and Disability Prevention Program (CHDP), 14.1 percent had weights for height above the 95th percentile (*SPM 10*). The health risks of overweight in children include the probability that the weight problem will continue into adulthood and earlier onset and more severe forms of a variety of chronic diseases such as high blood pressure, Type II diabetes, stroke and heart disease. In today's environment of convenience and readily available low-cost foods of high caloric density, it is likely that the problem of overweight among children will increase unless concerted efforts are made to reverse this trend through the creation of an environment that supports a healthy lifestyle.

Need for Health Referrals

In 1997-98, approximately 2.3 million children and adolescents received services through the CHDP program. CHDP serves children from families with incomes up to 200 percent of the Federal Poverty Level (FPL) and provides basic health assessments as well as screenings for problems in dental health, nutrition, development, vision and hearing. If problems are suspected, referrals are made for further diagnosis and treatment. The number of referrals made indicates the number of children for whom concerns about health status were raised. In 1997-98, of the children who were screened, 21.9 percent required referral for diagnosis and/or treatment for medical issues, 6.9 percent for dental and oral problems, 5.0 percent for vision, and 1.4 percent for hearing. Nutritional issues, including both over and underweight, led to a referral in 2.0 percent of children who were screened.

◆ *Health Status of Children with Special Health Care Needs*

Number of Children Receiving CCS Services

CCS authorizes medical services and provides case management for children with most of the serious medical conditions of a physical nature that can be cured, improved or stabilized. To be eligible for these CCS services, a child must be from a family with an annual income of \$40,000 or less, or the annual cost for medical care must be estimated to exceed 20 percent of family income. From 1997 to 1999, the number of children enrolled in the CCS program rose by 14 percent, to an active CCS caseload of 140,129.

Diagnoses of CSHCN

The major diagnostic categories of children in the CSHCN program, in FY 1994 through 1998, indicate that 24 percent had congenital anomalies and 17 percent had other perinatal conditions. Diseases of the nervous system were noted in 20 percent of the children and, of these, 31 percent had hearing loss.

If undetected, hearing deficits can interfere with language and neurologic development. To increase detection of congenital hearing deficits, CMS is instituting hearing screening (*FPM 10*) for all infants born in CCS approved hospitals (described further below, under Population-based Services, Section 3.1.2.4). The number of infants and young children in the CCS program with detected hearing loss is therefore expected to increase markedly over the next two years.

Referral for specialty medical treatment of children with the sentinel conditions of spina bifida, cleft palate and acute lymphoblastic or lymphocytic leukemia (ALL) (*SPM 2*) is one of the indicators CCS has been using to assess the care received by CSHCN. Of note, the percent of children in the CCS case management data system with these diagnoses has been declining over the past three years, from 6.4 percent in FY 1997 to 4.9 percent in FY 1998 and 3.6 percent in FY 1999. Small decreases in the percent of children with each of the diagnoses have contributed to this aggregate drop. (Spina bifida is a neural tube defect, *SPM 6*.)

While over 500 children in California are currently thought to be infected with HIV, only 86 children in the CCS program were identified as having HIV infection in the 1998-99 open case files. HIV infected children are eligible to receive services through CCS but many receive care through other programs (such as Ryan White) and there may also be some undercounting in the case files due to listing of these children under alternative diagnoses. Through the HIV Children's Program, described in Section 3.1.2.4., CCS assures that HIV infected children are identified and appropriately referred for health services.

The California newborn genetic screening program detects inborn errors of metabolism, endocrine disorders and hemoglobinopathies (*FPM 4*). All are eligible conditions for the CCS program. However, the number of California children found to actually have these disorders is small. In 1998, the number of confirmed cases (out of 522,653 occurrent births) was: 13 children with phenylketonuria; 200 with primary congenital hypothyroidism; 7 with classical galactosemia; and 132 with sickle cell disease.

Children Served by the Medical Therapy Program

The CCS Medical Therapy Program (MTP) provides physical and occupational therapy services to children with cerebral palsy and neuromuscular conditions, without regard to family income. The number of children requiring and using the MTP program has increased by 36 percent over the past nine years, from approximately 18,000 in 1990-91 to 24,500 in 1998-2000. Since the birth rate in California progressively fell over this time period and most children with qualifying conditions are referred to the MTP, the absolute number and relative proportion of children in the State with these conditions appear to be increasing.

VLBW Infants

VLBW infants (birthweight less than 1,500 grams) (*FPM 15, HSI 5A and 5B*) are at risk for a number of perinatal disorders and have a high neonatal mortality rate (NMR, birth up to 28 days). In 1995-97, the NMR for all California infants of 500-1,499 grams was 154.5 per 1,000 live births. The race specific NMR for this

weight group was highest for non-Hispanic whites, at 159.8 per 1,000 live births, and intermediate for Hispanic infants, at 156.7 per 1,000 live births. Black infants of VLBW have a survival advantage and in 1995-97 had the lowest NMR, at 141.1 per 1,000 live births. The major neonatal disorders that lead to mortality in VLBW infants are CCS eligible conditions. CCS eligibility provides access to needed newborn intensive care services, with the goal of reducing the high mortality rate.

VLBW infants are also at risk for long term sequelae from perinatal disorders. From 1987 to 1993, infant mortality rates in California decreased for the smallest infants, those weighing 500-999 grams at birth. Infant mortality rates dropped from 718 to 583 per 1000 live births for infants weighing 500 to 749 grams at birth and from 375 to 203 per 1000 live births for infants weighing 750 to 999 grams. The survivors from this period are now children and young adolescents.

A 1997 study of 500-999 gram infants born during a concurrent period (1979-1991) and cared for in tertiary level, Northern California nurseries, found that only 61 percent of the survivors were completely normal, when assessed at a mean age of 55 months³⁰. This 61 percent had no neurologic, neurosensory, or cognitive deficits. However, long-term abnormalities were noted in the other 39 percent, that were associated with health problems they had experienced in infancy such as intracranial hemorrhage and chronic lung disease. A number of these extremely low birthweight survivors have conditions that make them eligible for the CCS program and MTP services.

Improving the long-term outcome of VLBW infants and other critically ill neonates is a major component of CCS responsibility. CCS activities include development of standards for delivery of newborn intensive care, approval of hospitals and intensive care nurseries, and infant outreach and follow-up programs.

Additional Sources of Information on CSHCN

Additional information on the health status of CSHCN in California is anticipated in the next two years, with the implementation of new survey tools. The Maternal and Child Health Bureau, in conjunction with the National Center for Health Statistics, is carrying out a national telephone survey which will include our State. Locally, a biannual California Health Interview Survey (CHIS) is being instituted, which will have questions about serious and chronic illness and physical limitations. Separate CHIS questionnaires are being developed for children and adolescents. The Medically Vulnerable Infant Program (MVIP), successor to the California High Risk Infant Program, will provide services to many of the infants discharged from newborn intensive care units. A data system, including monitoring of outcomes, is being integrated into the MVIP program.

3.1.2.2 Direct Health Care Services

◆ *Access to Preventive and Primary Services for Pregnant Women, Mothers, and Infants*

No direct health care services are provided for pregnant women or mothers, unless these individuals are young women who are also served by the CHDP and CCS programs. The CHDP program provides direct health care assessments and screening for infants, which includes six visits during the first year of life. These include a physical examination and evaluation of growth, developmental, nutritional, and dental status, as well as anticipatory guidance, sensory screening, testing for anemia, blood screening for lead poisoning, and administration of immunizations. In 1997-98, 550,596 infants under one year of age received health assessments through CHDP.

Though the CHDP program includes an initial health assessment visit during the first month of life, an issue raised during the needs assessment was the need for an additional, immediate postnatal visit, during the first few days after birth. Current hospital stays for delivery are short and infant health problems may not become apparent for several days. With increasing breastfeeding rates as a State goal, early guidance for breast feeding mothers, reassurance and assessment of infant nutritional status, are needed.

◆ *Direct Health Care Services for Children and Adolescents*

The CHDP program provides nine health assessment and preventive guidance visits for children over one year and up through 20 years of age. Two visits are provided in the second year of life, one visit each at two and three years of age, and one visit each at 4-5, 6-8, 9-12, 13-16, and 17-20 years. Health examinations and screenings are provided as described for infants and additional services, such as TB testing, pelvic examinations, and counseling on risk behaviors are included. In FY 1997-98, 1,735,101 children and adolescents received health services through CHDP. CHDP also fulfills the role of referring children to other programs for further diagnosis and treatment, when problems are identified.

When the CHDP program periodicity of visits was established it conformed to national standards. However, national recommendations have changed. The number of health assessment visits provided in the CHDP schedule for children and adolescents do not allow for annual health assessment visits, for children in the State-only funded portion of the program. Annual examinations for children are currently recommended by national organizations (such as the American Academy of Pediatrics), are available for Medi-Cal beneficiaries, and are required of health plans participating in the Medi-Cal Managed Care and Healthy Families programs.

Increasing the periodicity of visits for the State-only funded component of CHDP was raised during the needs assessment and is an important CMS goal.

◆ *Direct Health Care Services for Children with Special Health Care Needs*

The CCS program covers health care services, through approved providers, for almost all serious medical conditions of a physical nature, that can be cured, improved or stabilized. Conditions such as birth defects, chronic illness and physically handicapping conditions are medically eligible. The active case load of CSHCN in the CCS program was 140,129 in 1999. However, since individual children may enter or leave the case load, greater numbers of children may actually be served. New, CCS eligibility regulations, that made modifications in eligible conditions, were developed last year and were issued as emergency regulations. The regulations are about to be re-issued, in final format, after allowing for public comment and revision.

CCS provides direct health care services for children with a CCS eligible condition in the Medical Therapy Units (MTU). There are 104 MTU units and satellite units located throughout the State, which provide physical and occupational therapy to close to 25,000 children based on medical need. Therapy services are provided based on medical prescription and services are coordinated between family, therapists and medical providers through medical therapy conferences. In recent years, MTU services have become more complex, involving use of additional equipment and interventions. MTU sites are located at schools, in a child oriented environment, and the overall approach to provision of services involves interagency cooperation between CMS and the Departments of Education, Developmental Services and Social Services.

Though MTUs are dispersed and situated at sites that would be focal within a community, given the size of California and the number of children served, some CSHCN and their families need to travel over distance to reach their MTU. Provision of home based therapy services is constrained by the time that would be required for therapist travel, numbers and reimbursement costs of available therapists, and lack of portability of some services.

3.1.2.3 Enabling Services

◆ *Access to Preventive and Primary Services for Pregnant Women, Mothers, and Infants*

Prenatal Care

Expanded access to prenatal services is a long-standing priority in California. Through enabling services such as the provision of health insurance coverage, the State has eliminated most financial barriers for reproductive and prenatal services for low-income women and preventive and primary services for infants. In 1998, birth certificate files indicate that less than three percent of resident women who delivered a live-born infant in California had either no identified payer source for prenatal care or were self-payers¹⁹.

In 1998, 82.4 percent of pregnant women who delivered in California obtained first trimester prenatal care (*FPM 18*); this represents a 13 percent increase from 1989 (72.6 percent). Progress has been achieved in narrowing the gap between white women and black and Latina women in relation to care initiation. While white women were over 35 percent more likely than Latina women to receive first trimester care in 1989, this figure was reduced to 13 percent in 1998. Despite this progress, further efforts are needed to achieve the Healthy People 2010 Objective of 90 percent first trimester care.

Medi-Cal prenatal coverage is provided for full-scope prenatal, delivery, and postpartum medical services. All pregnant women with incomes below 200 percent of the FPL are Medi-Cal eligible. A property disregard program, a mail-in application, and presumptive Medi-Cal eligibility facilitate early and speedy enrollment. Previous access barriers have been removed thereby allowing low-income pregnant women who are ineligible for federal benefits to receive State-only prenatal care coverage through Medi-Cal.

Table 2: Prenatal Care Utilization Indicators by Type of Insurance

Indicator	Year	<u>Type of Insurance</u>	
		<u>Medi-Cal</u>	<u>Non-Medi-Cal</u>
		(%)	(%)
First Trimester Care	1989	53.8	82.8
	1998	73.6	88.6
Adequate or Adequate Plus(Kotelchuk Index)	1989	45.7	65.7
	1998	68.9	78.9

Source: State of California, Department of Health Services, Vital Statistics, Center for Health Statistics, California Birth Certificate Master File, 1998.

In 1998, Medi-Cal covered the prenatal costs for 40 percent of the women who delivered a live-born infant in California. The gap between the Medi-Cal and non-Medi-Cal insured women in relation to the percent with first trimester care (*HSI 6C*) has narrowed significantly; the absolute difference between the two groups was reduced from 29 percentage points in 1989 to 15 percentage points in 1998.

Access to prenatal care is assessed in terms of the time of initiation and the frequency of visits in accordance with the Adequacy of Prenatal Care Utilization Index (Kotelchuck Index). In California, the percent of live born infants whose mothers' prenatal care use was adequate or adequate plus on the Kotelchuck Index increased from 60.2 percent in 1989 to 74.9 percent in 1998, an increase of approximately 25 percent (*HSI 3*). A comparison of the Kotelchuck Index for women on Medi-Cal and those not on Medi-Cal (*HSI 6D*) shows that the gap between the two groups was reduced from an absolute difference of twenty to ten percentage points between 1989 and 1998.

The Access for Infants and Mothers (AIM) Program provides state-subsidized third party insurance to uninsured pregnant women and infants with household incomes between 200-300 percent of the FPL. Annually, AIM serves approximately 4,000 moderate-income women²⁰. The combination of Medi-Cal, AIM and private health insurance means that near universal health insurance coverage for prenatal and maternity care has been achieved in California.

Prenatal Care Outreach

Insuring early and continuous use of prenatal care services requires both an adequate infrastructure and effective population-based outreach. MCH Outreach and other programs like Baby CAL, AFLP, and Black Infant Health (BIH) provide outreach to pregnant women to encourage early enrollment in prenatal care. Efforts to improve access can also be strengthened by information that identifies problem locations. The provision of enhanced support services and program incentives can also improve prenatal care utilization. Population-based programs like the Comprehensive Perinatal Services Program (CPSP) and BIH offer such enhanced services.

Early and adequate prenatal care is particularly important for women whose pregnancies are complicated by medical conditions such as diabetes, hypertension, or other disorders. Scientific evidence demonstrates that many of the problems experienced by the mother and infant that are associated with diabetes, can be reduced or prevented with optimal prenatal care and diabetes control. To improve access to adequate prenatal care

among women with special conditions, MCH supports such programs as the California Diabetes and Pregnancy Program (CDAPP).

Improvements in women's access to health care should extend through the intrapartum period to promote maternal and infant health. California created the Family Planning Access, Care and Treatment (Family P.A.C.T.) program in 1996. The program provides comprehensive family planning services for the many low-income men and women who are ineligible for Medi-Cal and have no other source of family planning coverage. Family P.A.C.T. makes available comprehensive family planning services, including contraceptive methods, screening for sexually transmitted infections, and breast and cervical cancer to all women and men in California with incomes at or below 200 percent of FPL. By December 1999, 1.9 million clients had been enrolled in the program, along with 2,764 provider entities. By improving the early diagnosis and treatment of sexually transmitted infections and reducing the number of unintended and/or unwanted pregnancies, Family P.A.C.T. is expected to make a significant contribution to the health status of the maternal and child population²².

Cultural Competency

Access to care can be enhanced through programs that recognize the cultural diversity of the population. Given California's diverse population, the design of culturally appropriate programs represents a critical challenge. The California SIDS Program, in collaboration with the California Black Infant Health (BIH) Program, developed a SIDS Risk Reduction campaign designed specifically for the African-American community to help reduce the racial disparities in infant health. Similarly, breastfeeding and folic acid promotion materials have been designed to address cultural practices and beliefs among a number of the State's many ethnic communities. Several other prenatal programs for high-risk women also incorporate materials that are adapted to the cultural norms of the client populations.

Infant Health Screening and Assessment

The CHDP program provides health services to Medi-Cal eligible children and other low-income children not eligible for Medi-Cal. In 1997-98, CHDP health assessments and screenings were carried out in 352,914 infants (up to 1 year of age) enrolled in Medi-Cal, or 84.5 percent of the total Medi-Cal infant population (*HSI 2A*). An additional 197,682 infants covered by State funding sources also received CHDP health and screening services.

◆ *Access to Preventive and Primary Services among Children*

Child Preventive Assessments and Screenings

Access to preventive health assessments and screenings is provided to diverse population of low-income children through the CHDP program. In 1997-98, over forty percent of all children from families with incomes up to 200 percent of FPL received at least one preventive medical exam through CHDP (*SPM 1*). The majority of the CHDP population is made up of young children, with 71 percent aged 0 through 5 years, 20 percent aged 6 through 12 years, and 9 percent aged 13 through 20 years. Of the children receiving services, approximately 63 percent are Hispanic, 11 percent White, 7 percent Black, 5 percent Asian, and the remainder are other or unknown ethnic groups. (Additional information on ethnicity of CHDP children is provided in Section 4.1.) In 1997-98, 2,285,697 children received CHDP services: 794,476 (34.8 percent) were in Fee-for-Service Medi-Cal; 442,525 (19.4 percent) were enrolled in Medi-Cal managed care plans; and 1,048,696 (45.9 percent) were covered by State funding. The number of children in the State-funded component of CHDP increased by 15.8 percent from 1996-97 to 1997-98.

Child Health Insurance

Assuring health care coverage for all children is a priority in California. An uninsured child is less likely to have a regular source of health care. The absence of a medical home is associated with less adequate preventive care and delayed and irregular treatment for acute and chronic health problems. In 1998, approximately 2 million children 0-18 years of age (21 percent) were uninsured (*FPM 12*) in California. Nationally, 15 percent of children were uninsured. The percent of children under 18 years of age without health insurance coverage in California increased from 16 percent in 1992 to 21 percent in 1998¹⁸. Part of this trend may be attributed to the delinkage of Medi-Cal and Temporary Assistance to Needy Families (TANF) benefits; some families that lost TANF benefits did not reapply for Medi-Cal despite their continuing eligibility. Transitional Medi-Cal coverage has been strengthened to address this problem. The percent of children with employment-based coverage did not change significantly from 1995-98 to offset the declining Medi-Cal enrollment. Another factor that may have played a role in the increase in uninsured children was the fact that many immigrant parents feared the consequences of applying for government programs, even for their citizen children. Clarification of the “public charge” concern was intended to reduce this fear.

A number of state-level approaches have been implemented to improve access to health services among children. Subsequent to the passage of the 1996 Federal Personal Responsibility and Work Opportunities Reconciliation Act welfare reform legislation, California enacted legislation to extend Medi-Cal eligibility to legal immigrants who arrived after August 1996, the cut-off for eligibility for federally-financed programs.

Following the passage of Title XXI, the State Children's Health Insurance Program, California created the Healthy Families Program (HFP) and expanded Medi-Cal eligibility. HFP was created on an insurance model to extend coverage to children in low-income working families. While originally providing coverage to children in families with incomes up to 200 percent FPL, HFP eligibility was extended to 250 percent FPL as of November 1999. To further increase enrollment, the State reduced the Healthy Families application from 26 to four pages, permitted a mail-in application, and allowed for 12-month continuous eligibility. Medi-Cal now accepts mail-in applications for children as well. Community outreach activities for public education and enrollment in Healthy Families and Medi-Cal were expanded. The Title V agency has collaborated with the Medi-Cal and Healthy Families programs to help insure access to care. Collaboration efforts have existed both at the Branch level and through the activities of the local MCH, CHDP, and CCS staff at county and local health departments.

Dental Health Services

Dental health services are a basic component of comprehensive primary care services. Nearly half of all preschool children and twelve percent of high school students in California had never visited a dentist. These figures are expected to improve with the introduction of the Healthy Families Program and Medi-Cal expansion, since both programs provide insurance coverage for dental services. The underlying barriers to dental care are lack of dental insurance and a limited number of providers serving low-income clients. In 1995, 28 percent of California children had no dental insurance. According to a recent study by the Center for California Workforce Studies, 97 of 487 (20 percent) Medical Service Study Areas--geographic regions defined by state agencies for the administration of various programs--are currently at or below the federal standard of one primary care dentist for every 5,000 people. Thirty-two Medical Service Study Areas, most of which are rural, do not have any dentists. Regions that have a shortage of dentists tend to have a higher percentage of minorities, lower median incomes and a higher percentage of children³¹.

Current estimates suggest that less than 40 percent of dentists in California treat Medi-Cal patients; this figure is below the national standard of 50 percent. In addition, many dentists who do enroll in Denti-Cal (Medi-Cal) limit the number of Denti-Cal patients they will see. According to the study by the Center for California Workforce Studies, existing programs to address the shortage have not been successful in attracting dentists to underserved areas³¹.

Ambulatory Care Sensitive Conditions: Asthma

The hospitalization rate for ambulatory care sensitive conditions is one measure of access to health services. Asthma is a medical condition that is commonly used to assess the extent to which children are receiving quality preventive care (*HSI 1*). Inadequate outpatient management of the condition or limited access to a medical home can result in increased asthma hospitalization rates. Among California's children, asthma is known to be a leading cause of hospital admissions and school absences³². State hospital discharge data indicate that asthma was the most common diagnosis for hospitalizations of 1-5 year olds, and the third most common diagnosis among 6-12 year olds in 1992³³. In 1998, the rate of hospitalizations per 10,000 children less than five years old was 23.9 (*HSI 1*).

CMS, in collaboration with the Chronic Disease Prevention Division in the DHS, is developing a new multicomponent asthma program that is designed to increase awareness about asthma in young children age 0-5 years and result in more appropriate and timely interventions. The program includes community participation and training, "safety net" drug subsidies, and education of CHDP and CCS providers, to achieve early recognition, monitoring and treatment of asthma.

Health Services for Adolescents

Health care providers can play a role in the early detection of significant health problems and the modification of risky behaviors that contribute to adolescent morbidity and mortality. Despite the need, adolescents visit office-based physicians less often than any other age group. They are also more likely to be uninsured or under-insured than any other age group⁷. All of the Primary Care and Family Health programs are now working to incorporate a youth development approach and achieve better coordination. Opportunities for health examinations and preventive counseling are provided by CHDP and increasing the number of these assessments to provide annual visits for adolescents might be able to increase their impact on health risks and behaviors.

Health Services for Children in Foster Care

Children in foster care have higher rates of medical and developmental problems and have more limited access to health care. An estimated 112,528 children are in foster care in California and under county supervision. To address the problem of health care access, a new State program is being implemented which will use public health nurses in county and local health jurisdictions to ensure that children in foster care receive

appropriate health services. This program is being carried out by CHDP conjunction with the California Department of Social Services.

- ◆ *Access and enabling services for children with special health care needs*

Outreach for CSHCN Services

Referral to the CCS program and outreach for CSHCN occurs through medical providers and many other health programs, such as CHDP, Medi-Cal, Healthy Families, WIC, the HIV Children's program, and the High Risk Infant Program. Referral and outreach through the new MVIP is anticipated. These services have population based, as well as enabling components. Appropriate identification of the CSHCN population and referral is key in getting needed services to these children.

Access to Specialty Services

CCS case manages aspects of the medical care of CSHCN that are related to their CCS eligible condition and authorizes needed medical services, which are paid on a fee-for-service basis. These CCS authorized services are specifically "carved out" from the Medi-Cal and Healthy Families programs. In FY1998-99, 74 percent of children in CCS were enrolled in Medi-Cal and 3 percent were estimated to be enrolled in Healthy Families.

With the rapid changes in health care delivery systems, concerns about perceived decreasing access to quality medical care for CSHCN were raised by many individuals and groups contributing to the needs assessment. CCS staff, staff from local county health programs, medical providers, parent representatives, individuals representing managed care plans and children's hospitals, and the Senate Office of Research all indicated that the current key issue for CSHCN was maintenance of access to a network of specialty and subspecialty providers.

One issue impacting on medical provider availability are low provider reimbursement rates for pediatric specialty services. A 39 percent increase in reimbursement for CCS authorized medical services has been included in the FY 2001 budget signed by Governor Davis and should help sustain physician participation in CCS.

Case Management

Through case management of the CCS eligible condition, the CCS program sees that CSHCN are referred to qualified specialty and subspecialty providers. However, the case managers in the county and State CCS program currently carry large caseloads that can exceed 500-1000 cases. The need for additional personnel, to facilitate case management, was also raised as a health care access issue.

The extent to which specialty medical care services are available and provided to CSHCN are evaluated in several of the Federal and State Performance Measures. CCS assures all of the categories of specialty and subspecialty services comprising *FPM 2*. Though California achieved a full score of 9, out of a maximum of 9 for the types of services offered CSHCN, it is the goal of CCS to continue to improve the individual accessibility and quality of those services.

Insurance Coverage

Potential access to health care is also evaluated by the percent of CSHCN who have a source of insurance for primary and specialty care (*FPM 11*). In 1999, 96 percent of CCS children had insurance; coverage included private sources as well as Medi-Cal. The CCS program assures payment for medical services related to the CCS eligible condition for eligible children without another source of coverage. The percent of CCS children who were insured met the 1999 State goal and efforts will continue to extend insurance coverage to all CSHCN.

Financial Eligibility

Last year when the income level for eligibility in the Healthy Families program was raised to 250 percent of the FPL, CCS income eligibility was extended for Healthy Families beneficiaries. This change allows all CSHCN enrolled in Healthy Families, who have a CCS eligible condition, to receive CCS services. However, the overall CCS financial eligibility level, of \$40,000 annual family income or medical expenses equal to 20 percent of annual income, is viewed by some as too low. The possibility of extending the family income limits has been raised.

Provision of Services

The percent of California Supplemental Security Income (SSI) beneficiaries under 16 years of age who receive services from CCS (*FPM 1*) has steadily risen over the past four years. In 1999, 28.5 percent of SSI children received CCS services, exceeding the annual objective.

The percent of CSHCN with three sentinel conditions (spina bifida, cleft palate and ALL) who were referred for specialty medical care by CCS (*SPM 2*) was 79.2 percent in 1998, the last year for which information is currently available. However, as noted previously, the percent of CSHCN with these conditions is decreasing and this combined measure will not continue to be a useful indicator for access to care for California CSHCN.

Medical Home

The percent of CSHCN who have a medical/health home (*FPM 3*), can be viewed as an indicator of both health access and also of potential coordination of care. However, the optimum method for assessing this measure is unclear and identification of the medical provider who best serves as a medical home for specific categories of CSHCN is complex. The percent of CSHCN who had a medical home rose from 19.3 percent in 1997 to 32.2 percent in 1999, when medical home was defined as the listing of a primary care provider in CMS Net. CCS is actively collaborating in programs, with organizations such as the American Academy of Pediatrics and with a Title V grantee at Children's Hospital in Los Angeles, to define "medical home" for CSHCN. CCS is also working to increase the number of CSHCN with a medical home and is exploring possible incentives that will encourage medical providers to assume this challenging, time consuming role.

Referral for Neonatal Services

To assure that ill newborns receive treatment in hospitals with appropriate facilities and expertise, CCS approves Neonatal Intensive Care Units (NICUs) around the State for different levels of intervention and care (NICUs are designated as Intermediate, Community and Regional Level). CCS will only authorize services at NICUs appropriate for the infant's acuity. CCS requires NICUs below the Regional level to maintain relationships with higher level NICUs, for consultation and transport out of sick infants. These relationships also facilitate back transport of infants, to NICUs closer to home, as their medical condition improves.

Partnership with Families

Family participation in the CSHCN program (*FPM 14*) plays a major role in reducing institutional and cultural barriers to both health care access and coordination of services. The family is an essential partner in the CCS program. While California scored 14 out of a possible 18 on this *FPM* and met the annual objective for 1999, efforts are continuing to further improve family participation. Examples of these efforts are the statewide trainings that CCS has been sponsoring on family centered care.

The new Medically Vulnerable Infant Program will also provide in home evaluations and family support services. The program will encourage parental care giving and facilitate parent-health care provider interactions.

3.1.2.4 Population-Based Services

- ◆ *Population based services for Pregnant Women, Mothers, and Infants*

Expanded Alpha-fetoprotein Screening of Pregnant Women

Through the Genetic Disease Branch, prenatal testing is carried out to detect neural tube defects, other anomalies and genetic abnormalities that present with abnormal levels of alpha-fetoprotein. In 1998, 356,742 pregnant women received this testing and 840 were found to have confirmed fetal abnormalities

Genetic Screening of Newborns

Prevention, screening and early intervention for children who are born with genetic defects can prevent premature death and disability. As noted earlier, the Genetic Disease Branch of the Department of Health Services provides statewide prenatal and neonatal screening for the prevention of genetic or congenital disorders or the amelioration of their impact on individuals and families. A screening rate of approximately 99 percent of California newborns for metabolic and hematologic disorders has been consistently achieved from 1995-98 (*FPM 4*).

Newborn Hearing Screening

In 1999, 9.4 percent of newborns in California were screened for hearing impairment before hospital discharge (*FPM10*). It is anticipated that newborn hearing screening in California will increase dramatically over the next few years. The largest newborn hearing screening program in the U.S. will be fully implemented here by the end of 2002. The program is currently designed to screen infants born in CCS-approved hospitals, who comprise approximately 70 percent of births in California. If abnormalities are detected, CCS will assure the availability of further audiologic diagnostic evaluation.

SIDS

The SIDS Program has facilitated the SIDS Risk Reduction campaign, also known as Back to Sleep in California. The program has helped reduce the incidence of SIDS by nearly 50 percent. Since its inception in 1994, the SIDS rate has declined from 93.2 to 49.7 per 100,000 live births. The California SIDS Program worked in collaboration with the California Black Infant Health (BIH) Program to develop a SIDS Risk Reduction campaign for the African-American community. In addition, the SIDS Program has continued to work closely with the FIMR Program to understand the causes of SIDS deaths, as well as to identify areas of the community in need of additional outreach with the SIDS Risk Reduction message.

Child Care

As the numbers of working mothers entering the work force has increased, there is a growing awareness of the potential of child care centers as sites for health promotion activities. Local activities under development under the California Children and Families Initiative include training of child care providers in such areas as early childhood development, injury prevention, and the importance of preventive health services. Linkages with Title V supported enabling services for mothers and pregnant women can be developed with such programs as AFLP and BIH.

◆ *Population-based Services for Children*

Immunizations

Although immunization rates in California have increased significantly, vaccine-preventable illnesses remain a cause of morbidity and mortality among infants and children. By 1998, 75.9 percent of children 19-35 months of age were

up-to-date on their vaccinations (*FPM 5*). California had achieved the national objective for three of the vaccines: measles-mumps-rubella combination, polio, and Haemophilus influenza type b (Hib). Coverage for the diphtheria, tetanus and pertussis vaccine reached 79 percent. Improved immunization coverage is a goal that CMS and MCH actively pursue through CHDP and local health departments. California is a pilot state for a Government Performance and Results Act (GPRA) immunization improvement project with CHDP measuring Fee-for-Service Medi-Cal immunization rates. County MCH staff often coordinate local interventions to improve vaccine coverage.

Lead Screening

The Federal General Accounting Office (GAO) released a report in January 1999, pointing out that children served by Federal health programs remain at significant risk for elevated blood lead levels. Seventy-seven percent of 1- 5 year olds with blood lead levels less than 10 ug/dl were from low-income families served by programs such as Medicaid and WIC. In April 1999, the California State Auditor released a report which concluded that less than 10 percent of California children needing medical care and case management related to lead poisoning were being identified. Less than 25 percent of low-income children receiving health services through CHDP and Medi-Cal were having their blood lead levels tested. To address this issue, a targeted screening policy that requires blood lead screening in all low income children has been adopted and widely promulgated by the California Childhood Lead Poisoning Prevention program and CHDP and is being implemented in the CHDP population.

- ◆ *Population based services for children with special health care needs*

HIV Screening

The CCS HIV Children's program provides funding for screening, diagnostic evaluation, medical monitoring and follow-up for children and adolescents at-risk for or suspected of having HIV infection. Over 10,000 children have received services through this program. Children and adolescents identified as having an immunodeficiency problem are eligible for medical services authorized through CCS.

Hearing Screening in Neonatal Intensive Care Nurseries

Infants who receive treatment in a CCS approved intensive care nursery are required to receive hearing screening prior to discharge. Infants found to have abnormal screenings are referred for further audiologic evaluation. If a hearing deficit is diagnosed, it is a CCS eligible condition.

3.1.2.5 Infrastructure Building Services

- ◆ *Infrastructure-building services for pregnant women, mothers, and infants*

Local Infrastructure

Local health departments carry out, in collaboration with the State Department of Health Services, the core public health functions of assessment, policy development, and assurance to improve the health of their MCH populations in accordance. There are 58 counties and three cities, which have their own local health departments. The local MCH staff are central to assuring the populations' access to quality health care services for pregnant women and children, preventive and primary care services for children and adolescents, and family-centered, community-based comprehensive health care services to children with special health care needs.

Perinatal Care

Care of high risk mothers at facilities providing complex perinatal care can reduce maternal morbidity and mortality (*SOM 1*). Very low birthweight infants are more likely to survive and thrive if their care is provided in a facility that is appropriately staffed and equipped, and serves a high volume of high risk deliveries and newborns. Since 1995, California has experienced a modest, but not statistically significant increase in the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates (*FPM 17*). This percent increased from 60 percent in 1995 to 64.6 percent in 1998. The Regional Perinatal Programs and other prenatal outreach and education initiatives will continue to work to improve access to the appropriate level of facilities.

Training

Support is provided to seven schools of nursing to prepare graduate nurses for advanced practice in fields that facilitate access to cost effective primary care for women in the reproductive years, infants, children and adolescents. This support has enabled these programs to add faculty, expand sites for clinical practice, develop distance learning opportunities, develop new recruitment materials, and expand internet access to the programs. Training is provided to prepare certified nurse midwives, pediatric nurse practitioners and women's health care nurse practitioners. All of the programs have national and state accreditation for their courses of study in midwifery, women's health, pediatrics and school health. All schools have been able to increase the number of students enrolled with the support of the Maternal and Child Health Branch.

Monitoring and Assessment

The MCH Branch has implemented small area analysis through geographic information systems (GIS), as a tool in the effective targeting of limited public health resources. The first mapping projects have focused on teen births, the adequacy of prenatal care utilization, and most recently, the distribution of low birthweight births. By providing powerful but simple evidence of the location of the particular problem, the maps assist local agencies in planning resource allocation and program design and provide key documentation to agencies seeking funds for preventive interventions. These maps will facilitate the planning of outreach activities to target high-risk groups. The MCH Branch will work to integrate the GIS maps into the county planning process by assisting in the identification of local hot spots in which to focus interventions

Quality Assurance

The California Fetal and Infant Mortality Review (see Section 4.1) has been used as a local level tool to improve local health care systems and community infrastructure. Standardized infant death review systems are used to identify, evaluate, and determine potential factors that contribute to a preventable infant death. Collected data are analyzed at both the local and state levels to define gaps in services or knowledge, to identify systems issues, to support system change, and to evaluate program effectiveness.

The *California Perinatal Quality Care Collaborative* (CPQCC) was developed in collaboration with the California Association of Neonatologists and the University of California at Berkeley School of Public Health. Its goal is to improve the quality and outcomes of perinatal health care in California. The Collaborative consists of participants from the public and private obstetric and neonatal provider community, health care purchasers, public health professionals, and business groups. The CPQCC objectives are to: (1) allow for the timely analysis of perinatal care, outcomes, and resource utilization based upon a uniform statewide process; (2) provide mechanisms for bench-marking and continuous quality improvement activities; and (3) serve as a model for other states. CPQCC will foster the development of an effective quality improvement infrastructure at state, regional, and hospital levels. Data is being reviewed to recommend quality improvement objectives, provide models for performance improvement, and assist providers in transforming data into information to improve care.

Perinatal Profiles is a project to improve services and outcomes for maternal and child health clients by providing up-to-date data on perinatal services, levels of risk, and perinatal outcomes for each of the State's perinatal regions, maternity hospitals, and birthing facilities. *Perinatal Profiles* are intended to promote quality

improvement initiatives by supplementing a facility's internal quality assurance data. The data are based on level of care and risk-adjusted analysis for fetal, neonatal, and post neonatal mortality. MCH staff work with contract staff at the UC Berkeley School of Public Health and Regional Perinatal Program representatives to enhance the effectiveness of these reports.

◆ *Infrastructure Building Services for Children*

The local health departments provide the infrastructure to meet the needs of all segments of the MCH population.

CHDP Infrastructure Activities

The local CHDP programs screen and set standards for participating providers, perform quality assurance, and participate in CHDP planning and policy development with the CMS Branch. CMS provides guidance and carries out site visits and reviews of the county and local CHDP programs.

Data Systems Capacity Building

The types of services being provided to infants and children through the CHDP program are monitored through the CMS data analysis unit and the local CHDP programs. Aggregate information at a Statewide level, and also county level data, are tracked in Sacramento, shared with the local programs and issued as an annual CHDP report. CHDP information used throughout this report comes from that data management effort.

Because of the many assessments, screenings, immunizations, care referrals, etc. contained in CHDP data, it is an important source of information for planning and policy development, as well as quality assurance monitoring. The CHDP program supplies 26 percent of the information used in national nutritional assessment and growth databases. As part of ongoing improvement within CMS, CHDP data is being continuously evaluated with respect to completeness and accuracy. CMS is also working with the Medi-Cal Managed Care Division, to improve data reporting on EPSDT services given through Medi-Cal managed care plans.

The GPRA immunization survey that is just being completed by CHDP in conjunction with Medi-Cal, is serving as a pilot program for future quality assurance and assessment analyses. The survey is utilizing both State administrative data and medical record based information to document immunization levels in young children. The process is increasing understanding of the capabilities and limitations of current State data bases. The

information gathered, while necessary for Federal HCFA reporting, is also helpful for policy planning and as a reference against CHDP immunization data.

◆ *Infrastructure Building for CSHCN*

Coordination of Services Between CCS and Other Programs and Agencies

Assuring enrollment in CCS for eligible children in other health care programs and coordination of services were additional concerns of many participants in the needs assessment. Coordination issues included those between CCS and other programs, such as Healthy Families and Medi-Cal, and within CCS at the State and county level.

Staff liaisons in CCS are working with other programs to address between program issues. Specific CCS staff are designated to work with Medi-Cal, Medi-Cal Managed Care Plans and Healthy Families. CCS is represented on the Interagency Coordinating Council (ICC) for Early Start and is an active participant in the ICC Health Services Committee. Through ICC efforts and other CCS activities, such as the MTP, CCS is working to coordinate services for CSHCN with the Departments of Education, Developmental Services and other agencies. Coordination with the Department of Social Services is integral for services to children in foster care and SSI. CCS works with the Childhood Lead Poisoning Prevention Program to coordinate services for children found to have elevated blood lead levels.

Coordination of Services Within CCS State and County Programs

The statewide, CMS Net automated case management system is facilitating coordination within CCS, including CMS branch and individual county programs. CMS Net is also increasing data processing and assessment for the overall CCS population. The percent of CCS enrolled children registered in CMS Net (*SPM 7*) has been increasing and in FY 1998-99 rose to 18.5 percent. This progress has been slower than initially anticipated but, with 45 counties entering data into the system now, it is anticipated that over 53 percent of current CCS children will be on CMS Net by the end of calendar year 2000.

Coordination with and support of county CCS programs is carried out on other levels. CMS Branch offices serve as consultation centers for CCS programs in independent counties and provide direct case management for the dependent counties. CMS Statewide conferences and conference calls address county questions and provide dialogue on program issues, as do CMS Branch site visits and county reviews. CMS also provides trainings in locations in the northern and southern parts of the State, on CCS related issues.

Coordination of CCS activities with programs at the community level is carried out through the county programs and community based MTUs. CMS branch site visits to community facilities, seeking and wishing to maintain CCS approval, assures that they meet CCS standards.

CCS Standards

Maintenance of standards for health care services and quality assurance activities were identified as concerns of some of the needs assessment participants, particularly with respect to CSHCN. CCS develops standards for hospitals, intensive care units, special care centers, and paneling of health care providers, who wish to participate in CCS programs. New standards for CCS approval of NICUs were issued in 1999 and CCS has participated in outreach sessions, to clarify any questions about the standards. Reviews of NICUs for CCS reapproval, based on the new standards, will begin this year. New CCS standards for Neonatal Surgery Centers and Special Care Centers are being developed.

Collaborative Relationships With Other Organizations

CMS has numerous collaborative relationships with organizations concerned with health care for children. Examples include: work with the American Academy of Pediatrics, California District on the medical home issue; the California Association of Neonatologists and University of California at Berkeley, School of Public Health on the California Perinatal Quality Improvement Program and maintenance of the provider network; and the California Children's Hospital Association on issues relating to access to care. (Please see further discussion in Section 4.2., Other Program Activities.)

3.2 Health Status Indicators

California data for the Core Health Status Indicators (*HSI*) is presented in Section 5.4. Data for all *Core HSI* are included. Retrospective figures from 1994-1998 are included for measures 1, 3, 4A, 4B, 5A, and 5B.

Data for calendar year 1998 are presented for *HSI* 2A, 6 and 7.

3.2.1 Priority Needs

The five year needs assessment has led to the identification of the following priorities for the population of pregnant women, mothers, infants, children, and CSHCN for the period of FFY 2001-2005. The priority needs encompass all levels of the health services pyramid and in some cases span pyramid levels.

The main priority need identified that relates to direct health care services is the need to maintain and improve the State health care programs for children and particularly CSHCN. These programs, CHDP and CCS, are the core "safety net" for children's health care in the State.

A number of priority needs were identified that relate to enabling services. The major needs in this area concern: racial and ethnic disparities in infant health and mortality; existing disparities in the proportion of low birthweight; issues of access to maternal health care; issues of access to health care for children and CSHCN; and the presence of community, family and domestic violence.

Priority needs relating to population based services are: the large number of adolescents giving birth; low breast feeding rates; and high intentional and non-intentional injury rates. Other population-based concerns are: the need for promotion of healthy lifestyle practices for children and adolescents; and the need for outreach through health programs to aid catchment of CSHCN.

An identified priority need for infrastructure building relates to the quality of maternal health care. Many of the ethnic disparities in infant health care and proportion of low birthweight infants also relate to infrastructure issues. Infrastructure building is pertinent to State priority needs for children with respect to: the quality of primary and specialty care providers for children and CSHCN; better coordination of services for CSHCN; and the need to expand the capabilities of the Statewide case management and data collection system for CSHCN (CMS Net).

The following California priorities, for Title V activities over the next five years, were developed based on the priority needs in the State:

California Title V Priorities

- ◆ Eliminate racial and ethnic disparities in infant health, including gaps in the infant mortality rate and the proportion of low and very low birthweight live-born infants.
- ◆ Promote safe motherhood by improving early access to and the quality of maternal health care for all women.
- ◆ Improve access to quality primary and specialty care providers, including dental, for all children, particularly Children with Special Health Care Needs.

- ◆ Reduce the adolescent birth rate.
- ◆ Increase breastfeeding rates among newborns.
- ◆ Promote healthy lifestyle practices among children and adolescents with emphasis on smoking prevention, adequate nutrition, regular physical activity, and oral health.
- ◆ Decrease intentional and unintentional injury death rates among children and adolescents.
- ◆ Reduce the prevalence of community, family, and domestic violence.
- ◆ Improve coordination and outreach with other health programs to facilitate delivery of health care services to Children with Special Health Care Needs.
- ◆ Continue to expand the CCS statewide automated case management and data collection system, CMS Net, to improve tracking and monitoring services and outcomes for CSHCN.

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

See detailed information in Forms 2,3,4, and 5.

3.3.2 Other Requirements

Since the enactment of OBRA 89, California has maintained the availability of 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 FFY2001 is \$43,010,496. The proposed activities are based on this figure. Preventive and primary services for pregnant women, mothers, and infants are designated to receive \$13,619,786 (31.67 percent of the total), preventive and primary services for children to receive \$14,122,761 (32.83 percent), and CSHCN to receive \$13,054,925 (30.35 percent). Administrative costs are proposed at \$2,213,024 (5.15 percent).

State Match/Overmatch

California will receive \$43,010,496 in Federal Title V Block Grant funds for FFY 2001. The required match is \$32,257,872. California's FFY 2001 expenditure plan for MCH programs includes \$664,726,146 in State funds. Consequently, the state-funded expenditures for preventive and primary health care services for the Title V populations exceeds the required 4:3 matching ratio.

Documentation of Fiscal Restrictions

Administrative Costs Limits

In FFY 2001, 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 2001, California will expend only 5.15 percent of Title V funds on administrative costs.

Definition of Administrative Costs

“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 20 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.

Maintenance of State Effort

The State Department of Health Services has an ongoing commitment to provide maternal and child health services to women and children within the State of California. This commitment includes continued support to local health jurisdictions, local programs, clinics and Medi-Cal providers for maternal and child health services.

It is the State’s intent to ensure that State General Fund contributions to these local programs, which are also funded in part by the Federal Title V Block Grant, be administered by the MCH and CMS Branches. The State’s General Fund contribution for FFY 2001 is \$664,726,146, which is \$557,567,396 greater than the State’s General Fund contribution of \$87,158,750 in base year FFY 1989.

Additional Program Budget Information

Other Funds

The State Children’s Health Insurance Program (Title XXI of the Social Security Act) makes available Federal funds for states to expand health insurance to uninsured children. California’s response to this legislation is the

Healthy Families Program. With this program, California has expanded access to health coverage for uninsured children through:

- 1) A health insurance program for children whose family incomes are above those which provide eligibility for no-cost Medi-Cal but are at or below 250 percent of the FPL (this was increased from 200 percent of the FPL in November 1999).
- 2) Changes to the Medi-Cal system, which simplifies eligibility to increase enrollment of the eligible population.
- 3) Coverage through the Access for Infants and Mothers (AIM) program of infants up to 12 months whose family income is between 200 and 250 percent of the FPL.

3.4 Performance Measures

3.4.1 National "Core" Five Year Performance Measures

Figure 3 TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM

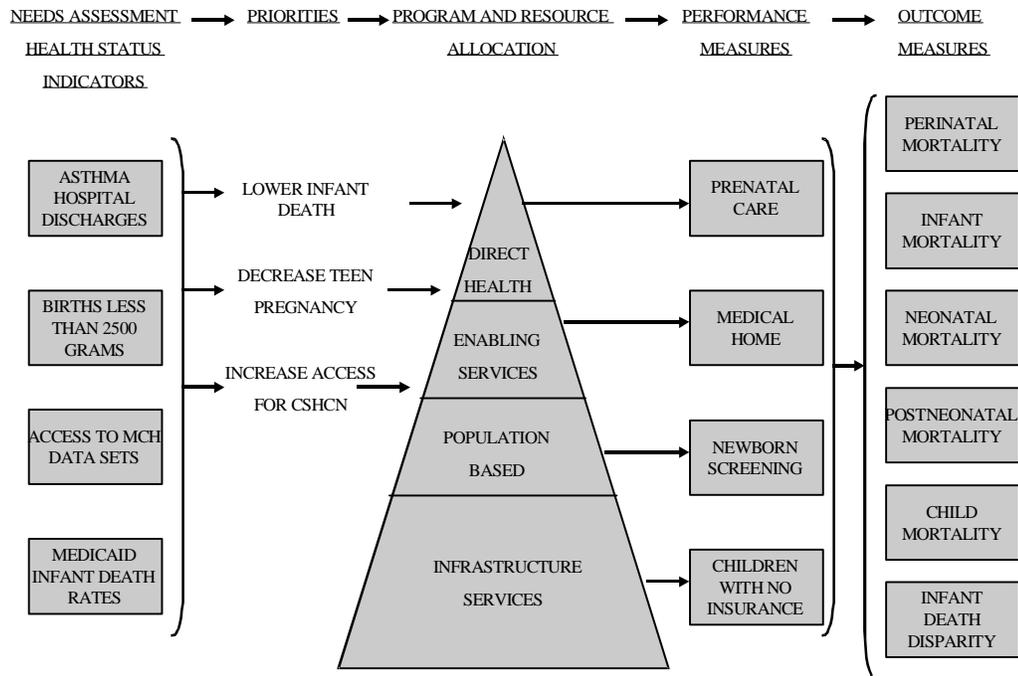


Figure 4
PERFORMANCE MEASURES SUMMARY SHEET

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) 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.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home”		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 0-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN program				X		X	
15) Percent of very low birth weight live births				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1. The percent of children whose family income is less than 200 percent of the Federal Poverty Level who received at least one preventive medical exam during the fiscal year.	X						X
2. The percent of CCS children with cleft palate, spina bifida, and acute lymphoid leukemia, who were referred to Special Care Centers for multidisciplinary, coordinated evaluation and treatment.		X				X	
3. The rate of deaths caused by drowning in swimming pools per 100,000 children aged 1 through 4 years.			X				X
4. The rate of deaths caused by homicide per 100,000 adolescents aged 15-19 years.			X				X
5. The rate of deaths caused by motor vehicle injuries per 100,000 adolescents aged 15-19 years.			X				X
6. The incidence of neural tube defects (NTDs) per 10,000 live births and fetal deaths among counties participating in the California Birth Defects Monitoring System							
7. The percent of California Children's Services (CCS) enrolled children registered in CMS Net, the statewide automated case management and data collection system for CCS.							
8. The percent of youth aged 13-17 years who report having smoked a cigarette in the past 30 days.			X				X
9. The percent of women at least 18 years of age who report experiencing intimate partner physical abuse in the past 12 months.		X					X
10. The percent of low-income children enrolled in California's Child Health and Disability Prevention program who were above the 95 th percentile of weight for height.			X				X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.1.1 Five Year Performance Objectives

Please see Form 11 for specific annual objectives.

3.4.2 State "Negotiated" Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

The selection of the State Performance Measures is based on a number of considerations. The major criteria include the following:

- a) The needs assessment conducted in preparing the Title V application highlighted the importance of the problem either in terms of its being a major contributor to mortality and/or morbidity in a maternal, infant, child, or CSHCN population group, or the assessment indicated a deteriorating situation worthy of ongoing monitoring. Input from the local jurisdictions, the stakeholder community, and the statewide review was also used to determine importance and relevance of the problem for California.
- b) The State of California has demonstrated a strong commitment to addressing a specific health problem such as reducing the teen birth rate, the prevalence of domestic violence, and tobacco use among California's youth.
- c) Effective and affordable interventions can be identified to address the health problem.
- d) Reliable and valid data to monitor the problem are available from existing data systems.
- e) Existing programs merit continuing support to achieve further improvement in areas related to the State's Title V priorities.

3.4.2.2 Discussion of State Performance Measures

State Performance Measure 1 is the percent of children whose family income is less than 200 percent of FPL who received at least one preventive medical exam during the fiscal year.

Insuring appropriate health service utilization often depends on more than health insurance coverage. The availability of providers who are geographically and culturally accessible can also affect utilization. Preventive medical examinations are an ideal method for the identification and early intervention of medical conditions. While it would be desirable to measure whether all children have received the age-appropriate recommended preventive health services at appropriate intervals, California does not currently have this capability. Nevertheless, the CMS Branch is able to track whether low-income children have received at least one preventive medical examination per year, using the CHDP program data. This measure provides an indication of whether California's low-income children are accessing the services for which they are eligible for financial coverage through Medi-Cal or CHDP. However, the FY1997-98 data does not yet include Healthy Families, which began enrollment in July 1998. Over time, the measure will help assess whether expanding health care coverage is actually increasing access to and utilization of care. It should be noted that annual health examinations and screenings are not currently provided by CHDP, for children over age 3 years in the State-only funded portion of the program. Assessments every 2-3 years are included. Therefore, a score approaching 100 percent on this measure is not currently achievable. In FY 1997-98, 4,832,348 children in California were from families with incomes up to 200 percent of FPL. 40.2 percent of these children received a health services through CHDP.

SPM 1 is directly related to the State Title V priority of improving children's access to primary and specialty care. It measures a direct health care service that relates to the risk factor of low-income. Timely diagnosis and treatment of medical problems can contribute to reducing infant and child mortality and mortality rates. Preventive exams and screenings provide critical opportunities for identification of problems that may interfere with normal development or school performance, as well as opportunities for health promotion counseling related to breastfeeding, diet, physical activity, and injury prevention.

State Performance Measure 2 is the percent of CCS children with Cleft Palate, Spina Bifida, and Acute Lymphoid Leukemia, who were referred to Special Care Centers for multidisciplinary, coordinated evaluation and treatment plans.

This measure was initially chosen as a means of monitoring appropriate referral and access to care for CCS children. However, the number of children with these conditions is decreasing and the relevance of this subset of diagnoses to the overall CCS population is diminishing. This performance measure will be deleted in future application/ reports. As CMS Net expands (***State Performance Measure 7***) and CCS data capabilities increase, other, broader based assessments of care delivered by the CCS program will become available.

State Performance Measure 3 is the rate of deaths per 100,000 children aged 1 through 4 years caused by drowning in swimming pools.

Drowning has remained a leading cause of injury death to children ages 1 through 4 in California for the past decade. *SPM 3* is directly related to the State's priority of childhood injury prevention. The intervention strategies are population-based and address the risk factor of access to swimming pools among young children. Effective prevention efforts can contribute to continuing declines in the child mortality rate.

State Performance Measure 4 is the rate of homicide related deaths per 100,000 adolescents aged 15-19 years.

Homicide is the second leading cause of death among adolescents aged 15-19 years in California, following closely behind motor vehicle deaths. In 1998, there were 17.1 deaths per 100,000 adolescents aged 15-19 years. The corresponding figure for African American adolescents was 48.2 deaths, and for Latinos, 28.9 deaths per 100,000 15-19 year olds. *SPM 4* relates to the priority need of injury prevention in childhood and adolescence. Interventions for homicide prevention are population-based and address the risk factors associated with homicide deaths such as access to firearms. The prevention of homicide deaths contributes to the reduction of the child mortality rate.

State Performance Measure 5 is the rate of deaths resulting from motor vehicle injuries per 100,000 adolescents 15-19 years of age.

In 1998, California's motor vehicle mortality rate was 17.2 per 100,000 adolescents aged 15-19 years. Although motor vehicle related deaths are decreasing, they remain the number one cause of death in this age group. *SPM 5* is directly related to the priority need of childhood injury prevention. The interventions are population-based and address the risk factors associated with adolescent development such as alcohol and illicit drug use and limited driving experience. The reduction of motor-vehicle related injury deaths will contribute to the reduction of the overall child mortality rate.

State Performance Measure 6 is the incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring Program (CBDMP).

Focus on the problem of NTDs is based primarily on the preventable nature of this devastating condition more than the numbers of newborns and families affected. The Centers for Disease Control and Prevention estimate that 50 percent of neural tube defect births could be prevented. In 1997, there were 134 NTDs among 252,159 live births and fetal deaths registered in CBDMP, for a rate of 5.3 NTDs per 10,000 live births and fetal deaths. *SPM 6* relates to the priority of reducing ethnic and racial disparities in infant health status. The programs are population-based and address the known risk factors associated with the occurrence of NTDs such as a prior infant born with NTDs. The State Performance Measure also addresses the health outcome measures of improvement of infant mortality as well as neonatal, post-neonatal, and child mortality rates.

State Performance Measure 7 is the percent of California Children's Services (CCS) enrolled children registered in CMS Net, the statewide automated case management and data collection system for CSHCN.

This performance measure addresses coordination of care of the CSHCN population. In the past, each individual county CCS program had its own case management and data tracking system, with different formats, that did not communicate with each other or with State systems. CMS Net was developed to create a common format for case management and data collection. The information stored on CMS Net, about CCS children and authorized health services, is accessible to each county. As counties come into the CMS Net system, coordination of services between counties is improving. Statewide information on the overall CCS program is also becoming available to monitor the health services provided, perform quality assurance, track health outcomes and formulate CCS policy.

Proposed New State Performance Measures

State Performance Measure 8 is the percent of women at least 18 years of age who reported being the victims of intimate partner physical abuse during the past twelve months.

In California, 196,832 incidents of domestic violence were reported to law enforcement, and 56,892 domestic violence arrests were made in 1998. According to population-based data collected in the 1998 CWHS, 6.0 percent of women aged 18 years and older were victims of intimate partner physical abuse in the past twelve months. The violence impacts the family as well as the woman. The CWHS data indicate that about 75 percent of intimate partner physical domestic violence (IPP-DV) victims have children younger than 18 at home compared to 46 percent of the women who are not victims. IPP-DV victims also have a substantially higher proportion of children aged 1 to 5 in their households (47 percent) compared to women who are not victims of IPP-DV (23 percent).

The adoption of this performance measure is based on both the scale of the problem and the level of State commitment to prevention. Since 1994, a number of California laws have been passed to protect and assist women who are victims of intimate partner abuse. The Battered Women's Shelter Program was established in 1994 as a result of legislative action, and funds direct shelter services for abused women and their children and community prevention activities.

Proposed *SPM 8* is directly related to the MCH priority of reducing domestic, family, and community violence. The services provided by the Domestic Violence Section of the MCH Branch are primarily enabling services. They address the risk factors that are associated with the incidence of domestic violence. Existing Federal Outcome Measures do not relate directly to the proposed State Performance Measure but can be indirectly related to infant and child death rates.

State Performance Measure 9 is the percent of 12-17 year olds who report smoking cigarettes in the past thirty days.

California has witnessed marked declines in the rate of smoking among the adult population. Similar gains have not been observed among youth. In 1998, 10.7 percent of youth 12-17 years old reported smoking cigarettes in the past thirty days. Based on data from the California Tobacco Control Section, this percent has shown no significant change over the past five years. Tobacco is the number one preventable cause of death. More than 80 percent of adult smokers had tried smoking by their 18th birthday and more than half had become regular smokers by that time. One of every three of the young people who become regular smokers each day nationally will have their lives shortened from tobacco-related diseases.

A portion of the funds becoming available to the State and counties from the cigarette surtax imposed following the passage of Proposition 10 will be allocated to youth smoking prevention. This State Performance Measure reflects California's commitment to the reduction of youth smoking. It relates directly to the priority need of improving the lifestyles of the State's children and adolescents. Services are population-based and designed to address specific risk factors. Federal Outcome Measures do not relate directly to the problem of youth tobacco.

State Performance Measure 10 is the percent of low-income children who are above the 95th percentile of weight for height, or overweight.

The prevalence of overweight among California's children is higher than the national average and is increasing annually according to data collected in the Pediatric Nutrition Surveillance System³⁴. The California data for this system comes from CHDP. Sedentary lifestyle and dietary habits contribute to the problem. Among the over two million low-income children served in the CHDP program in 1998, 14.1 percent had weights for height above the 95th percentile. This figure has increased gradually from 12.3 percent in 1991. The State's concern with pediatric overweight relates to the association of childhood weight problems with adult overweight and obesity, and the increased risk of a number of chronic diseases, such as high blood pressure, Type II diabetes, stroke and heart disease. In addition, childhood overweight serves as a sentinel event for broader issues of unhealthy lifestyle practices. Population-based interventions to promote optimal child health through regular physical activity and a healthy diet are necessary to prevent pediatric overweight and obesity. Without preventive interventions to address the problems of poor diet and lack of regular physical activity, the observed trend of increasing pediatric obesity and overweight is likely to continue.

State Performance Measure 10 relates directly to the priority need of improving the lifestyles of California's children and youth. Outcome measures do not relate directly to the problem of childhood overweight and obesity.

3.4.2.3 Five Year Performance Objectives

Please see Form 11 for specific information on the Annual Objectives established for each State Performance Measure.

3.4.2.4 Review of State Performance Measures

The State Performance Measures will be reviewed by central and regional staff of the Maternal and Child Health Bureau. Discussions and negotiations will be carried out with State MCH and CMS Branch staff during the application and annual report review session.

3.4.3 Outcome Measures

Please see Form 12 for specific information on the Outcome Measures. Form 16 provides the detail sheet for the State Outcome Measure, maternal mortality.

IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505 (a)(2)(A)]

4.1 Program Activities Related to Performance Measures

The California Department of Health Services utilizes the Title V Grant funds to support a broad range of maternal and child health programs that address the needs of the State's target population of women of childbearing age, infants, children, adolescents, and Children with Special Health Care Needs. Title V programs and activities have been discussed in Section 1.5.1.2., Program Capacity. The programs and activities contribute to meeting the objectives established in the Federal and State Performance measures. Their relationship to the specific measures are described in the following section according to the level of service and population group. The performance measures, outcome measures, and health status indicators that relate to each activity are indicated in parentheses. The relevance of Title V activities to meeting the priorities identified for California are also noted.

◆ *Preventive and Primary Services for Pregnant Women, Mothers, and Infants*

Direct Health Care Services and Enabling Services

Health coverage for prenatal, intrapartum, and infant health care services for low-income women and infants is provided by Medi-Cal, AIM, Healthy Families and CHDP through a network of private and public providers. Family P.A.C.T. provides access to reproductive health services. California's MCH Block Grant activities serve to assure the quality of care in direct medical and enabling services related to reproductive health through a variety of program efforts. Standards for health care services for pregnant women are maintained primarily through CPSP and CDAPP. Quality of care in CHDP services is assured through EPSDT and State program requirements and State program policy.

CDAPP is an outpatient-based multidisciplinary diabetes self-management education program that is intended to reduce mortality and morbidity of women and their infants among the pregnant women in California who have pre-existing diabetes or develop gestational diabetes. Regional CDAP centers train perinatal care providers to deliver these comprehensive services and to establish referral systems to assure appropriate care. CDAPP guidelines for care have been adopted in the State's Diabetes Control Program. CDAPP will continue to work in the managed care environment to promote the adoption of the "Sweet Success" guidelines in health plans statewide (*FOM 1,3,4, 5 and SOM 1*).

The Comprehensive Perinatal Services Program is a four-pronged multidisciplinary approach to perinatal services that has been shown to improve the health of low-income pregnant women and their newborns. Participating Medi-Cal providers conduct comprehensive perinatal risk assessment and appropriate perinatal treatment services in the areas of medical and obstetric care, health education, nutrition services, and psychosocial support to pregnant women prenatally and postpartum. CPSP services are provided by approximately 1,400 Medi-Cal providers in both the fee-for-service and managed care systems. Provider certification and training is conducted by the MCH Branch. These services are primarily enabling (*FPM 15, FOM 1,2,3,4,5, SOM 1, HSI 3, HSI 4A and B, HSI 5A and B, HSI 6A, 6B, 6D*).

The Black Infant Health Program works in partnership with local communities to address the continuing disparity in the infant mortality rate and birth outcomes among Black and white infants. Local MCH programs, under the guidance of the MCH Branch, have developed and implemented a set of integrated intervention strategies that include intensive prenatal care outreach, case-management, health behavior modification, prevention of health risk behaviors, male involvement, social support, and empowerment. The more recent activities have focused on the multiple etiologies of term and pre-term low birthweight infants and the identification of clients who are most at-risk for delivering preterm infants, and providing intensive home visiting (*FPM 15, FOM 2, HSI 4A, 4B, 5A, 5B*).

BIH highlights the critical importance of increasing awareness among community groups, public and private agencies, and health care providers of issues related to African-American pre-term births, low birth-weight, and their relationship to infant mortality. The development of clinical tools such as treatment algorithms for bacterial vaginoses, the identification of high-risk women, and a nurse home visitation component are all parts of effective interventions. In the next few years, there will be a focus on the problem of anemia among African American pregnant women and the expansion of smoking cessation services.

Four American Indian Health projects are supported by MCH to improve the health status of pregnant women and infants. The activities at these sites include intensive case management for high-risk mothers and infants, and education on the benefits of early and continuous prenatal care, and the development of parenting skills. The services are designed and delivered by culturally competent staff (*FPM 15, FOM 1 through 5, HSI 4A, 4B, 5A, 5B*).

The Adolescent Family Life Program (AFLP) provides case management for pregnant and parenting teens to prevent or reduce second pregnancies, improve pregnancy outcomes, and develop parenting skills. AFLP currently serves 16,000 clients in 42 counties each year. AFLP is generally co-located with another case

management program serving teens receiving Temporary Assistance to Needy Families (TANF). While they are in school, these pregnant and parenting adolescents receive services through the Cal-Learn Program, administered by the Department of Social Services. The Adolescent Sibling Pregnancy Prevention Program (ASPPP) is a primary prevention program that provides case management services to almost 7,500 siblings of teens in AFLP and Cal Learn in an effort to reduce the incidence of early pregnancy (FPM 6, FOM 1,3,4,5, HSI 3, 4A, 4B, 5A, 5B).

To combat the serious health threat of domestic violence, the Battered Women's Shelter Program was established in 1994 as a result of legislative action. The program funds direct shelter services for abused women and their children and community prevention activities. The Domestic Violence Section of the MCH Branch provides a spectrum of enabling services to women threatened by domestic violence. The section currently administers 137 grants and supports 85 shelters. There are 27 prevention grants, 15 underserved grants, and 10 statewide technical assistance contracts in local communities throughout California. Domestic violence agencies provide shelter-based services, domestic violence community prevention programs, evaluation, technical assistance and training projects designed to build capacity within organizations and communities to eliminate domestic violence issues. Program goals and objectives are based on "Preventing Domestic Violence: A Blueprint for the 21st Century", a strategic plan developed by the statewide Domestic Violence Advisory Council, which is convened and facilitated by MCH (*SPM9*).

The CHDP program assures low-income infants of health services during the first year of life, through 6 health and screening assessments, carried out between 0 and 12 months of age. If problems are identified, infants are referred for further diagnosis and treatment and CHDP provides access to the needed diagnostic and treatment services, by outreach to programs such as Medi-Cal, Healthy Families, and CCS. CHDP programs are administered through 61 county and local health departments. Based on prior years' numbers, it is estimated that over 500,000 infants (under age 1 year) will receive CHDP services this year. The State funded portion of CHDP will continue to provide health services to infants from families not eligible to, or willing to, enroll in other health care programs. It is anticipated that the program will continue to provide health care to a diverse population of infants. In 1997-98, approximately 350,000 of the infants served were identified as Hispanic, 66,000 as white, 37,000 as black, 21,000 as Asian, 3,000 as Filipino, 1,600 as American Indian, 1,200 as Pacific Islander, and the remainder as other ethnic groups. The CHDP program has direct health care, enabling and population based activities (*FPM 5, 12, 13, SPM 1, FOM 1 through 4, HSI 2A*).

The activities planned will work toward meeting the targets on indicated performance measures, as well as improving outcome measures and health status. They will address California priorities to: eliminate racial and ethnic disparities in infant health, mortality, and the proportion of low birthweight infants; promote safe motherhood; reduce the adolescent birth rate; reduce family and domestic violence; and improve health care and access to health care for infants.

Population-based Services

The reduction of births to adolescents is a priority in California. A variety of publicly-funded programs have been established to reduce adolescent births. The four main components of the Partnership for Responsible Parenting initiative include: 1) community involvement (Community Challenge Grants), 2) male partner involvement (Partnership for Responsible Parenting and Male Involvement Project), 3) mentoring, and 4) prosecution for statutory rape. The MCH Branch participates in these programs by monitoring the number and distribution of teen births and utilizing geographical information system (GIS) techniques to provide maps of teen births by county and census tract. These maps facilitate targeting of teen pregnancy prevention interventions by State, county, and local agencies and organizations (*FPM 6*).

Efforts to increase early and continuous utilization of prenatal care among all pregnant women include population-based outreach and education programs like Baby Cal and the MCH outreach programs. BabyCal is a statewide comprehensive multimedia health education campaign to inform low-income pregnant women about the importance of early prenatal care and the availability of programs like Medi-Cal and the Access for Infants and Mother Program (AIM), that pay for prenatal care. BabyCal combines multilingual advertising, a toll-free information service, community outreach, public relations, collateral marketing materials and special sponsorship efforts to reach California's diverse population. The campaign also emphasizes the importance of healthy behaviors during pregnancy, stressing the dangers of using drugs, alcohol, or tobacco. BabyCal has collaborated with the 16 local Black Infant Health (BIH) programs, placing ads in African American community newspapers. (*FPM 15 and 18, SOM 1, HSI 3, 6C and 6D*)

MCH Outreach programs provide consolidated funding to local health departments to carry out a range of outreach and care coordination activities. These activities include the Title V mandated toll-free telephone line for health information and provider referrals, Medicaid funded outreach for pregnant women and infants, and state-funded tobacco education and referral networks. (*HSI 6D*)

In 1999, the MCH branch consolidated these programs into one program that gives local jurisdictions increased flexibility to design and conduct outreach. Local agencies will be better able to target these activities with the assistance of the Geographic Information System maps produced by the MCH Branch. These maps provide detailed information down to the census tract level on prenatal care access and the adequacy of prenatal care utilization (Kotelchuck Index).

California's population-based statewide prenatal and neonatal screening for the prevention of genetic or congenital disorders or the amelioration of their impact on individuals and families is administered by the Genetic Disease Branch (GDB). GDB conducts two large screening programs, one for newborn screening and the other for prenatal screening. Services include testing and counseling for patients as well as public information and professional education. Genetic screening is a statutorily mandated service available to all women and infants and their families.

In 1998, 98.8 percent of California's newborns received at least one genetic screening. The current testing panel for newborns includes primary screening for phenylketonuria (PKU), hypothyroidism, galactosemia, and hemoglobinopathy. The program follows the infant until a confirmatory diagnosis is received and the infant is treatment is established with a health care provider (*FPM 4, FOM 1, 3,4 and 5*).

The expanded alpha fetoprotein program is a prenatal screening program for the detection of neural tube defects (spina bifida, anencephaly, encephalocele), abdominal wall defects, trisomy 21, 18, 13, and other chromosomal abnormalities. Screenings are optional for the client, but all providers must offer the services. Approximately 70 percent of eligible women participate in this program. Women with positive screening tests are referred to prenatal diagnostic centers under contract with GDB. All follow-up testing and counseling is funded by the program (*SPM 6, FOM 1, 3,4 and 5*).

The California Newborn Hearing Screening Program is already training and approving hospitals for screening of all inborn infants for hearing deficits. There are five geographic tracking regions, for follow-up, support services, and referral of infants for further audiologic evaluation and intervention. Three hearing coordination center contractors have been chosen to service the five geographic regions. When initially implemented in CCS approved hospitals, the NHSP will be screening over 70 percent of the infants born in California. The program will be expanding rapidly over the coming year and should impact on infant development and learning (*FPM10*).

The reduction of the rate of neural tube defects through improved folate consumption is one element of the Title V programs to improve infant health status and reduce disparities across racial and ethnic groups. MCH collaborates with and provides technical assistance to the March of Dimes and related programs in DHS, such as WIC, GDB, the Nutrition Network, as well as other agencies, to provide technical assistance and promote the consumption of folic acid among women of reproductive age. Promotion activities include the development of educational materials in English and Spanish to be used by perinatal service providers, MCH contractors, and managed care providers. The MCH Branch provides technical assistance to local health jurisdictions that are designing folic acid promotion campaigns. The use of folic acid during the intrapartum and prenatal periods as well as knowledge and beliefs regarding use, are monitored through the population-based surveys, the Maternal and Infant Health Assessment and the California Women's Health Survey (*SPM 6, FOM 2 and 5*).

The California SIDS Program assists providers and families through community education, training programs, support services to families when SIDS deaths occur, and data collection and analysis. The SIDS Program has facilitated the SIDS Risk Reduction campaign, also known in California as Back to Sleep. The program has helped reduce the incidence of SIDS by nearly 50 percent. Since 1994, the SIDS rate has declined from 93.2 to 49.7 per 100,000 live births in 1998. The California SIDS Program worked in collaboration with the California Black Infant Health (BIH) Program to develop a SIDS Risk Reduction campaign for the African-American community. This campaign aims to reduce the racial disparity in the postneonatal mortality rate. In addition, the SIDS Program continues to work with the FIMR Program to further our understanding of the causes of SIDS deaths, and to identify areas of the community in need of additional outreach with the SIDS Risk Reduction message (*FOM 1, 2, and 4*).

Increasing the prevalence of breastfeeding is a priority of the Title V agency. Interventions that have been implemented in California focus on increasing public awareness and education, changing hospital practices, and promoting increased collaboration among breastfeeding advocates. MCH and CMS participate with the WIC Branch in State breastfeeding promotion activities, including the Breast Feeding Advisory Group and the Breast Feeding Strategic Planning Committee. MCH and CMS are working to insure the inclusion of up-to-date, accurate breastfeeding materials in all their relevant programs such as the AFLP, CPSP, and CDAPP and CHDP. With the implementation of the Baby Friendly Hospital Initiative, formation of the National Breastfeeding Committee and breastfeeding promotion programs such as the Best Start Breastfeeding Promotion Campaign, public awareness of the benefits of breastfeeding is expected to increase. It is predicted that this will result in increased breastfeeding rates. Breastfeeding surveillance has

been improved through the inclusion of a series of breastfeeding questions on MIHA and the development of data linkages with WIC (*FPM9*).

The CHDP program provides population based activities that will continue in the coming year. These include infant health screenings, immunizations, and preventive counseling and education for care givers. Screening is carried out for anemia at 7-9 months and blood lead screening is required at 12 months of age. Immunizations begin by 2 months of age. Preventive counseling and caregiver education include tobacco smoke exposure, nutrition, and hazards in the infant's environment (*FPM 5, and FOM 1 and 4*).

The program activities planned address State priorities to: decrease the adolescent birth rate; increase breast feeding; eliminate disparities in infant health, mortality and low birthweight; and decrease injury death rates among children (infants).

Infrastructure Services

In California, the State MCH Branch supports local health departments to carry out the core public health functions of assessment, policy development, and assurance to improve the health of their MCH populations in accordance with Title V requirements. At the local level, the MCH services are provided by local MCH Programs under the direction of public health professionals and in concert with community agencies, in all 58 counties and three cities which have their own local health departments. The local MCH Programs are central to assuring the populations' access to quality health care services for pregnant women and children, preventive and primary care services for children and adolescents, and family-centered, community-based comprehensive health care services to children with special health care needs. As noted in Section 3.1.1., the preparation of local needs assessments by each of the jurisdictions was an essential component of the statewide needs assessment. The local jurisdictions work with Title V-supported programs and technical staff such as the California Center for Injury Prevention and with the MCH dental consultant to develop local responses to priority health needs.

MCH supports capacity building of the local infrastructure through Title V activities to enhance the data analysis and planning capability of the local MCH Programs. The MCH Branch contracts with the UCSF Family Outcomes Project (FHOP) to provide consultation and training to MCH Directors and their staff at local health jurisdictions. Assistance is offered in the following areas: monitoring and updating of their local five year plan, data-related planning issues such as data collection, identification of data sources, data analysis and survey development.

California maintains an infrastructure to provide access to quality maternal health services to all pregnant women. Title V programs support this infrastructure. The Regional Perinatal Programs seek to improve the quality of risk-appropriate perinatal care through regional coordination. There are currently fourteen regional programs that provide statewide coverage; twelve receive Title V funds. The RPPC activities include: performing statewide perinatal assessments; leading local perinatal advisory councils; publishing a statewide newsletter; providing resource directories, provider education; and consultation on quality assurance standards and protocols (*FPM 17 and 18, FOM 1 through 5, and SOM 1*).

The Regional Perinatal Dispatch Centers coordinate transport of pregnant women and ill neonates, to centers that provide varying levels of intensive care. The dispatch centers also track the types of transports, frequency and location of services. This allows an overview of maternal and infant problems necessitating higher levels of care and the patterns of flow of health care requiring movement away from local facilities. (*FPM 17, FOM 1 through 5, and SOM 1*).

The California Perinatal Quality Care Collaborative (CPQCC) is a new partnership for the RPPC. CPQCC was implemented by the California Association of Neonatologists and others to improve the quality and outcomes of perinatal health care in California. The Collaborative consists of participants from the public and private obstetric and neonatal provider communities, health care purchasers, public health professionals, business groups, MCH and CMS. CPQCC fosters the development of an effective quality improvement infrastructure at state, regional, and hospital levels. Data will be reviewed as quality assurance for CCS approval, to recommend quality improvement objectives, and to assist providers in transforming data into information that will improve care for high-risk neonates (*FOM 1 through 5, and HSI 6B*).

The Improved Perinatal Outcome Data Report provides information on perinatal risk factors, services, and outcomes at the state and local levels, to improve services and outcomes for women and infants. IPODR provides information for health planning, resource allocation decisions, and program evaluations. To facilitate data analysis, training, consultations and special reports are available. Providing data at the zip code level and in an interactive software program enable the user to conduct statistical analyses at the local level and to conduct small area analyses combining sociodemographic data with information on neonatal and infant health outcomes and health care resources (*FPM 17 and 18, FOM 1 through 5, SOM 1, and HSI 3 through 6D*).

Since 1991, the California Fetal and Infant Mortality Review program has contributed to the improvement of the health care system and community infrastructure. In 21 counties, FIMR groups have used a standardized infant death review system to identify, evaluate, and determine potential factors that will improve the delivery of services to women and children. The cases of fetal, neonatal, or postneonatal death that are selected for review, are reviewed by both a multidisciplinary technical review panel and a community panel to attempt to identify underlying factors or systems issues that may have contributed to the loss. A family interview is conducted for each case. Both panels are also charged with recommending and implementing interventions to prevent future deaths from the identified problems. An important component of these reviews is the involvement of community members and service providers other than those in the medical community, e.g., social services, alcohol and drug, or law enforcement. The data are analyzed at both the local and state levels to define gaps in services or knowledge, to identify systems issues, to support system change, and to evaluate program effectiveness (*FPM 17 and 18, FOM 1 through 5, SOM 1, and HSI 3 through 6D*).

Other ongoing efforts to promote access to high quality prenatal care services through infrastructure development include the collaboration of MCH with Medi-Cal managed care programs and contracted health care plans to develop and evaluate systems of comprehensive perinatal care. MCH provides support and technical assistance to training programs for Certified Nurse Midwives and Advanced Nurse Practitioners to address the needs of underserved areas of the state.

The MCH Branch is responsible for the collection and analysis of data for the monitoring, surveillance and assessment of the health status and health risks of women of childbearing age, infants, children, and adolescents. By working in collaboration with staff throughout state government, the Branch analyzes the available data to assess the adequacy of health services utilization, the distribution of health risks, and health outcomes of the MCH population. Data is also provided in response to requests from local MCH programs (*HSI 8*).

Several collaborative projects have been undertaken to improve the quality of perinatal care. The small area analyses of the adequacy of prenatal care use, the incidence of teen births, and most recently, the rate of LBW, through mapping of geographical information are examples of State and local MCH staff collaboration in needs assessment and program planning. Collaboration for data collection and analysis with other sections of DHS include all primary care and family health programs including WIC, EPSDT, Lead Screening, and Genetics.

The Maternal and Infant Health Assessment (MIHA) is an ongoing, statewide representative survey of mothers and infants in California, designed to provide information to guide health policies and programs for women,

children, and families in California. MIHA was developed by the MCH Branch in collaboration with researchers at the University of California at San Francisco and Berkeley. The primary objectives of MIHA are: 1) to monitor progress toward decreasing modifiable risk factors for adverse maternal and infant health outcomes during the periods immediately prior to and during pregnancy, and during early infancy; 2) to analyze relationships between selected behaviors and conditions in the perinatal period and pregnancy outcomes; and 3) to serve as an information resource for the development, targeting, implementation, and monitoring of intervention programs funded by the MCH Branch and other programs of the Department of Health Services (*HSI 8*).

Data analyses in the CMS Branch are also providing information for monitoring, quality assurance, planning and policy development, with respect to infant health. The large amount of data available through the CHDP program tracks services rendered, population groups served, and infant health characteristics, on a Statewide and county level. Growth patterns, immunizations, screening tests and referral for further diagnostic workup and treatment are documented (*FPM 5, SPM 1, FOM 1 through 4, and HSI 2A*).

Annual data is also submitted by CCS approved nurseries on infants requiring intensive care at the intermediate and higher levels. Combined with vital statistics information, this provides an overview of infant health and morbidity, not just mortality. The CPQCC will also begin coordinating submission of data from its participating nurseries, with CCS data reporting this year. (*FPM 17, FOM 1 through 5, HSI 4A, 4B, 5A, 5B, 6A and 6 B*).

The planned infrastructure activities that are described above will impact on California priorities to: eliminate racial and ethnic disparities in infant health, mortality and proportion of LBW; promote safe motherhood; and improve access to quality providers for infants.

The following priority activities are planned to promote the health of pregnant women, mothers, and infants by addressing the issues and problems identified in this application/report. They focus on reducing the racial and ethnic disparities in infant health status, the promotion of safe motherhood and infant breastfeeding. Equally important are improving access to high quality health services among pregnant women, mothers, and infants, and reducing the prevalence of domestic violence.

- ◆ Special projects to reach the populations of women at highest risk of delivering a LBW or VLBW infant. These populations include African American women and adolescents.

- ◆ Outreach and education to reduce perinatal exposure to tobacco, including risk assessment and referral to smoking cessation programs.
- ◆ Continued activities to further reduce the teen birth rate.
- ◆ Continued support to domestic violence shelters and other enabling services for victims of domestic violence, including prevention programs.
- ◆ Promotion of risk-based care to address the complications of pregnancies, including diabetes.
- ◆ Perinatal quality improvement programs.
- ◆ Expansion of breastfeeding promotion activities through increased collaboration with other programs.
- ◆ Implementation of the Newborn Hearing Screening Program.
- ◆ Continued activities to assure provision of quality health care to infants and pregnant women.
- ◆ Outreach activities to achieve access to health care and health care coverage for infants.
- ◆ Continuing assessment of Title V programs, through data tracking and analysis.
- ◆ *Preventive and Primary Services for Children*

Direct Health Care Services

The CHDP program provides basic health services, to low income children from age 1 up to age 19 years (State funded component) or up to age 21 years (with Medi-Cal funded coverage). Nine childhood health assessments are assured. Physical examinations are performed, growth and development are evaluated, immunizations given and screenings for problems such as T.B., blood lead levels, and anemia are carried out. If problems are identified, children are referred for further diagnosis and treatment. Outreach for Medi-Cal, Healthy Families and CCS is done, to provide coverage for needed services. Preventive counseling and anticipatory intervention is an integral part of CHDP. This includes tobacco and drug avoidance, healthy life

habits, safety concerns and risk behaviors, and early recognition of symptoms of disease (eg. asthma). Based on numbers of children in the CHDP program in prior years, it is estimated that approximately 1.7 million children will receive CHDP services this year. It is anticipated that the population of children in CHDP will continue to represent the diverse ethnic groups in California. In 1997-98, approximately 1 million children participating in CHDP were identified as Hispanic, 190,000 as white, 130,000 as black, 87,000 as Asian, 8,900 as Filipino, 5,600 as American Indian, 3,500 as Pacific Islander, and the remainder as other ethnic groups. The CHDP program for children has direct health care, enabling and population based activities (*FPM 5, 6, 8, 12, 13 and 16, SPM 1, 3, 4, and 5, FOM 6, and HSI 1*).

The Medi-Cal program is the largest single payer of medical and dental services to children in California. It funds primary, preventive, and urgent care services through managed care and fee-for-service systems. Healthy Families further expands children's financial access to health services by extending medical, dental, and vision insurance coverage to those children and youth living in households with incomes up to 250 percent of the FPL. The impact on access to dental services is suggested by the reported statistics from Delta Dental, which has contracted with the state to provide dental care to 187,000 children in HFP, indicating that 80 percent of the enrolled children visited a participating dentist at least once after enrollment. To begin to address the problem of limited provider participation in Denti-Cal, the dental benefit program under Medi-Cal, the proposed state budget requests a 6.8 percent rate increase for Denti-Cal services. California's FY2000-2001 budget includes increased funding for benefits for families and children, including Medi-Cal, Healthy Families, AIM, and outreach to families and children. Proposed changes to the eligibility process should facilitate expanded and continuous enrollment in the Medi-Cal and Healthy Families programs (*FPM7 and 13*).

The direct health care activities planned for the coming year will address State Title V priorities to: improve access to quality care providers, including dental, for children; promote health lifestyle practices among children and adolescents; and decrease injury death rates among children and adolescents.

Enabling Services

Enabling services provided by DHS are central to the expansion of child health insurance coverage. Outreach efforts build on the State's experience with public media campaigns and draw on the capacity of community-based and other local organizations to reach California's diverse population with culturally appropriate messages. California's budget for FY2000-2001 includes significant resources to support media efforts to reach the families of HFP eligible children. The Title V agency collaborates in these outreach efforts at both the State and local levels. The MCH Branch's School Health Connections initiated the Healthy Families/Medi-Cal

for Children School Outreach Efforts with support from the David and Lucille Packard Foundation. Working through school lunch program directors and school district superintendents, SHC has collaborated with the Department of Education to expand outreach to the families of HFP eligible children (*FPM 12*).

The CHDP program serves as a major outreach component for enrollment in Medi-Cal and Healthy Families. 54 percent of children in CHDP were Medi-Cal beneficiaries in 1997-98. CHDP program activities are based in county and local health departments and coordinate with school based health requirements (eg. report of health examination prior to school entry) (*FPM 12*).

These planned activities impact on California's priority for improving access to primary and specialty providers for children.

Population-based Services

The CHDP program provides screenings on a defined periodicity schedule that include nutritional status and weight/ht, blood pressure, vision and hearing, anemia, T.B., urinalysis, and blood lead levels. Additional screenings are carried out on subgroups of children, as warranted by history and the health assessment. For example, in 1997-98, approximately 2,500 children and adolescents were screened for sickle cell disease, 5,300 for chlamydia, and 7,500 for ova and parasites.

CHDP visits include preventive counseling on health habits and risk behaviors, in areas such as nutrition, safety and substance abuse. CHDP will also be an active participant in childhood obesity control efforts being planned in California by the WIC program. CHDP immunization efforts will continue in the coming year, as will CHDP participation in the Federal GPRA immunization improvement program, which is being coordinated in California by Medi-Cal. (*FPM 5, 8, 13, and 16, SPM 1, 3, 4, and 5, proposed SPM 8 and 10, and FOM 6*).

Screening for lead poisoning and measurement of blood lead levels in low-income children served by CHDP will receive increased attention in the coming year. Because of concerns that low income children with elevated lead levels are not being detected and treated, CHDP has issued a new blood lead screening policy, in conjunction with the Childhood Lead Poisoning Prevention Program. The goal is to have blood lead levels measured in all CHDP children at one and two years of age.

The Children's Asthma Program is being developed to increase medical and community awareness about asthma in young children, 0-5 years. By increasing identification of asthma and timely intervention, asthma

hospitalizations and morbidity should be reduced. CHDP medical providers will be among those targeted for education about asthma (*HSI 1*).

Preventive oral health care is a basic component of primary care. Access to dental sealants provides one indication of access to preventive dental services. California strives to improve the oral health of its Title V population through a variety of strategies. One strategy focuses on improving access to dental services. In FFY 1997-98, the CHDP program conducted over 2 million dental assessments on 1.9 million children. CHDP includes dental health assessments in each of fifteen health assessments. Anticipatory guidance is provided regarding feeding, mouth, tooth, and gum care during these visits. In addition, CCS assures payment for and case manages dental services for children with a number of health conditions. Denti-Cal provides dental prophylaxis and treatment, including dental sealants, for Medicaid eligible children. The Healthy Families Program will also improve access to dental services by extending dental health care coverage to children in households with incomes up to 250 percent of FPL who are not eligible for Medi-Cal (*FPM 7*).

A second strategy involves improved coordination among agencies and programs working to improve the oral health of California's children. The MCH Branch coordinates the California Department of Health Services Dental Workgroup for the purpose of improving the coordination of oral health activities within maternal and child health programs. In line with this goal, the MCH Branch is incorporating dental health messages into the guidelines and/or curricula of its many prenatal programs, such the Black Infant Health, Comprehensive Perinatal Services, and Adolescent Family Life programs. The Title V agency collaborates with the Medi-Cal Managed Care Division, the Office of Medi-Cal Dental Services (OMDS), and CMS to support contracting health plans to carry out their responsibility to routinely refer to a dentist and counsel children and their parents on age-appropriate preventive dental care. DHS administers the Children's Dental Disease Prevention Program which serves approximately 300,000 high-risk children in preschool through sixth grade. The program provides daily fluoride supplements, plaque control activities, and oral health education. Technical assistance is provided to local MCH programs interested in developing a dental health intervention.

A third strategy involves raising the profile of the oral health needs of California's children. The Dental Health Initiative has played a key role in this area with the publication of the report "Oral Health of California's Children: Halting the Neglected Epidemic". The purpose of the report is to heighten awareness of the "hidden epidemic" of dental disease in California and identify strategies for improving oral health. The MCH Branch is a member of the Children's Dental Health Initiative Advisory Committee.

Population-based services have been developed to address the problem of child and adolescent injury-related deaths in relation to the problem of motor vehicle-related injury deaths, the MCH Branch works with the Department of Transportation (DOT), the Office of Traffic Safety, and WIC to implement the National Highway Traffic Safety Administration Safe Communities Initiative, to support efforts to reduce fatalities in three rural counties, and to provide technical assistance on passenger safety restraints, and bicycle helmet use. Title V funds support the California Childhood Injury Prevention Program (CIPP) which aims to prevent intentional and unintentional injuries among California's youth through increasing public awareness of the magnitude and preventable nature of injuries, coalition development at the local, state, and regional levels to develop interventions, and organization of the Annual Statewide Injury Prevention Conference. CIPP provides technical assistance to local MCH programs in the development of interventions addressing injury-related problems identified at the local level. CCIPP works with the Epidemiology and Prevention for Injury

Control Branch (EPIC) to develop policy and guidance for Medi-Cal managed care plans in relation to assessment and counseling for youth at risk of motor-vehicle occupants injuries and deaths. The adoption of the graduated licensing program for teens will also further adolescent road safety (*FPM 8, SPM 4, and FOM 6, DHSI 2B, and 2C*).

MCH works with EPIC, the Office of Criminal Justice, the Attorney General, community-based organizations and others to explore youth homicide prevention efforts. EPIC is participating in an effort called "Shifting the Focus" that is designed to better coordinate youth violence prevention efforts among the participating partners and to create a unified vision and strategy to address youth violence in California. Current participants are EPIC for DHS, the Attorney General's Crime and Violence Prevention Office, the Department of Education, the Health and Human Services Agency, the Department of Mental Health, the Youth Authority, Alcohol and Drug Programs and Prevention Institute (a nonprofit organization with a history of working in violence prevention) (*SPM 4, and FOM 6*).

The prevention of pool drownings among children 1-4 years of age has also been addressed through population-based services. Working with CIPP and local coalitions, MCH has increased public awareness of the hazards of unprotected swimming pools and promoted legislation to require fencing around swimming pools. CIPP strategies include the development of coalitions, public awareness promotion, training of professionals and the public, and the development of locally appropriate injury prevention and control programs (*SPM3 and FOM6, DHSI 1A and 2A*).

California now has some of the most stringent gun control laws in the nation. California law restricts the types of weapons that individuals can purchase, requires background checks of gun purchasers (including waiting periods), and requires citizens wishing to carry concealed weapons to obtain permits to do so. Following a series of school homicides across the nation, California school districts have also begun to implement programs to enhance school safety through a variety of strategies ranging from conflict resolution training to increased collaboration with local police departments (*SPM4 and FOM6*).

An assets-based approach to adolescent-focused programs can also provide a long-term strategy for homicide prevention by building on youth's existing resources to develop the skills to negotiate and mediate conflicts. The MCH Branch will be reviewing its programs to incorporate more of a strengths-based, resource development perspective to its adolescent programs (*SPM4*).

To foster collaboration and develop strategies for adolescent suicide prevention, MCH has convened a work group called CLASP (California Liaisons for Adolescent Suicide Prevention). Participants include representatives of MCH and EPIC within DHS, the Department of Education, the Department of Mental Health and the California Center for Childhood Injury Prevention at San Diego State University. CLASP members also participate in SPAN-CA a newly formed California Chapter of National SPAN (Suicide Prevention and Advocacy Network) that is looking at ways to prevent suicide and support survivors (*FPM16, FOM6*).

Infrastructure Building Services

Title V support to the local MCH infrastructure at the county and municipal level is essential for the assessment, planning, monitoring, and quality assurance functions at the local level for children and adolescents. In coalition building for injury prevention, outreach for child health insurance coverage, as well as prenatal care outreach, the local MCH programs have played a central role in program development and implementation.

The county and local CHDP programs carry out a number of infrastructure activities. These include assessment of provider qualifications, review of CHDP services provided in their jurisdiction, provider training and education, and outreach activities for health coverage programs. They participate with CMS in statewide planning and policy development for CHDP. CMS provides statewide coordination of CHDP services and review of local programs. A CMS and local CHDP effort to look at provider standards is anticipated in the coming year (*FPM 12 and 13*).

The data analysis and tracking functions of CHDP are important for monitoring health services provided to children, quality assurance, planning and policy development. Data is supplied to individual CHDP programs, to help in their monitoring and quality assessment functions. CHDP information will remain part of ongoing Title V assessment activities and continued improvement in the CHDP database is a CMS goal (information particularly relevant to *FPM 13, SPM 1 and HSI 2A*)

School Health Connections was initiated in recognition of the fact that schools provide an extensive infrastructure through which to expand health promotion and prevention activities. To address the health of children and youth in a more coordinated and comprehensive manner, the California Department of Education (CDE) and the California Department of Health Services collaborated to develop the infrastructure to support coordinated school health. The process was funded by a grant from the Centers for Disease Control and Prevention, CDE and DHS. Working with a statewide planning body, SHC produced the report, “Building Infrastructure for Coordinated School Health: California’s Blueprint”, which identified the goals and actions required for coordinated school health. Increased collaboration among DHS, DOE and other state and local agencies was among the recommendations along with policy development to address school health programs. Schools also serve as a portal for assessment of health insurance coverage, immunization coverage, and health status (*FPM5 and 12, SPM 1*).

Adolescent health issues are a growing concern at the State and local level. The need for a comprehensive plan for addressing the health and developmental needs of California’s adolescents was identified by the Adolescent Health Collaborative, a broad-based, statewide group with representatives of the public and private sectors. In response to this need, the California MCH Branch contracted with staff of the National Adolescent Health Information Center of the University of California at San Francisco, to develop a strategic plan. The document provides background information and recommendations for future directions for the adolescent health programs in California. The recommendations focus on the assets and needs of adolescents. The plan is being reviewed by the MCH Branch in order to identify strategies for strengthening its programs to improve adolescent health services particularly through the incorporation of an assets-based approach to health promotion (*FPM 16, SPM 4 and 5, FOM 6, DHSI 1C, 2C 3A and 5*).

The infrastructure building program activities planned for the coming year and described above address the Title V priorities of improving access to comprehensive high quality primary and specialty services for all children and the promotion of healthy lifestyle practices.

The following priority activities are planned to address the issues and problems identified above for children:

- ◆ Collaboration with MRMIB, Medi-Cal, WIC, and other State agencies to implement the outreach and other enabling components of the Healthy Families initiative, to provide comprehensive health care services, including dental care, to an expanding target population.
- ◆ Continue to assure provision of quality health services to children
- ◆ Promote the integration of oral health activities in MCH programs at State and local levels.
- ◆ Collaboration, education, and coordination activities to decrease the rates of child and adolescent injury mortality and morbidity, specifically in the area of motor vehicle injuries, pool drowning, homicide, and suicide.
- ◆ Promote healthy lifestyle practices among California's children and youth, with a focus on regular physical activity and diet, through preventive counseling and other health promotion activities.
- ◆ Collaboration with the Immunization Branch, Vaccines for Children, and others to increase the rate of age-appropriate immunizations.
- ◆ Collaboration with the Childhood Lead Poisoning Prevention Program to facilitate a targeted, screening program to detect lead poisoning.
- ◆ Continue to improve data collection and analysis to aid planning and program development on child health issues.
- ◆ *Preventive and Primary Care Services for Children with Special Health Care Needs*

Direct Health Care Services

In the coming year, CCS will continue its direct health care activities. The CCS program covers provision of direct health care services, through approved providers, for almost all serious medical conditions of a physical nature which can be cured, improved, or stabilized. Medical eligibility includes conditions such as: birth defects; chronic illness; genetic diseases; physically handicapping conditions (which are present at birth or develop later). Infants requiring neonatal intensive care are a major category of CCS beneficiaries. Modified eligibility criteria were developed last year and will soon be released, after revision based on public comment. (*FPM 2, FOM 1 through 5, and HSI 6B*)

The CCS program case manages the care of CCS-eligible Medi-Cal beneficiaries and CCS eligible children participating in Healthy Families. CCS also case manages and pays for CCS-eligible specialty and sub-specialty services for non-Medi-Cal, non-Healthy Families children whose annual family income is less than \$40,000, or whose projected medical expenses exceed 20 percent of the family income. With expansion of

financial eligibility for the Healthy Families program this past year (to 250 percent of FPL), CCS broadened its financial eligibility to include all children enrolled in Healthy Families, regardless of absolute family income, since some families at 250 percent of FPL may exceed incomes of \$40,000. Many children with CCS-eligible conditions meet the criteria for SSI and receive Medi-Cal through this eligibility pathway. CCS also refers children, who meet eligibility requirements, to Medi-Cal and Healthy Families for health care coverage (*FPM 1 and 11*).

The CCS Medical Therapy Program directly provides physical and occupational therapy services, to children with CCS eligible conditions. There is no financial eligibility requirement (*FPM 2*).

Additional direct health care services are provided for children enrolled in the Genetically Handicapped Persons Program (GHPP). GHPP is administered by CCS for clients with specified genetic diseases, including cystic fibrosis and neurologic and metabolic diseases. GHPP eligible services are case managed and paid for through the GHPP program for children under the age of 21 whose families are not financially eligible for CCS (*FPM 2*).

Through the neonatal intensive care unit (NICU) hospital based infant follow-up program, CCS offers assessments and evaluations for infants who are discharged from a CCS-approved NICU and are at risk for developing a CCS-eligible condition. Three assessments are provided over the first two years of life and include a comprehensive history and physical examination, developmental testing, family psychosocial assessments, and ophthalmologic and audiologic evaluations. If a child is diagnosed with a CCS-eligible medical condition, he/she is then enrolled in the treatment and case management part of the CCS program, if other eligibility criteria are met. If the child is identified as having a developmental disability, he or she is referred to the Early Start Program,IDEA, Part C (formerly part H). (*FPM 2*)

The direct health care activities planned for the coming year address priorities to: improve access to quality primary and specialty care providers for children with special health care needs; and to improve coordination with other health programs in facilitating delivery of health care services to CSHCN.

Enabling Services

CCS will continue to assure access to diagnosis for children suspected of having CCS eligible conditions and treatment for those identified with eligible conditions. Children are referred to CCS from medical providers and programs such as CHDP. Children found to have elevated blood lead levels, for example, would be referred

from CHDP and the number of these children is expected to increase in the coming year, with the focus on blood lead testing (*FOM 1,4 and 6*).

Enabling Services for CSHCN will continue to include case management of the eligible condition for CCS and GHPP enrolled children. The medical, nutritional, psychosocial, and dental needs of CSHCN are complex. Appropriate specialty referral will continue to ensure that CSHCN have access to multidisciplinary, coordinated evaluation and treatment services from specialists with documented pediatric expertise in a tertiary Special Care Center (*FPM 2*).

With streamlining of health care, continued availability of appropriate providers for CSHCN has become a concern. The 1999-2000 State budget acknowledged this issue and, for the first time, included a differential in payment. Payment rates for physicians providing care to CSHCN were increased 5 percent, over Medi-Cal rates. An additional payment increase of 39 percent for CCS authorized medical services was just included in the 2000-2001 State budget.

The individual, time consuming attention required by CSHCN from their primary medical care giver, may make it difficult to find and establish a medical home. CMS will continue to participate in programs that are helping to define what constitutes a medical home for CSHCN and to encourage providers to assume this role. Through case management activities CCS, will also continue to increase the number of CSHCN who have a medical home (*FPM 3*).

The new Medically Vulnerable Infant Program for children up to age 3 years will provide referral of CSHCN to CCS. The program, which targets categories of children who have required neonatal intensive care, will provide family support services, caregiver education, health care assessments, coordination with other programs and home based visits (*FPM 14, FOM 1,2,4 and 6*).

The enabling programs described address Title V priorities to: improve access to quality primary and specialty care providers, including dental, for children with special health care needs; and to improve coordination and outreach with other health programs to facilitate delivery of health care services to CSHCN.

Population-Based Services

Screening programs carried out through CHDP and assessments in the MVIP and hospital based infant programs will continue. Children who are identified with special health care needs will be referred to CCS. (*FOM 1,2,4 and 6*).

The HIV Children's Program will continue to screen infants and children at risk for HIV, This program is paid for by CCS and children documented with HIV infection become eligible for CCS case management and health services (*FOM 1,2,4, and 6*).

Infants cared for in CCS approved intensive care nurseries are required to have hearing screening performed before discharge. Infants with abnormalities on screening are referred for further diagnostic evaluation. An identified hearing deficit is a CCS eligible condition (*FPM 10*).

These population-based activities address the State priority to improve outreach to facilitate delivery of health care services to CSHCN.

Infrastructure Building Services

To ensure that CSHCN have access to evaluation and treatment by appropriate specialists and facilities, CCS reviews and approves specialist health care providers, hospitals providing special services, and inpatient and outpatient tertiary Specialty Care Centers. Revised standards for hospitals and Neonatal and Pediatric Intensive Care Centers were issued in 1999. Facility reviews, based on the new standards, are being planned (*FPM 17, and FOM 1 through 6*).

CMS and MCH participate in the CPQCC project, which is developing a hospital specific database with information from participating intensive care nurseries. This will complement data from other sources on the youngest patients with special health care needs and will lead to improved case management and quality improvement (*FOM 1 through 5, and HSI 6B*).

Collection and analysis of data on CSHCN is of particular importance to the infrastructure building capacity of the CCS program and will continue in the coming year. The ongoing development and implementation of CMS Net is allowing the CMS Branch to monitor and analyze aggregate data on the CCS population and to determine issues, such as the number of CSHCN with a source of insurance or with a medical home. The CMS Branch will track health service provisions and health outcomes for CSHCN through CMS Net and will use the information to provide a basis for programmatic and health policy development (*FPM 3, 11, and SPM 7* and is also related to *HSI 8* which focuses on other aspects of data capacity)

Parent participation in program and policy activities will continue to be encouraged. CMS collaborates with parent representatives and diverse parent groups through the Interagency Coordinating Council for Early Start

and State trainings on family centered care. Parents of CSHCN have been included in the Title V Needs Assessment and other planning activities (*FPM 14*).

The relationship between the CMS branch and the University of Southern California University Affiliated program (UAP) will also continue. The UAP oversees "California Connections", one of 24 National Maternal and Child Health Improvement Projects funded by the Federal MCHB. The goal of the project is to train primary care providers serving CSHCN in the areas of nutrition, oral health, family support and mental health. California Connections addresses the key elements of a community system- community based, family centered, culturally competent, and coordinated and comprehensive care. Staff from CMS, that include nutrition, dental, social work, and parent consultants, meet with the UAP to provide technical assistance.

The CMS branch will also continue other special project activities. An example is the coordination of the transition of adolescents with special health care needs into adult care.

The described infrastructure activities will address priorities to: improve access to quality specialty care providers, for CSHCN; improve coordination with other health programs to facilitate delivery of health care services to CSHCN; and will improve tracking and monitoring services and outcomes for CSHCN, by expansion of CMS Net.

In summary, the following priority activities are planned to address the issues and problems identified for CSHCN:

- ◆ Continue to assure access to specialty health care for CSHCN.
- ◆ Maintain and improve collaborative efforts with Medi-Cal and Healthy Families to assure referral of CSHCN to CCS for case management and coordination of care.
- ◆ Improve outreach, case finding and referral of CSHCN to CCS through individual medical providers and health care programs, such as CHDP, HIV Children's program, MVIP, and infant follow-up programs.
- ◆ Better define and establish the medical home for CSHCN.
- ◆ Continue to assure quality of care for CSHCN by developing and maintaining standards for CCS approved providers, hospitals, and Special Care Centers.
- ◆ Continue to implement CMS Net, the statewide automated case management and data collection system

for CCS, to increase data assessment and analysis capabilities for issues impacting CSHCN.

- ◆ Promote data collection and analysis for neonatal intensive care patients and participate in quality improvement initiatives for this population.

4.2 Other Program Activities

The CMS Branch maintains collaborative relationships with many organizations at the State and local level, in both public and private sectors to improve the health care services for CSHCN. Three of the Branch's most significant collaborative efforts include:

Department of Developmental Services (DDS)

Early Start: The State CCS program and Medi-Cal provide a range of medically necessary services that fulfill the early intervention needs of eligible infants and toddlers served by the Early Start Program. The CMS Branch plays an important collaborative role, on behalf of DHS, in the planning, management, and delivery of services to these children. Through a CMS Branch liaison, a position partially funded through an interagency agreement with the DDS, and CMS physician participation on the Interagency Coordinating Council and Health Services Committee, the CMS Branch maintains ongoing communication with the lead agency (DDS), the Department of Education, regional centers, local education agencies, community-based organizations, advocates, parents, families, and other interested parties involved with early intervention. CCS and Regional Centers serving children with developmental disabilities share many of the same children. Collaboration is required to assure continuity and non-duplication of services.

California Department of Education (CDE)

Medical Therapy Services: The CCS program has been collaborating and negotiating with the Departments of Education and Mental Health to promulgate interagency regulations defining respective responsibilities in delivering medical therapy services to students eligible for special education. These regulations require changes in how the CCS program reviews requests for occupational and physical therapy services identified in a child's Individual Educational Plan. A new Memorandum of Agreement has been written for cooperation between CCS (DHS) and the CDE and is ready for final approval by the DHS Director.

Department of Social Service (DSS)

Children in foster care: California has been selected by the National Academy for State Health Policy as one of five states to improve the health services for children in foster care through collaboration with the Departments of Social Services and Mental Health. Children in foster care setting often do not receive necessary health care evaluations and services. These high-risk children often have been abused and/or neglected and may have significant medical, mental, and dental problems. When appropriate medical evaluations are not performed, serious health problems are not identified or treated. To resolve this problem, the CMS Branch, in conjunction with DSS, worked with the County of San Francisco Health Department and University of California Los Angeles (UCLA), School of Public Health, to develop health care guidelines for children in foster care. These activities served as the basis for the new Health Care Program for Children in

Foster Care. As part of this program, monies received by DSS have been transferred to CHDP, for funding of public health nurseries to coordinate and oversee delivery of appropriate health services to children in foster care.

The CMS and MCH Branches maintain working relationships for ongoing program operations with numerous organizations. Among the many linkages, the following are examples of interagency activities, which will be occurring in FY2000-2001.

DHS, Office of AIDS

HIV Children's Program: The CCS program provides funding to screen children at risk for HIV infection. Children under the age of 21 at risk for, or suspected of having, HIV infection are eligible for screening, diagnostic evaluation and/or medical monitoring, and follow-up through the HIV Children's Program. Children enrolled in the HIV Children's Program are eligible for Infectious Disease/ Immunology Centers services, which include direct services by medical and allied health professionals. Services have been provided to over 10,000 children since inception of this program. Children with documented HIV infections are transferred to the CCS program for treatment. CCS approves special care center services for infants, children, and adolescents in counties without CCS funded HIV coordinators and oversees budget proposals for HIV Children's Program services for counties electing to submit budget requests.

DHS, Childhood Lead Poisoning Prevention (CLPP) Branch

Lead Poisoning Prevention: Lead poisoning causes irreversible damage to the developing brains and organ systems of young children. The CMS Branch, through its CHDP program, provides lead screenings for children. CCS covers the cost of the evaluation and treatment of serious lead poisoning cases. Because of concerns about inadequate identification of low income children with lead poisoning, CHDP and CLPP have developed a new approach to lead screening that considers all low income children to be at risk and requires blood lead screening in this population. CHDP and CLPP have just issued a joint policy letter that has been sent to all CHDP providers.

DHS, Immunization (IZ) Branch

Childhood immunizations: The CMS Branch actively collaborates with the Immunization Branch and its Vaccines For Children program by providing vaccinations through the CHDP program.

DHS, Medi-Cal Managed Care Division (MMCD)

GPRA immunization project and encounter data: The CMS Branch is collaborating with MMCD on measurement of immunization rates in the Medi-Cal population and on improvement in immunization rates. Combined activities to increase and improve reporting of EPSDT services are also underway.

DHS, Genetic Disease Branch

Newborn Screening Program: CCS provides services for conditions identified on newborn screening tests. CCS also develops standards for and approves Special Metabolic and Endocrine Centers, where these children are treated. The MCH Branch is working with GDB on a campaign to educate women about pre-pregnancy folate use.

DHS, Birth Defects Monitoring Program

Birth defects: The CMS Branch and the Birth Defects Monitoring Program share some mutual target populations. CMS continues to collaborate with Birth Defects Monitoring, particularly in the area of cerebral palsy.

California District of the American Academy of Pediatrics (AAP)

The CMS Branch continues to coordinate efforts with experts from the AAP on the “medical home” issue for CSHCN. The program will develop guidelines for local CCS programs regarding the definition of a “medical home” and authorization of pediatricians and other primary care providers to provide these services. The AAP has also been actively involved in planning the Newborn Hearing Screening Program.

California Association of Neonatologists and University of California Berkeley School of Public Health

The CMS and MCH Branches are working with these groups on a perinatal and neonatal morbidity and mortality reporting system that will provide valuable information regarding quality of care and serve as a basis for quality improvement in participating hospitals (CPQCC).

California Medical Association and California Health Care Association

The CMS Branch continues to interact with these two groups on issues concerning providers for CSHCN and on services provided through CHDP.

County Health Executives Association of California and California Conference of Local Health Officers (CCLHO)

The CMS Branch works with these associations on issues related to county program operations for CSHCN and preventive health services for children. MCH Branch leadership participate in ongoing activities and committees of the CCLHO.

California Children's Hospital Association

The CMS Branch has ongoing collaboration with this organization on numerous issues, including standards for managed care compliance, the Newborn Hearing Screening Program, and maintaining access to specialty health care services for children.

4.3 Public Input [Section 505(a)(5)(F)]

Public input to the FFY 2001 Title V Report and Application was provided by a broad range of stakeholders, which included health care providers, local and State agencies, community groups, families, and advocates. (Please see Needs Assessment Process, Section 3.1.1.) Input was sought by CMS at meetings attended by populations served by Title V programs and their families, such as Early Start meetings, and at presentations to groups of health care providers, such as intensive care nurses and nurse managers. A combined MCH/CMS stakeholder meeting held in October 1999, provided an opportunity for discussion of the health status and health care access measures in the statewide needs assessment as well as the priority needs. A presentation on the Title V process and requirements at the MCH Annual Conference held in June 2000 provided MCH professionals an opportunity to discuss the preparation and contents of the Title V document. The local needs assessments prepared by the County and municipal MCH programs were integral components of the needs assessment. CCS and CHDP program directors and deputy directors were surveyed by CMS for the identification of priority needs.

Comments submitted to CMS after distribution of the FFY 2000 Application and Report presented valuable material and raised pertinent issues for the needs assessment and preparation of this year's document.

Comments were received from individuals representing the American Academy of Pediatrics, the California Children's Lobby, the Child and Adolescent Health Policy Board, the Los Angeles Department of Health Services, State CHDP staff, and the Medi-Cal Policy Division. Some of the specific issues raised and their incorporation into this year's Application and Report are summarized below:

- 1) *Given the diversity in California information should be provided on ethnic groups other than white (non-Hispanic), Hispanic, Asian/ Pacific Islanders, and African-Americans.* Where, available information on other ethnic groups, such as American Indians, Filipinos, and distinctions among Asian and Pacific Island groups has been included in the FFY 2001 report. This more detailed information will be considered in health service and policy decisions.
- 2) *While infant mortality has improved overall, there are still subgroups, such as African Americans, who deserve additional effort to close the gap in their infant mortality rates.* Eliminating racial and ethnic disparities in infant health and mortality has been chosen as a California Title V priority. Considerable efforts are underway to eliminate disparities in black infant health including the Black Infant Health program.
- 3) *CCS needs to be strengthened and eligibility expanded to improve access for children with severe health needs.* Outreach to improve delivery of health care for CSHCN and improvement in access to specialty providers have been made Title V priorities.
- 4) *Coordination between CCS services and other health programs needs to become as seamless as possible.* Improved coordination with other health program to facilitate delivery of health care to CSHCN is a State priority. Expansion of CMS Net and linkage with other health information systems should greatly improve service delivery.

Other points raised concerned: clarification of which performance measures were Federal versus State; clarification of the budget discussion; explanation of the purpose of any memoranda of understanding (MOUs) that are mentioned; clarification of program eligibility; better indication of how performance measure numerators and denominators were derived; and comments on how Title V programs function in a specific county. To the extent possible, these points have been addressed in this year's application report. Additional comments commended the

progress being made in meeting the performance measures and supported the goals outlined with respect to improvement in health care access.

A summary draft of the FFY 2001 Title V Application and Report was distributed to approximately 350 stakeholders throughout the State in early June 2000. Respondents were encouraged to transmit their comments by email and/or letter. Input was received from State and county employees. The comments presented valuable material, particularly in relation to the discussion of the needs of the Title V population in the Needs Assessment. These comments and the relevant response include the following:

- 1) *A very important issue that is missing in the draft is the health of children in child care settings.* Child care was added to the discussion of the needs of California's children.
- 2) *Thank you for including domestic violence and pediatric overweight as both Title V priorities and State Negotiated Performance Measures.*
- 3) *Substance abuse is a significant contributor to youth suicide.* This point has been noted in the discussion of the problem of adolescent suicide.
- 4) *Increased risks among Latinos for selected health outcomes were not identified.* The heightened risk of adolescent homicide among Latinos was added to those risks already discussed such as lack of health insurance and a higher rate of neural tube defects.
- 5) *The importance of diagnosable mental health disorders with biochemical/genetic components in adolescent suicides was not acknowledged.* This point was added to the discussion.
- 6) *There is no discussion of the problem of alcohol and drug use among teens.* A section was added to the needs assessment of children.
- 7) *The document leads the reader to think that most of the local input was from the county jurisdictions— not always a clear indicator that a diverse population was sought.* The fact that many counties worked with community groups and agencies in preparing the local needs assessments was further explained. The participation of advocacy groups at statewide meetings was also indicated. Nevertheless, the ability to adequately represent the needs of the diverse populations of California is identified as one limitation of the needs assessment process. Efforts to achieve broader representation at the State and local levels will be ongoing.

4.4 Technical Assistance [Section 509 (a)(4)]

Please see Form 15. No Technical Assistance Funds have been received.

CMS is requesting \$20,000 in Technical Assistance funds for the coming year. This assistance will be used to develop CCS data capabilities and linkages with other data systems, to allow better understanding of the California CSHCN population.

V. SUPPORTING DOCUMENTS

California's Response to the FFY 2000 Title V Grant Recommendations

Grant Recommendations:

1. Describe the efforts of the MCH Branch in providing assistance to MRMIB in the following:

- a. **The potential adaptation of the Geographic Information System (GIS) to assist in the outreach and enrollment efforts of the Healthy Families program; and,**

The MCH Branch is in negotiations with the Managed Risk Medical Insurance Board, which oversees the Healthy Families Program, to facilitate the exchange of information necessary to apply GIS techniques. Issues related to enrollee confidentiality and privacy are currently under review to assure compliance with all necessary consumer protections.

- b. **The development of performance and health outcome measures and standards of care.**

The MCH Branch participates on the Healthy Families Quality Assurance Workgroup. The Workgroup, which is comprised of representatives from health plans, consumers, employer purchaser organizations and providers, has developed a blueprint for measuring quality in the Healthy Families Program. The blueprint includes HEDIS measures, consumer satisfaction surveys, and the use of a quality of care instrument. The implementation of quality assurance measures has already begun and further steps await legislative and fiscal authorization. The Workgroup's Report of Activities has been filed with the MRMIB Board. In addition, MCH provided technical assistance to MRMIB on methodologies for calculating tests of significance for the analysis of quality of care surveys.

2. **In the State Five Year Needs Assessment, describe the efforts to update the 1993-94 Statewide Oral Health Needs Assessment; also, provide a multi-year annual plan that describes programmatic, policy, legislative, and regulatory efforts to address the current oral health needs of the Title V population.**

The participation of the MCH Branch on the California Dental Health Initiative Advisory Committee which developed the policy recommendations for the oral health plan, *The Oral Health of California's Children: Halting a Neglected Epidemic* is noted in Section 4.2.2. Needs Assessment Process. This report provides updated data and recommendations for addressing the problems that are identified. The MCH Branch is currently integrating dental health promotion messages into its many perinatal outreach programs, such as AFLP and BIH. (An oral health update is included in Section 5.3., Other Supporting Documents.)

3. Describe the Title V efforts to increase consumer input in the five-year needs assessment process and in program and policy development activities.

Public input is discussed in Section 3.2.2. Needs Assessment Process and Section 4.3. Public Input. The local health jurisdictions were encouraged to seek broad-based representation in the development of their needs assessments. Representatives of consumer and advocacy groups were also invited to participate in the statewide stakeholder conference convened in October 1999. In this forum, they participated in discussions of the needs assessment and the development of Title V priorities. A representative of Family Voices participated in the stakeholder conference. Family Voices is a national organization of families and professionals caring for CSHCN and has an active involvement in California. Public input was also sought at other conferences and meetings attended by families and professionals working with CSHCN, including the Interagency Coordinating Council for Early Start (serving children 0- 3 years, IDEA part C) and regional health care provider meetings.

4. Describe the Title V program activities, including its relationship with the Office of Minority Health, in assuring culturally appropriate services to the ethnically and culturally diverse Title V population.

Assuring culturally appropriate services to the maternal and child health population in California is a key issue for the Title V agency. To highlight this need, the theme of the statewide MCH conference, held in May 2000, was “Realizing the Promise of Diversity in the 21st Century”. More than 700 participants met to gain new insights into the rich diversity of California’s population and to learn about strategies that will improve the delivery of health care services to different population groups. The Title V agency has worked to promote culturally appropriate services in collaboration with the Office of Minority Health and with other programs in the department on initiatives such as domestic violence prevention, asthma prevention, diabetes education, smoking cessation, HIV education, and SIDS prevention. One of the criteria used in approving CCS Special Care Centers is the ability to communicate with families in a culturally and linguistically appropriate manner.

5. Describe the Title V interface with the community clinic system.

- ◆ State-level planning and coordination between Title V programs, both MCH Branch and CMS Branch, and the Primary Care and Rural Health Systems Branch are coordinated for the Department through the office of the Deputy Director for Primary Care and Family Health.
- ◆ The local maternal and child health directors in the rural jurisdictions have formed a rural health caucus that has identified significant issues related to developing comprehensive systems of care for women and children living in these areas. Key among these issues are provider availability and access to a full range of primary care and public health services.

- ◆ A member of the MCH Branch serves on the advisory board of the California Primary Care Association's prenatal care initiative and the Branch has assisted in the development and dissemination of multi-lingual health education materials for community clinic patients.

6. Update the following two Memoranda of Agreement (MOAs).

- a. Between the California Children's Services (CCS) and the State Department of Education, Office of Special Education; and,**
- b. Between CCS and the State Department of Developmental Services.**

A Memorandum of Agreement between California Children's Services (Department of Health Services) and the Department of Education has been written and signed by Children's Medical Services. It is awaiting final approval by the DHS Director. The Memorandum of Agreement between California Children's Services (DHS) and the Department of Developmental Services is still under development, with respect to definition of and concordance on specific roles and relationships.

5.1 Glossary (Definitions provided by the Federal MCH Bureau)

Adequate prenatal care - Prenatal care were the observed to expected prenatal visits is greater than or equal to 80 percent (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)]*

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *(Title V Sec. 501(b)(4))*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - *(For budgetary purposes)* Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. *(For planning and systems development)* - Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations. States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities. State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems. A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level. A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is **not possible**. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care*.

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is to aimed at determining: 1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDs monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State do our program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__." This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building", "Population Based Services", "Enabling Services" and "Direct Medical Services".

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

Glossary of Acronyms and Abbreviations (provided by the California Title V Program)

AAA	Associate Administrative Analyst
AB	Assembly Bill
AC	Account Clerk
ALL	Acute lymphoblastic (lymphocytic) leukemia
AT	Account Technician
AFLP	Adolescent Family Life Program
AGPA	Associate Governmental Program Analyst
AHPA	Associate Health Program Advisor
AIDS	Acquired Immune Deficiency Syndrome
AIM	Access for Infants and Mothers
ASPPP	Adolescent Sibling Pregnancy Prevention Program
BDMP	Birth Defects Monitoring Program
BIH	Black Infant Health
BWSP	Battered Women Shelter Program
CA	State of California
CalPERS	California Public Employees Retirement System
Cal Works	California's cash assistance program for children and families
CATS	Common Application Transaction System
CCLDMCAH	California Conference of Local Directors of Maternal, Child & Adolescent Health
CCS	California Children's Services
CDAPP	California Diabetes and Pregnancy Program
CDC	Centers for Disease Control and Prevention
CDHI	Children's Dental Health Initiative
CHDP	Child Health and Disability Prevention
CIPP	Childhood Injury Prevention Program
CISS	Community Integrated Services System
CLPP	Childhood Lead Poisoning Prevention program
CMS	Children's Medical Services
CPQCC	California Perinatal Quality Care Collaborative
CPSP	Comprehensive Perinatal Services Program
CQI	Continuous Quality Improvement
CSHCN	Children with Special Health Care Needs
CWHS	California Women's Health Survey
CY	Calendar Year
DDS	Department of Developmental Services
DHS	Department of Health Services

DOE	Department of Education
DOT	Department of Transportation
DSS	Department of Social Services
DTP/DtaP/DT	Diphtheria and tetanus toxoids and pertussis vaccine/diphtheria and tetanus toxoids
DV	Domestic Violence
EPIC	Epidemiology and Prevention for Injury Control Branch
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
Family P.A.C.T.	Family Planning, Access, Care & Treatment
FFY	Federal Fiscal Year (October 1 – September 30)
FHOP	Family Health Outcomes Project
FIMR	Fetal Infant Mortality Review
FPL	Federal Poverty Level
FY	State Fiscal Year (July 1 – June 30)
GDB	Genetic Disease Branch
GHPP	Genetically Handicapped Persons Program
GIS	Geographic Information Systems
GPRA	Government Performance and Results Act
HCFA	Health Care Finance Agency
HEC	Health Education Consultant
HFP	Healthy Families Program- California's State Children's Health Insurance Program
Hib	<i>Haemophilus influenzae</i> type b vaccine
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HPS	Health Program Specialist
HPM	Health Program Manager
HRIF	High Risk Infant Follow-up
HRSA	Health Resources and Services Administration
IPODM	Improved Perinatal Outcome Data Management
ISIS	Integrated Statewide Information System
LBW	Low Birthweight (<2500 grams)
MCAH	Maternal, Child, and Adolescent Health
MCH	Maternal and Child Health
MCMC	Medi-Cal Managed Care
MCV	Measles-containing vaccine
MIHA	Maternal and Infant Health Assessment
MIS	Management Information System
MMCD	Medi-Cal Managed Care Division
MOU	Memorandum of Understanding

MRMIB	Managed Risk Medical Insurance Board
MVIP	Medically Vulnerable Infant Program
NC	Nurse Consultant
NHSP	Newborn Hearing Screening Program
NHTSA	National Highway Traffic Safety Administration
NICU	Neonatal Intensive Care Unit
NIS	National Immunization Survey
NTD	Neural Tube Defect
OA	Office Assistant
OBRA	Omnibus Budget Reconciliation Act
ODHS	Office of Dental Health Services
OFP	Office of Family Planning
OMDS	Office of Medi-Cal Dental Services
OSS	Office Services Supervisor
OT	Occupational Therapy
OT	Office Technician
OTS	Office of Traffic Safety
PCFH	Primary Care and Family Health Division
PCP	Primary Care Provider
PHMA	Public Health Medical Administrator
PHMO	Public Health Medical Officer
PHNC	Public Health Nurse Consultant
PHSWC	Public Health Social Work Consultant
P.L.	Public Law
POE	Perinatal Outreach and Education
PRAMS	Pregnancy Risk Assessment Monitoring System
PT	Physical Therapy
RA	Research Analyst
RFA	Request for Application
RM	Research Manager
RPPC	Regional Perinatal Programs of California
RPS	Research Program Specialist
RS	Research Scientist
SIDS	Sudden Infant Death Syndrome
SSA	Staff Services Analyst
SSDI	State System Development Initiative
SSI	Supplemental Security Income
SSM	Staff Services Manager

TAC	Technical Advisory Committee
UC	University of California
UCB	University of California, Berkeley
UCD	University of California, Davis
UCLA	University of California, Los Angeles
UCSF	University of California, San Francisco
USC	University of Southern California
USPHS	United States Public Health Service
VLBW	Very Low Birthweight (<1500 grams)
WIC	Women, Infants, and Children Supplemental Nutrition Program
WPT	Word Processing Technician

Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)
14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace,
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,” generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions. (If needed, Standard Form-LLL, “Disclosure of Lobbying Activities,” its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.4 Core Health Status Indicator Forms

Please see Forms C1, C2, and C3.

5.5 Core Health Status Indicator Detail Sheets

Please see Health Status Indicator Detail Sheets in ERP

5.6 Developmental Health Status Indicator Forms

Please see Forms D1 and D2.

5.7 Developmental Health Status Indicator Detail Sheets

Please see Developmental Health Status Indicator Detail Sheets in ERP.

5.8 All Other Forms

Please see the Forms on the ERP.

5.9 National “Core” Performance Measure Detail Sheets

Please see National “Core” Performance Measure Detail Sheets in ERP.

5.10 State "Negotiated" Performance Measure Detail Sheets

Please see State “Negotiated” Performance Measure Detail Sheets in ERP.

5.11 Outcome Measure Detail Sheets

Please see Outcome Measure Detail Sheets in ERP.

Endnotes

1. City/County Population Estimates, State of California, Department of Finance, May/2000.
2. County Population Projections with Race/Ethnic Detail July 1, 1990-2040 in 10-Year Increments, State of California, Department of Finance, December 1998.
3. State of California, Department of Finance Press Release, 2/9/2000.
4. Actual and Projected Births by County, State of California, Department of Finance, 12/08/99.
5. Race/Ethnic Population with Age and Sex Detail, 1970-2040. Sacramento, CA, December 1998.
6. CCS Program data.
7. Clayton SL, Brindis, CD, Hamor JA, Raiden-Wright H, Fong, C. (2000). Investing in Adolescent Health: A Social Imperative for California's Future. San Francisco, CA: University of California, San Francisco. National Adolescent Health Information Center.
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9. Profile of the Foreign-Born Population in the United States: 1997, Current Population Report Special Studies P23-195, US Census Bureau, Washington D.C.
10. Managed Care Annual Statistical Report, April 1999, Medical Care Statistics Section, California, Department of Health Services.
11. <http://www.mrmib.ca.gov/MRMIB/HFP/HRPEptSum.html>.
12. State of California, Department of Finance, City/County Population Estimates, with Annual Percent Change, January 1, 1999 and 2000. Sacramento, California, May 2000.
13. Current Population Survey, 1999.
14. National Survey of America's Families, Urban Institute Jan. 1999, Washington, DC.
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<http://www.MRMIB/HFP/HFPRpt2.html>.
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22. Family P.A.C.T. Program Highlights; California Department of Health Services, Office of Family Planning, Nov. 1999; <http://www.dhs.ca.gov/org/pcfh/ofp/FamPACT/proghi.htm>.
23. SCHIP Annual Report Federal Fiscal Year 1998.
24. California's Medical Assistance Program Annual Statistical Report, Calendar Year 1998, Medical Care Statistics Section, California Department of Health Services.
25. Office of AIDS, California Department of Health Services.
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27. Rayburn, W.F., Stanley, J.R., and Garrett, M.E. Periconceptional folate intake and neural tube defects. *Journal of the American College of Nutrition* 1996;15(2):121-125.
28. Maternal Mortality in Los Angeles County 1994-96, County of Los Angeles –Department of Health Services Family Health Programs, Fetal-Infant Mortality Review Project, May 1998.
29. Skager R. and Austin G. Seventh Biennial Student Substance Use Survey. Grades 7, 9 and 11. 1997-98. Sponsored by: California Department of Justice, Office of the Attorney General, Crime and Violence Prevention Center, California Department of Education, Department of Alcohol and Drug Programs, Department of Health Services, Office of AIDS.
30. Picuch R, Leonard C, Cooper B, Sehring S. Outcome of extremely low birth weight infants (500 to 999 grams) over a 12 year period. *Pediatrics* 1997;100:633-639
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Appendix 1: Pediatric Oral Health Update

Recognizing that data on the oral health status of California's children were not available, the Maternal and Child Health (MCH) Branch funded a comprehensive oral health needs assessment of children ages 2 to 15 years old in 1993-94. The results and recommendations were published in the September 1995 "Our Children's Teeth: Beyond Brushing and Braces" Report. Dental caries, including baby bottle tooth decay (early childhood caries), was identified as the most prevalent oral condition. In addition, lack of dental insurance, periodontal diseases and oral injuries were of considerable magnitude.

Based on the findings of that assessment, the *Maternal and Child Health Plan for Oral Health of California's Children* was included as part of the 1998-99 California Grant Application and Annual Report for the MCH Services Title V Block Grant Application. This Plan provided a blueprint for improving pediatric oral health by summarizing the data on the unmet dental needs of children, recommending strategies for addressing those needs, and establishing specific goals and actions to address the needs. A guiding principle of the Plan was the integration of oral health into ongoing and proposed activities for primary care and prevention, rather than the establishment of a separate and parallel system of dental health care.

The major strategies identified in the 1998 Plan to address the oral health needs of children from birth through adolescence were:

Primary Prevention Strategies:

- Promote fluoridation of water supplies
- Promote dental sealants among Denti-Cal and Healthy Families beneficiaries and develop approaches to deliver dental sealants in school-based/linked programs.
- Promote effective dental health practices among parents, childcare providers, MCH/CMS program staff, and primary health care providers.
- Promote referrals to dental health services at an early age.
- Expand access to dental health services by expanding dental health insurance coverage, the provider network serving low-income communities, and caregivers' knowledge of available sources of care.

Progress has been achieved in each of these priorities. In 1995, the State legislature and former Governor Wilson approved legislation (AB 733) authorizing municipalities to fluoridate water supplies once funds were available. The Fluoridation 2000 Workgroup has received most of its initial fund for fluoridation from the California Endowment (Foundation). Additionally, smaller amounts have been received from the Sierra Health Foundation and from the Centers for Disease Control and Prevention. Up to the passage of AB 733, only 17 percent of the population in California were served by water fluoridation. Currently, it is expected that approximately 4.3 million additional people will be receiving the benefits of fluoridation. This includes the City of Los Angeles with 3.7 million additional people.

The next phase is to consider medium sized cities that were part of the 13 cities initially identified as qualifying for funding, cities that have already considered fluoridation, those that have held initial hearings or cities that have a portion of their systems already fluoridated.

In 1998, the MCH Branch hired a dental health consultant to promote the integration of oral health promotion activities into ongoing MCH programs. Dental health messages for infants and pregnant women are being incorporated into the “Steps to Take” guidelines for the Comprehensive Perinatal Services Program. Educational messages focus on the following: 1) promotion of proper child feeding practices including breastfeeding; 2) the appropriate use of fluoride supplements; 3) use of toothbrushing with fluoride toothpaste; 4) dental sealants; 5) appropriate referral of clients to dental services; and 6) assessing the clients’ oral hygiene habits as part of the assessment of their other health habits. Plans are also underway to include oral health into the *Nutrition during Pregnancy Period: A Manual for Health Care Professionals* guidebook. Future strategies are to incorporate similar dental health messages into other MCH programs such as Adolescent Family Life Program and Black Infant Health.

The MCH Branch has conducted several activities to increase the visibility of the oral health needs of California’s children. In 1998, the MCH Branch surveyed the 61 local health MCH directors to assess current dental activities and future plans to address oral health. Over half of the respondents indicated that their five-year Title V needs Assessment for 2001-2005 would include oral health. As a result of these Community Health Assessments, a total of 18 local MCH programs (31 percent) included oral health as one of their priorities for the next five years. One county identified dental as an emerging issue. Most of the objectives identified by the 18 MCH programs are related to increasing access to dental care services and sealant placement. Other areas of interest are water fluoridation, reduction of dental caries, and the prevention of early childhood caries.

The 1999 MCH Annual Conference featured presentations focusing on the impact of dental disease on the MCH population. Specifically, it highlighted recent studies that suggest that periodontal diseases are a risk factor for preterm low birthweight babies. Ongoing monitoring of dental needs will be facilitated by the expansion of the CMS Net system, which provides data on dental health services to the CSHCN population. In addition, the MCH Branch will work on the development of a methodology to collect data on dental sealant prevalence among third grade students (*FPM 7*). For the past two years, the Branch has used a simple average of the Denti-Cal and Delta Dental sealant utilization rates to estimate the sealant prevalence among third graders.

Several programs contribute to improving the access to dental services among children. Key among these is the Child Health and Disability Prevention Program (CHDP), which provides dental assessments and referrals for low-income children, and Denti-Cal, the dental programs for Medi-Cal eligible children. In federal FY 1997-98, the CHDP program conducted 2,374,491 dental assessments in 1,923,264 children. Of those assessments, 133,309 “reduced risk” though diagnosis, treatment, and/or referral.

The implementation of California's Healthy Families Program (HFP) in July 1998, under the federal Child Health Insurance Program, has made a major contribution to expanding dental insurance and access to dental services to children of low-income working parents. HFP dental services include comprehensive preventive, basic and major restorative services. Over 211,000 children had been enrolled in the HFP by the end of 1999. By June 1999, data from the largest of the four available dental plans, serving nearly 80,000 HFP enrollees, revealed that approximately 70 percent of the plan enrollees sought dental services within the first six months of participating. Of those who visited a HFP dentist under the insurance plan, 61 percent received preventive and diagnostic care, while 30 percent received restorative care.

Future Plans for the MCH Branch:

- 1) Provide technical assistance to the local MCH programs that included oral health activities as part of their five-year MCH plan.
- 2) Continue to promote the inclusion of oral health activities into all appropriate MCH programs and/or program guidelines.
- 3) Work in collaboration with the Epidemiology and Evaluation Section of the MCH Branch to plan the development of a surveillance system to collect data on the proportion of children with sealants in at least one of the permanent molar teeth. The Branch may utilize the "Screening Training Project" manual developed by the Association of State and Territorial Dental Directors.
- 4) Seek grant funds from various sources to conduct a longitudinal pilot study to examine women prenatally to prevent the transmission of dental caries from mothers to their babies. This study would also address the prevention and control of periodontal diseases as one of the ways to prevent preterm low birthweight babies.
- 5) Continue to create strategies to increase access to dental care among children. This will be partially accomplished by support provided to the MCH dental activities by the DHS Dental Workgroup. This group has representatives from Managed Risk Medical Insurance Board (MRMIB) which is the management board for the Healthy Families Program, California Dental Association, Denti-Cal, the Fluoridation Project, the Children's Dental Disease Prevention Program, CHDP, among others.

In addition the CMS Branch will:

- 1) Promote oral health counselling and preventive services through CHDP.
- 2) Continue to assure coverage of dental services that relate to the CCS eligible condition for CSHCN.
- 3) Promote access to dental care through improved healthcare coverage outreach activities by CMS programs, including CHDP, CCS, and MVIP.

Considerable progress has been made in integrating oral health into the vision of primary health care in California. Continued advocacy, training, technical assistance for program support and development, data collection, and expanded access to dental care will be essential to insuring improved dental health among California's children.