

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: **CA**

APPLICATION YEAR: **2005**

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I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

See Attachment for the State of California's Assurances and Certifications and Memorandums of Understanding.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

/2005/ An abridged draft of the FY2004-05 Application/Report, including data tables, was posted on the Maternal and Child Health (MCH) Branch website for review and comment. MCH partners, including local Maternal Child and Adolescent Health (MCAH) Directors, contractors and other stakeholders were advised of the availability of the draft. The Children's Medical Services (CMS) Branch added a Title V link on the CMS website that connected to the MCH website and made the draft Application/Report available to its partners. A CMS Information Notice was placed on the CMS Website informing stakeholders, including the California Children's Services (CCS) administrators, local Child Health and Disability Prevention (CHDP) program directors, deputy directors and medical consultants, and CMS Branch staff, about accessing the draft Application/Report. //2005//

See Attachment for further details on Public Input. Responses to last year's Grant Recommendations are also included in this attachment.

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

/2005/

Demography

California is the most populous state in the nation with a total of 36.1 million residents as of January 1, 2004. This represents an increase of 1.5 percent over the previous calendar year. The state's population comprises 12 percent of the nation's total; one out of every eight of the nation's residents lives in California. The population increase between July 1, 2002 and July 1, 2003 reflects a natural increase (births over deaths) of 301,000, and net immigration of 296,100. [1]

California had 531,285 births in 2000; this was the State's first increase in the number of births after a decade-long decline in the 1990s. The number of births declined to 527,371 in 2001, then rose in 2002 to 529,245, and again in 2003 to 540,827. The California Department of Finance (DOF) projects that the number of births per year will continue to rise through 2012, and at an increasing rate. The number of births projected for 2012 is 617,917, an increase of almost 17 percent over 2002.

The birth rate for 15-19 year olds declined to a record low of 41.1 per thousand in 2002, 43 percent lower than its 1991 peak. Birth rates have increased for older women (ages 25-44), and this trend is expected to continue.

In 2003, California's population included an estimated 2.6 million infants and children under the age of five years (7 percent of the total population), 4.8 million children 5-12 years old (13 percent of the total population), and 3.7 million adolescents 13-19 years of age (10 percent of the total population), for a total of over 11.1 million infants, children and adolescents (31 percent of the total population). There were 8 million women of childbearing age, 15-44 years old (22 percent of the total population). [2]

The number of children with eligible medical conditions enrolled in California Children's Services (CCS), the designated Title V Children with Special Health Care Needs (CSHCN) program, grew in FY 2002-03 by 4 percent from the prior year to 172,340 . There were 26,663 children enrolled in the CCS Medical Therapy Program (MTP) in FY 2001-02, an increase of 3.5 percent. For FY 2002-03, there were 27,197 children enrolled in the MTP, an increase of 2 percent from the prior year. [3]

Racial and Ethnic Diversity

California is the nation's most ethnically diverse state, with Hispanics constituting the fastest-growing ethnic/racial group. As of March, 2003, the State's population is comprised of 33.2 percent Hispanics, 11.8 percent Asians and Pacific Islanders, 6.2 percent African Americans, and 46.8 percent Whites. Two percent of individuals identify as other or multiple races and ethnicities. [4] California has 27.9 percent of the nation's foreign-born population among its residents.[5]

California Hispanics are younger on average than members of other racial/ethnic groups, and the difference in median age is increasing. The Hispanic median age of 26 is 7 years younger than the median age for the overall population (33), and 14 years younger than the median age of the White non-Hispanic population (40).[6] In the previous year, the median age differences were 6 years and 12 years, respectively.

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.

The state's cultural diversity places added demands on the health care system in relation to both access to and quality of care. California's cultural and linguistic diversity represents a barrier to health care for the 20 percent of Californians who have Limited-English Proficiency (LEP). In 2003, almost 50 percent of California's Medi-Cal and Healthy Families (HF) recipients primarily spoke a language other than English. [7]

Geography

California's 36.1 million people reside in 58 counties. The state's population is predominantly urban with over 9 percent of the state's residents living in urban areas as of the 2000 Census. The state's 58 counties range in size from Alpine, with a population of 1,210, to Los Angeles, with over 10 million as of July 1, 2003. From July 1, 2002 to July 1, 2003, four counties experienced growth rates of 3 percent or more: Riverside (4.5), Placer (4.4), Madera (3.4), and Merced (3.0). [8]

The state's geography contributes to access to care problems. 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. Rural populations have higher rates of uninsurance (20% vs. 16%) and are typically uninsured for longer periods of time when compared with urban populations. [9]

Barriers to access to health care in rural areas remain significant as the availability of providers is a major problem in the more remote areas. CCS is actively pursuing the improvement of access for children in rural areas of the state through a variety of methods. CCS has partnered with the University of California Davis (UCD) and Sutter Medical Center to increase the use of telemedicine in delivering pediatric specialty level services to remote areas of Northern California for children enrolled in the CCS program. For example, UCD pediatric cardiologists use tele-echocardiography on a 24/7 basis with the CCS approved Mercy Medical Center Neonatal Intensive Care Unit (NICU) in Redding. Tele-echocardiography, performed on 180 infants in the past year, has assisted the facility to meet CCS program standards for NICU quality care of neonates. The recently established unique UCD FamilyLink program helps families in remote areas stay connected with their hospitalized children via a special camera and phone combination unit; parents and siblings can see and talk from home with their hospitalized family members.

County CCS programs located in rural areas have increased reimbursement of maintenance and transportation (M and T) expenses for children and their families needing help in accessing medical care at CCS approved Special Care Centers (SCCs) located in urban medical centers. A state policy letter on M and T was issued in February 2004 to provide county CCS programs with (1) uniform policies for approving M and T benefits to support optimum access to authorized medical services for CCS clients, and (2) procedural guidelines for reimbursement for the costs of M and T through the administrative support budget. County programs continue to work and coordinate funding for M and T with hospitals in their regions that also have resources for families.

Economy

In March 2003, 18.9 percent of California's children under five years, and 19.6 percent of

children 5-17 years, were living in poverty. Among families with children, 8.1 percent were living in poverty. Of those 699,000 families, 43 percent were single-parent families with a female head.[10] An estimated 29.7 percent of children under five years and 25.2 percent of children 5-17 years were enrolled in Medi-Cal, California's Medicaid program. Due to the poor economy, the number of families eligible for Medi-Cal is increasing and putting an ever-greater strain on the health care system. [11]

Due to budget constraints, the State experienced a thirty-two month hiring freeze during which the MCH and CMS Branches lost several positions. In FY 2003-04 the loss of positions has diminished the ability to optimally perform MCH and CMS Branch activities. Overall, 16,000 state government positions were reduced.

State departments were prohibited from signing any new contracts or acquiring new equipment, and most travel was disallowed. For the MCH and CMS branches, this sharply curtailed the ability to travel to local jurisdictions and counties for technical assistance and training, which compromised the ability to sustain program quality. For the CMS Branch this meant the inability to accomplish site reviews of hospitals and SCCs and forced cancellations of meetings with other agencies and organizations. MCH also saw cuts of \$1.6 million to the Adolescent Family Life Program (AFLP) for pregnant and parenting teens, and to the Adolescent Sibling Pregnancy Prevention Program (ASPPP) for the siblings of AFLP participants.

Private Sector Participation in Health Services

The private sector is the principal provider of California's health services, including services for low-income populations. Programs such as Child Health and Disability Prevention (CHDP), Comprehensive Perinatal Services Program (CPSP), HF, and Family Planning Access Care and Treatment (Family PACT) offer services through a broad network of providers in private practice, community health centers, and other private non-profit clinics. Health care services for CSHCN are an example of cooperation and coordination between private and State health care providers. Private foundations are also playing 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 CHDP program (serving infants, children, and adolescents from families having incomes less than 200 percent of FPL) provided health assessments to 2.1 million clients in FY 2001-02, a decrease of 4.8 percent from the prior year. Medi-Cal Managed Care (MCMC) plans screened 36.3 percent of the 2.1 million total, a 3 percent increase from the prior year. Although the number of CHDP services delivered by MCMC plans continues to increase, an unknown percentage of plan assessments likely remain unreported due to incomplete data on the "Information-Only" PM 160 reporting form which is not tied to compensation of the service.

California's version of the State Children's Health Insurance Program, HF, relies on the private sector delivery of health services to children in low-income working families. HF provides health insurance coverage to children from families with incomes up to 250 percent of the FPL who are above Medi-Cal eligibility limits. As of December 30, 2003, 683,787 children were enrolled in HF, a 10.3 percent increase from December 2002. [12]

A collaborative initiative between the California HealthCare Foundation and the State of California led to the development of Health-e-APP, a web-based application for HF. Health-e-App became available in 2003 and has improved speed, accuracy, and consumer satisfaction with the application process.

The CCS program is moving aggressively to decrease barriers to provider participation. A recently completed Web page (<http://www.dhs.ca.gov/pcfh/cms>) provides important

information to providers on programs, program policies, forms and publications, and letters and notices.

Much work over the past year has gone into enhancing the CMS Net case management system for CCS. This process, under development for many years, is called Enhancement 47 (E47). For several years the State System Development Initiative (SSDI) grant has provided partial funding for this effort. Trainings on all the changes in E47 were conducted statewide to CMS state and regional staff, county CCS programs, hospitals and individual providers, in preparation for implementation on July 1, 2004. The benefits to E47 include: quick payment to providers, reduction of rejected claims, reduction of provider costs for billing, preservation of the CCS network of providers, compliance with the Health Insurance Portability and Accountability Act (HIPAA), better client information, cleaner data and the ability to capture required data. There have been many partners involved in E47, and over the coming year, these partnerships will be maintained as implementation occurs.

//2005//

Major State Initiatives

> Early childhood development /Proposition 10

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 resulted 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 state-level commission, now called First Five California, receives 20 percent of the funds, while the local First Five Commissions in each of the 58 California counties receive the remaining 80 percent. The major "signature" initiative of First Five California is its School Readiness Initiative (SRI). First Five California has devoted \$206.5 million over four years to SRI with local commissions being required to match the amount. SRI describes five "essential and coordinated elements," one element being: "health and social services, including services such as health plan enrollment; provision and/or referral to basic healthcare (e.g., prenatal care, services for children with disabilities and other special needs, oral health, and nutrition); comprehensive screening and assessment; mental health counseling; and others." Local MCAH directors work closely with their First Five Commissions in the preparation of local SRI proposals. First Five California has identified other "Focus Areas" which link with SRI. Some areas are linked to MCH program activities, specifically 1) The Migrant Families Initiative, 2) Children with Disabilities and Other Special Needs (to include early mental health), and 3) Oral Health.

First Five has four other efforts addressing "Early Health." They are 1) Childcare Health Linkages which link services of health agencies with childcare facilities; 2) The Infant, Preschool and Family Mental Health Initiative which funds eight counties to develop new mental health services for young children and their families; 3) the Childhood Asthma Initiative (CAI) which funds eleven local projects and provider education; and 4) the Oral Health Initiative (described below). The MCH Branch follows the activities of First Five and helps local staff identify the connections between their programs and First Five activities.

//2005/ The CMS Branch has been part of the First Five Commission funded Childhood Asthma Initiative that targets children with asthma between birth and five years of age. The demonstration projects of the Asthma Treatment Services (ATS) component of the CAI are being discontinued due to insufficient funding, but the CMS Branch has received approximately \$1 million for the coming fiscal year to continue to train and provide educational support on asthma for CHDP providers, and to develop and provide education materials for children and their families. CHDP providers serve almost 1.3 million children under 5 years of

age, so educating these providers and requiring asthma screenings as part of their CHDP health assessments can have a huge impact on early identification and early appropriate treatment of childhood asthma. The CMS Branch is also working with the First Five Commission School Readiness Program to raise asthma awareness. //2005//

//2005/ In addition, MCH has received a two-year planning grant for 2003-2005 from the Health Resources and Services Administration (HRSA) for the State Early Childhood Comprehensive Systems (SECCS) project. The goal is to provide state-level leadership for early childhood health programs to help California's children be emotionally, socially, and physically healthy and ready for kindergarten. The project will coordinate a myriad of health-related programs at the state and local levels. The grant will culminate in the completion of a statewide needs assessment and strategic plan that addresses and coordinates critical components of early childhood health care systems related to access to medical homes, mental and social health, childcare education, parent education, family support, and safety in out-of-home care. //2005//

> Child health insurance coverage

A second major State initiative is insuring children's access to health services through expanded health insurance coverage in order to improve the health of the Title V population. The key strategy for improving access to care is the expanded enrollment of Medi-Cal and HF-eligible children. The Title V Agency, through the School Health Connections (SHC) Section of the MCH Branch, has taken a lead role in conducting the state-based school outreach efforts for Medi-Cal and HF as well as other affordable health coverage programs.

//2005/ Efforts to increase enrollment in the state-sponsored children's health care programs appear to be impacting the percentage of uninsured children. Estimates from the March 2003 Current Population Survey indicate that the proportion of children 0-18 years who were uninsured declined from 15.3 to 14.3 percent between 2001 and 2002 as a result of increases in employment-based insurance and enrollment in Medi-Cal and HF. //2005//

On July 1, 2003, the California Department of Health Services (DHS) implemented an electronic "gateway" at CHDP provider offices and clinics to facilitate the enrollment of eligible children for up to two months of presumptive eligibility for Medi-Cal health care coverage. The CHDP Gateway contains the important features of electronic eligibility screening, enrollment of children receiving CHDP assessments into two months of no-cost full-scope Medi-Cal benefits, and an "extended enrollment" process into continuing Medi-Cal/HF coverage if a formal application is submitted within the two month initial period. Families can obtain medical or dental care immediately following the Gateway enrollment.

//2005/ Throughout the past year DHS has focused on post implementation of the CHDP Gateway. Through the end of June, 671,557 children have been pre-enrolled in the Gateway and approximately 80 percent have requested joint applications from Medi-Cal/HF. The monthly average pre-enrollment has increased to 63,863 from January through June of this year, compared to a monthly average of 47,063 for the first 6 months. //2005//

> Oral health promotion

DHS is responding to the high prevalence of dental disease among California's children with a variety of strategies to increase awareness of oral health as an integral component of comprehensive primary care, and to promote effective prevention strategies.

MCH Branch staff work to ensure the inclusion of oral health promotion activities within existing programs of the Branch. Prominent among these efforts has been the development of a revised edition of the CPSP guidelines that include oral health guidelines for pregnant women, infants, and

children. Local MCH program staff use these during consultation to women during and after pregnancy. Toothbrushes and children's fluoride toothpaste have been distributed to local MCH programs including AFLP, Black Infant Health (BIH), and CPSP as incentives and education tools.

In order to meet the growing demand for technical assistance at both the state and local levels, the MCH Branch contracted with University of California San Francisco (UCSF) for a licensed dentist to serve as the MCH Oral Health Policy Consultant. In the fall of 2002, the MCH Oral Health Policy Consultant, MCH Nutritionists, Pediatric Consultant and members of the DHS Dental Workgroup developed oral health educational materials.

//2005/ The oral health educational materials, a brochure and poster in English and Spanish, entitled "Stop the Spread of Tooth Decay," were printed in 2004 and will be distributed in 2004 and 2005 to MCH, CMS and Women, Infants & Children (WIC) Supplemental Nutrition Branch programs. In addition, the following organizations have requested the materials: dental societies, community clinics, hospitals, and OB/GYN and pediatric offices. The materials will be distributed to health professionals at the various county MCH presentations conducted by the Oral Health Policy Consultant around the state. Presentations have focused on the infectious nature of tooth decay, how to prevent early childhood caries, the possible connection between periodontal infection and preterm/low-birth weight babies, and dental treatment of women during pregnancy. //2005//

//2005/ The State First Five Commission has listed oral health as one of its five priorities. The First Five California Oral Health Initiative consists of 1) a \$7 million Early Childhood Oral Health Education and Training Project, and 2) a \$3 million Oral Health Demonstration Project. The Education and Training Project targets both providers (dental and primary care providers) and consumers (parents, caregivers and others who work with young children). Training for providers and consumers will start in 2004 and will last for the four years of the grant. The MCH Oral Health Policy Consultant has been involved in this process since its inception. //2005//

//2005/ The First Five Oral Health Demonstration Project is a collaborative effort of the Managed Risk Medical Insurance Board (MRMIB), dental and pediatric care providers, clinics, dental and health plans of HF, local First Five Commissions, dental schools, and others. The Project will test innovative ways to 1) increase the utilization of preventive dental benefits among young children, 2) increase the capacity of medical and dental providers to serve the oral health needs of young children (including CSHCN), and 3) increase access for young children in rural and other underserved areas to dental services. //2005//

//2005/ The MCH Branch, in collaboration with UCSF, will be analyzing two years of data regarding oral health behavior during pregnancy. The questions are part of the Maternal and Infant Health Assessment (MIHA) Survey. Data analysis should be completed by spring of 2005. //2005//

//2005/ The first statewide oral health needs assessment was conducted in 1993-1994, and plans are currently underway for a follow-up needs assessment to be conducted in 2004-2005. The California Office of Oral Health (OOH) is partnering with the MCH Branch and the Dental Health Foundation to conduct the study, which is funded by the Health Resources and Services Administration (HRSA) and the California Dental Association Foundation. //2005//

The Dental Health Foundation, in collaboration with the MCH Branch, will establish a statewide oral health surveillance project utilizing the Association of State and Territorial Dental Directors' screening materials. Part of the screening will include a determination of whether sealants are present on 3rd graders. These data will assist the MCH Branch to comply with the federal National Performance Measure 09 which relates to the prevalence of sealants on 3rd grade children.

The CMS Branch continues to work toward improving oral and dental health in California's children

through the CHDP and CCS programs. Assessments of oral health are part of each CHDP health assessment examination. The CHDP Gateway, with its two months of pre-enrollment of children into Medi-Cal, is a temporary source of reimbursement for dental treatment for CHDP children. Certain dental abnormalities were included as conditions that allow CCS program eligibility, in the final CCS regulations (issued July 2000), and dental problems that impact on a CCS medically eligible condition are being covered as part of CCS case management.

/2005/ As of July 2004 the CCS program implemented electronic billing and other associated CCS program revisions (E47), which include procedural changes for dentists and orthodontists. In addition to these program changes, the CHDP Dental Periodicity Schedule has been revised to recommend referral to a dentist beginning at one year of age. A CHDP program letter and provider information notice were sent announcing this new recommendation and providing the revised schedule for the CHDP Health Assessment Guidelines (HAGs). The provider notice also included the MCH website, www.mchoralhealth.org/PediatricOH/index.htm, that includes seven teaching modules for pediatricians.

In FY 2001-02, 1,734,835 children received dental screenings through the CHDP program, a decrease reflective of the overall decrease in CHDP enrollment for this fiscal year. This number should increase in FY 2004-05 with the new recommendation for earlier screenings.[13] //2005//

> Preventing childhood obesity

/2005/ California, like the nation, is experiencing an increase in the prevalence of obesity and related health problems. In response to the state's accelerating epidemic of obesity and physical inactivity, a DHS Nutrition and Physical Activity Action Team has been established by the Director of DHS with a department-wide focus. The Action Team is addressing how DHS can best confront the obesity epidemic and assist California's communities in empowering their residents to lead healthier lives. Short, intermediate, and long term strategies are being developed to increase healthy eating and physical activity for all of California across all ages and ethnicities. These strategies are being coordinated internally within DHS and externally with other agencies. Both MCH and CMS have representatives on the Action Team. //2005//

/2005/ Childhood obesity in low-income children is assessed through the Pediatric Nutrition Surveillance System (PedNSS) data that are now on-line on the CMS Branch website. Data for FY 2001-02 show the percentage of low-income children under 5 years receiving healthcare through CHDP who are overweight is 16.2 percent (16.1 percent in FY 1999-00 and 15.9 percent in FY 2000-01). For low-income children 5 to 20 years, the percentage overweight for FY 2001-02 is 20.8 percent (19.7 percent in FY 1999-00 and 19.9 percent in FY 2000-01). For low-income children 2 to 5 years, the prevalence for at risk for overweight for FY 2001-02 is 16.3 percent (16.2 percent in FY 1999-00 and 16.3 in FY 2000-01). For children 5 to 20 years, the prevalence for at risk for overweight for FY 2001-02 is 18.1 percent (17.7 percent in FY 1999-00 and 17.8 percent in FY 2000-01). [14]//2005//

/2005/ Ethnic variation in the prevalence of overweight still exists, with the highest prevalence in American Indian/Alaskan Native for children 5 years to less than 20 years at 24.8 percent for FY 2001-02 (24.7 percent for FY 2000-01). The second highest ethnic group in this age category is Hispanic children with a prevalence of 22.2 percent in FY 2001-02 (21.2 percent for FY 2000-01). For children less than 5 years, the prevalence of overweight was greatest for American Indian/Alaskan Native at 19.3 percent(18.6 percent for FY 2000-01) followed by Hispanic children at 17.5 percent (17.0 percent for FY 2000-01).[15] //2005//

/2005/ In response to this growing problem, childhood obesity prevention has become a major statewide initiative. The five priority areas identified by the Centers for Disease Control (CDC) for reducing obesity - the promotion of breastfeeding, energy balance, five fruits and

vegetables per day, increased physical activity, and reduced TV viewing - have been assimilated into existing MCH and CMS programs. To expand the coverage and scope of programs implemented in response to the growing problem of childhood obesity, the MCH, CMS, and WIC Branches of DHS and the UC Berkeley Center for Weight and Health collaboratively hosted the first statewide California Childhood Obesity Prevention Conference in March 2001. The second biannual statewide conference was entitled, "Making an Impact Now: Environmental, Family, and Clinical Approaches." This conference, held in January 2003, was the largest conference ever held on obesity prevention and received national attention. The third biannual California Childhood Obesity Conference is planned for January 9-12, 2005 in San Diego. The program is currently under development and is entitled, "Launching a Movement: Linking Our Efforts to Make a Difference." //2005//

//2005/ Five CHDP local programs are funded by the Nutrition Network from January 2004 through September 2004 for CHDP Nutrition Special Projects: Merced, Sonoma, Yolo, San Bernardino, and San Francisco. All the projects have a focus of nutrition and physical activity. Each of the projects involves forming partnerships which may include schools, parks and recreation, CHDP providers, WIC, local health departments and social services, local hospitals, colleges/universities, and community agencies/organizations. San Bernardino County is targeting low-income African-American children, youth, and their families. This project couples nutrition education with the history and traditions of African/African-American cultures and dance, to promote healthy weight and to deliver Five A Day and physical activity messages. //2005//

//2005/ In collaboration with WIC programs, CPSP providers and other health professionals that work with pregnant women as well as with middle schools, four additional projects have been funded by the Nutrition Network for 2003-2004 in Contra Costa, Fresno, Long Beach and Los Angeles Counties. Similar to the CHDP projects, the focus is on nutrition, physical activity and obesity prevention; however, the target population is food stamp eligible recipients. Core elements that are being addressed by all four counties are dietary quality, food security, food safety and food resource management/shopping behaviors. //2005//

School Health Connections promotes healthy food choices and physical activity in schools through the endorsement of nutritional assessment tools, including the CDC's School Health Index. These tools assess physical activity and nutrition in the school environment and identify areas in need of improvement.

California Diabetes and Pregnancy Programs (CDAPP)/Sweet Success has increased the emphasis in postpartum recommendations on preventing or delaying the onset of maternal diabetes, childhood diabetes, and the early onset of Type II diabetes. Diabetes is now addressed as a family disease and pregnancy is used as an opportunity to educate patients about lifestyle risk factors and determine appropriate diabetes treatment. Emerging research on fetal development in the intrauterine environment has recognized the cycle of diabetes from mother to child to mother. This adds impetus to the goals of providers in client education regarding the importance of a normal fetal glucose environment (fetal normoglycemia).

//2005/ AFLP, ASPPP, and the Oral Health programs have been provided guidelines and educational materials to address healthy eating, including the five-a-day fruit and vegetable message. BIH and CPSP target the prevention of low-birth weight babies and promote breastfeeding, which have been documented to reduce the risk for developing obesity. BIH also has an anemia campaign supporting the food guide pyramid; promotes breastfeeding; and is considering other activities to address the obesity crisis. //2005//

The MCH and CMS Branches have been involved in the California Obesity Prevention Initiative (COPI). COPI, funded by CDC, includes an internal DHS coalition to assist in program planning, implementation and evaluation. In addition, the MCH and CMS Branches are involved in the Physical Activity and Nutrition Coordinating Committee (PANCC).

/2005/ Governor Schwarzenegger is very interested in obesity prevention and fitness promotion, and, in May 2004, Kim Belshe, Secretary of the California Health and Human Services Agency, gave a presentation on the subject to the Governor and his Cabinet. A copy of Secretary Belshe's presentation is available at <http://intranet.chhs.ca.gov/whatsnew/pdfs/CHHS%20slides%20on%20obesity%20051304.pdf>. //2005//

/2005/

> Eliminating racial and ethnic disparities in health

Racial and ethnic disparities exist in many areas of maternal and child health in California. In 2001, California's infant mortality rate was 5.4 deaths per 1,000 live births. The rate for Hispanic infants was near the state average (5.1), while the rate for non-Hispanic White and Asian/Pacific Islander infants was below the state average (4.7 and 4.2, respectively). The infant mortality rate for African Americans was over twice the rate for the state, 11.1 deaths per 1,000 live births. The African American infant mortality rate has decreased steadily for several years, but a substantial gap remains. [16] Similar disparities have also been demonstrated in perinatal outcomes such as neonatal mortality, preterm delivery and low birth weight.

Disparities are seen in measures of maternal health as well. For instance, the maternal mortality ratio is approximately three times higher for African-American women than for White women. Over the period from 2000 to 2002, the statewide average maternal mortality ratio for California was 10.6 maternal deaths per 100,000 live births. The maternal mortality ratios for White and Hispanic women were both below this state average (9.4 and 10.0, respectively), while the ratio for African American women far exceeded the state average at 27.7 maternal deaths per 100,000 live births.

Additionally, racial and ethnic disparities in the adolescent birth rate persist despite the marked declines that have occurred across all racial and ethnic groups over the past decade. In 2002, the teen birth rate among non-Hispanic White adolescents (aged 15-17 years) was 7.5 births per 1,000 teens. The corresponding birth rate among Hispanic adolescents was 46.3 per 1,000 teens, and 24.7 per 1,000 among African American teens.

Given California's diverse population, racial and ethnic disparities in health status and health care access significantly impact the overall health of the state's population. Therefore, DHS has made the elimination of racial and ethnic disparities in maternal and child health one of its Title V priorities.

California's BIH programs have served as a national model by successfully identifying and enrolling the highest risk population, pregnant and parenting African-American women, for focused interventions. Comprehensive services offered to this population include the development of client-centered, culturally sensitive education, case management, and prenatal and pediatric care. An evaluation of the BIH Program from 1994 through 1998 showed the program was effective in reducing the rates of very preterm delivery and very low birth weight among very high-risk women and their newborns.[17] The MCH Branch is currently updating this study.

The MCH Branch not only has program activities that target specific ethnic and racial groups at higher risk of poor health outcomes, but also makes cultural sensitivity a cornerstone of every program activity, including AFLP, ASPPP, the Battered Women's Shelter Program (BWSP), BIH, and CPSP. CDAPP is addressing the needs of California's increasingly ethnically and culturally diverse population by incorporating cultural competency awareness in all CDAPP trainings and materials. Direct services are being provided by a well-trained, ethnically diverse work

force of diabetes and pregnancy specialists. At-risk women (including Hispanic, African American, and Asian/Pacific Islander women), their communities, and their providers, are being targeted.

CPSP includes cultural competence in its Model of Care description. For example, Certified Perinatal Health Workers are included in the list of eligible practitioners for the program. Comprehensive perinatal health workers are required to be at least 18 years of age, have a high school degree or equivalency, and have at least one paid year of work experience in perinatal health care. The MCH Branch provides a 2 day training in "Steps to Take" which reviews how to do an initial combined assessment, provide nutrition counseling, health education and psychosocial assessment for these medical assistant type staff and obstetrical providers in various parts of the state each year. Staff are representative of the communities served by their providers, and are often Hispanic, bicultural, and bilingual. Cultural competency is being developed for other indigenous and immigrant groups, including recent Russian, Oaxacan, Mixtecan, and Somali immigrants.

The CHDP and CCS programs also continue to increase cultural competency. The CHDP program is developing a plan for assisting providers in attaining a culturally competent environment and for implementing the culturally competent clinical assessment through revisions in the CHDP HAGs on conducting a culturally competent clinical assessment. In order to meet the needs of culturally diverse families, the CHDP and CCS programs have been translating information resources into threshold languages and including culturally relevant artwork and materials.

State outreach efforts to increase health insurance coverage for low-income children have been designed to reduce the disproportionately high rates of uninsurance among California's ethnically diverse populations, particularly Hispanic children. To improve access to Medi-Cal services, all MCMC materials are to be made available in ten threshold languages. These include: Spanish, Chinese, Vietnamese, Cambodian, Hmong, Laotian, Korean, Russian, Farsi, and Tagalog.

Many of the surveillance and monitoring activities of the MCH Branch include racial and ethnic analyses of program-relevant issues. Data analyses are based on statewide surveys supported by the MCH Branch, including MIHA Survey and the California Women's Health Survey (CWHS); program-specific databases, such as that for AFLP; program evaluations such as the BIH evaluation; and ongoing monitoring systems such as the Improved Perinatal Outcome Data Reports and the Perinatal Profiles. The MCH Branch works to translate results of these assessments into a reduction of disparities. For instance, culturally competent "Back to Sleep (BTS)" campaigns were developed to meet the needs of the Hispanic and African American communities in response to the high rates of Sudden Infant Death Syndrome (SIDS) among these groups. In addition, folic acid promotion materials are being modified in response to analyses which showed a lower prevalence of folic acid and multivitamin use among Hispanic women of childbearing age.

Local communities seek input from constituency and advocacy groups and work to achieve cultural competency and reduce health disparities. San Diego's Mid City Community Action Network conducts focused meetings to address the needs of the immigrant Somali refugee population in central San Diego. The Multicultural Health Promotion Program, a northern California organization, provides pregnant and parenting women culturally competent health care information.

In many ethnic communities, one of the most important partnerships in effective disease prevention and treatment is between the health worker and the client's family. The Orange County MCH "Promotores" program used matching funds through the First Five program to work with pregnant Hispanic women and their families to ensure they have access to all appropriate services and are enrolled in prenatal care.

Local MCH staff must respond to the changing cultural composition of the communities they serve. In Contra Costa County, the Perinatal Service Coordinator has conducted an Ethnic Diversity Training Day to engage medical and health care providers to provide culturally sensitive care. The Contra Costa County Health Department distributed the Steps to Take (STT) Guideline Client Handouts and SIDS materials in several languages. The MCH Branch plans to disseminate Contra Costa's material to all Perinatal Service Coordinators and CPSP providers to enhance the services provided by CPSP practitioners.

Some local jurisdictions are responding to the high rate of low birth weight among African American infants by tailoring programs to the specific characteristics of their community. The City of Berkeley conducted a community-based survey of low birth weights among African American infants, then requested and received additional funds from the State MCH Branch to address the problem.

Because of DHS's concern about persisting health disparities, selected sections of this report addressing National and State Performance Measures include data on racial and ethnic differences. Future analyses will provide data on racial and ethnic disparities for additional measures. //2005//

> Adolescent health promotion

The growth of California's adolescent population and growing awareness of adolescence as an opportunity for the prevention of health risk behaviors that are the leading causes of death among this age group, and major contributors to adult mortality, have led the State to expand its focus on adolescent health promotion. In response to the interest among county MCAH directors and local agencies, the MCH Branch is contracting with the National Adolescent Health Information Center (NAHIC) at UCSF to work with local programs to promote the plan and provide technical assistance in the development of activities. Local initiatives have been developed in response to the formulation and presentation of the plan.

//2005/ NAHIC has continued to provide technical assistance services on adolescent health planning to local jurisdictions. Staff worked with the Alameda County Youth Health Services Coordination Team to define priorities and assistance in implementing their work plan activities to support a comprehensive model of adolescent health, wellness, and development. Staff also provided support and information to the incoming county director for adolescent health in Los Angeles. NAHIC staff in collaboration with the California Adolescent Health Collaborative (AHC), local MCAH programs, the Bay Area Adolescent Health Working Group, and the National Center for Youth Law co-hosted trainings on "Confidentiality and Minor Consent" in four jurisdictions (Shasta, San Joaquin, Contra Costa, and Solano Counties). //2005//

//2005/ NAHIC produced the Guide to Adolescent Health Data Sources to assist local MCAH Directors and others interested in adolescent health to better assess the needs of youth in their community. The guide corresponded to Title V guidance and also the California Adolescent Health Strategic Plan outcome areas. In addition, a California Adolescent Data Update on Intentional and Unintentional Injury was developed for dissemination at the California Conference on Childhood Injury Control. It is also available to AHC membership (by website, email, and at meetings), and to MCAH personnel (through MCAH Action). //2005//

//2005/ The California Adolescent Health Collaborative continues to be a vital forum for local MCAH programs, community programs and providers, and state agencies to share information on important adolescent health activities and provide up-to-date training on specific issues. Mental Health financing and services were highlighted at several of the meetings during 2003-04. Meetings were held with a specific focus on at-risk youth (transition-aged youth in out-of-

home care and gay, lesbian, and transgender youth). Also, NAHIC helped to facilitate a workshop on adolescent suicide prevention at the California Conference on Childhood Injury Control. //2005//

//2005/ The MCH Branch has also participated in the DHS Physical Activity and Nutrition Coordinating Committee and California Obesity Prevention Initiative's health system. Federal funding was utilized by the MCH Branch, in collaboration with the Nutrition Network and the Sutter Memorial Hospital AFLP, to publish a cookbook specifically designed for teens. In addition, the MCH Branch funds domestic violence (DV) shelters that have provided trainings to enable youth to foster healthy relationships, obtain feedback to identify gaps in services, work as peer counselors, and serve on the advisory boards. //2005//

//2005/ The MCH Branch also participates in the multi-agency California Coalition for Youth Development. The coalition promotes positive youth development throughout California through the annual Youth Development Summit and other projects. Participants include the Attorney General's Office, the Department of Education (CDE), 4-H Center for Youth Development, Friday Night Live, Alcohol and Drug Program, and the Department of Mental Health (DMH). //2005//

//2005/ The MCH Branch will be represented on CDE's Content Review Panel for K-8 health instructional materials for 2004. MCH also collaborates with CDE and the Sexually Transmitted Disease (STD) Control Branch in improving HIV/STD/teen pregnancy integration. A meeting was held in June 2004 with key leaders of involved Departments. //2005//

//2005/ The MCH Branch is concerned about the rising teen motor vehicle death rate in California. We have been collaborating around joint areas of interest with the Epidemiology and Prevention for Injury Control (EPIC) Branch and the Child Death Review Team (CDRT) State Council. A new prevention subcommittee of the State CDRT is being planned for 2004 on Vehicle Occupant Safety, and MCH plans to participate in this work group. In addition, the MCH Branch is a member of the Statewide Coalition on Traffic Safety. //2005//

> Foster care

Children and youth in foster care settings often do not receive necessary health care evaluations and services. They are high-risk individuals, who may have been neglected or abused, and often have unrecognized and untreated medical, mental and dental problems.[18] California has over 90,000 foster children. To improve access to and oversight of health care for these children, the Health Care Program for Children in Foster Care (HCPCFC), which is a collaboration between the Department of Social Services (DSS) and CMS, was initiated in January 2000. This program, administered locally by the CHDP program, is placing public health nurses (PHNs) in welfare service agencies and probation departments, to assure delivery of preventive, diagnostic and treatment health services to children and youth in foster care.

//2005/ PHNs consult and collaborate with the foster care team members to promote access to comprehensive preventive health and specialty services. PHNs liaison with health care professionals and providers; assist in collecting and interpreting health care information; develop health care resources; and provide training for caseworkers, court officers, foster family caregivers, and others on the unique health care needs of children and youth in foster care. //2005//

//2005/ The HCPCFC PHN directory is now online, providing contact information for PHNs and supervisors, to facilitate communication; a calendar of events, including regional meetings and statewide subcommittee meetings, is also available online at www.dhs.ca.gov/pcf/cms/hcpcfc/. The program is utilizing CHDP DHS form 4484 (also online) to track and document information about barriers to health care access for children and youth

B. AGENCY 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.

//2005/ The programs of the MCH and CMS Branches include the following:

Adolescent Family Life Program (AFLP)

Adolescent Sibling Pregnancy Prevention Program (ASPPP)

AFLP/ASPPP Management Information System

Adolescent Health Program

Advanced Practice Nursing Program

Battered Women's Shelter Program (BWSP)

Black Infant Health (BIH)

BIH Management Information System

California Children's Services (CCS)

California Diabetes and Pregnancy Program (CDAPP)

California Perinatal Transport Centers

Child Health and Disability Prevention Program (CHDP)

Childhood Injury Prevention Program (CIPP)

Comprehensive Perinatal Services Program (CPSP)

Comprehensive Perinatal Services Training

Family Health Outcomes Project (FHOP) and Local MCH Data

Fetal Infant Mortality Review Program (FIMR)

Genetically Handicapped Persons Program (GHPP)

Health Care Program for Children in Foster Care (HCPCFC)

Maternal and Child Health Program (MCH)

Medical Therapy Program (MTP)

Medically Vulnerable Infant Program (MVIP)

Newborn Hearing Screening Program (NHSP)

Oral Health

Perinatal Profiles and Improved Perinatal Outcomes Data Reports Website

Regional Perinatal Programs of California (RPPC)

Sudden Infant Death Syndrome (SIDS)

Youth Pilot Program (YPP) and Integrated Health and Human Services Pilot //2005//

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

Support to local infrastructure:

//2005/ Several systemwide programs, including MCH, CCS, and CHDP, are administered by local health departments under the direction and guidance of the MCH and CMS Branches. In addition to setting statewide policy, the State funds local health departments for these activities. //2005//

//2005/ State statute established the YPP which authorizes a total of six counties to implement programs which provide integrated, comprehensive services for children and their families. YPP focuses on high-risk, multi-need, low-income youth and their families and permits the blending of certain state funds. The YPP pilots allow counties to make decisions locally

regarding the best use of state and local human services funds without a reduction of state and federal funds. YPP was established in 1995 and reauthorized for 2000-2004. There is proposed legislation to extend the YPP to January 1, 2009.//2005//

Quality of maternity services:

The California Perinatal Quality Care Collaborative (CPQCC), organized in 1998, is a cooperative effort of public and private obstetric and neonatal providers, insurers, public health professionals (including MCH and CMS), and business groups. It is working to develop an effective perinatal and neonatal quality improvement infrastructure at state, regional, and hospital levels. CPQCC is financially supported by the David and Lucile Packard Foundation and the MCH Branch of DHS. The CPQCC Data Center is partnering with Stanford University's Center for Health Policy and Research for statistical programming and other resources. The CMS Branch is collaborating with CPQCC in retrieval and analysis of NICU data.

/2005/ CPQCC hospital membership for collecting perinatal and neonatal data has grown to over 80 hospitals and accounts for most of the newborns requiring critical care in California. Participating hospitals receive an annual online report with comparative analysis. The Perinatal Quality Improvement Panel (PQIP), a subcommittee of CPQCC, recommends quality improvement objectives, provides models for performance improvement, and assists providers in a multi-step transformation of data into improved patient care through the use of toolkits, workshops, and follow-up. MCH and CMS staff are members of the CPQCC Executive Committee and PQIP. //2005//

/2005/ The MCH Branch is currently developing the Maternal Quality Improvement (MQI) Project, a collaborative effort between the CPQCC and UCLA's Maternal Quality Indicators group. The MQI Leadership Council will include members from CCS, MCH, MCMC, and Medi-Cal Policy Section. MQI will direct statewide maternal quality improvement activities utilizing the methodology developed by the CPQCC. MQI will measure maternal quality of care in California, beginning with the use of data sets from the California Office of Statewide Health Planning and Development (OSHPD) to determine hospital-level outcomes for maternal/neonatal infections and postpartum hemorrhage. Dr. Susann Steinberg, Chief of the MCH Branch, presented California's MQI project model in a CDC MCH Epidemiology Webcast on April 7, 2004; the webcast is available at <http://www.uic.edu/sph/cade/mchepi/meetings/april2004/index.htm>. //2005//

A number of other Title V supported programs address quality issues in relation to maternal and infant care. The fourteen RPPC promote access to risk appropriate quality health services to pregnant women and their infants.

Infants' access to care:

Medi-Cal, HF and Access for Infants and Mothers (AIM) provide health insurance coverage for infants. Medi-Cal reaches infants living in households with incomes below 200 percent of FPL. HF provides insurance coverage for infants in households with incomes up to 250 percent of the FPL; monthly premiums and copayments for certain types of visits and prescriptions are required. AIM provides state-subsidized third party insurance for infants in households with incomes between 200 and 300 percent of FPL.

/2005/ For FY 2001-02, the most current year for which data are available, there were 476,809 infants enrolled in Medi-Cal, a 7.3 percent increase from the prior year and reflective of the overall increase in the Medi-Cal population between those years. As of December 2003, 7,177 infants less than one year of age were enrolled in HF. (These are infants who are over income eligibility for Medi-Cal). There was no increase in enrolled infants from March to December

2003 (compared to a 22 percent increase the prior year), and this leveling off may in part be due to the fact that there was no funding for certified application assistants (people from community organizations trained to help fill out the joint Medi-Cal/HF applications) after July 1, 2003. //2005//

Infant Health Promotion

//2005/ Preventive screening and basic health services are provided to infants under a year of age by the CHDP program. In FY 2001-02, 516,367 infants under one year of age received health services through CHDP. This was a less than 1 percent drop from the prior year. Of these infants, 61.2 percent had Medi-Cal coverage and 38.8 percent were state-funded (compared with 60 percent and 40 percent in FY 2000-01). //2005//

//2005/ Of the 516,367 infants served in FY 2001-02, 67.7 percent were Hispanic, 9.8 percent White, 5.3 percent African American, 4.5 percent Asian, 0.6 percent Filipino, 0.3 percent American Indian, 0.2 percent Pacific Islander, and 11.6 percent were other or unknown. While there was little change in Hispanic, White, or Pacific Islander ethnic groups served compared with the prior year, African-American decreased by 7.7 percent, Asian increased by 9 percent, Filipino increased by 8.9 percent, and American Indian decreased by 9.9 percent. //2005//

DHS has adopted a comprehensive approach to breastfeeding promotion that includes the promotion of exclusive breastfeeding initiation at birth and of prolonging breastfeeding during infancy. Breastfeeding is promoted across all programs serving pregnant women and infants. Informational materials regarding breastfeeding, nutrition and immunizations for women, adolescents, children, and infants, are regularly disseminated to AFLP and BIH providers as well as to Cal Learn and Cal SAFE program administrators. The CDAPP Guidelines for Care include a chapter on breastfeeding. Patient education materials have been developed for women who breastfeed after gestational diabetes, and for those who take insulin and breastfeed.

//2005/The MCH website includes a page devoted to breastfeeding. The page includes data on postpartum hospital breastfeeding discharge rates, local breastfeeding coalitions, links to other breastfeeding resources, and model breastfeeding policies. //2005//

//2005/ Birth defects remain the number one cause of infant deaths. While the causes of many congenital defects have yet to be identified, effective measures for the prevention of a significant portion of neural tube defects are known. MCH Branch activities focus on folic acid promotion during the preconception and prenatal periods to reduce the risk of neural tube defect-affected pregnancies. The MCH Branch is an active participant in the National Council on Folic Acid and the California Folic Acid Council. //2005//

//2005/ Several programs of the MCH Branch address additional causes of infant mortality and morbidity. The SIDS Program has facilitated the SIDS Risk Reduction campaign, also known as BTS in California. The rate of death due to SIDS in California declined from 94.5 per 100,000 live births in 1992 to 31.7 in 2002. While there has been a continuing decline in the SIDS death rate, the rate for African Americans remains high. In 2002 the rate of African American infant deaths from SIDS was more than twice that of any other group: 95.6 per 100,000 for African Americans, 45.6 for Whites, 19.0 for Hispanics, and 17.3 for Asian/Pacific Islanders. (Between 1990 and 2000, there was an increase in the number of "Undetermined" infant deaths due to co-sleeping. In some jurisdictions the coroner will not call an infant death SIDS if co-sleeping is involved.) //2005//

//2005/ In FY 2002-03 funding for the FIMR Program was reduced by 33 percent. As a result of the cuts, the number of participating counties declined from 21 to 17. Several counties are incorporating the Perinatal Periods of Risk approach into their FIMR Program. Community

interventions that have resulted from the FIMR review include perinatal substance abuse programs, development of pregnancy tracking forms, education on monitoring fetal movement and signs of preterm labor, SIDS risk reduction activities, and protocols and standards of care. The State consultant for SIDS and FIMR has been attending the State Advisory Meetings for the CDRT. //2005//

//2005/ The MCH Branch prepared a grant application to CDC for a Fetal Alcohol Syndrome Program, but it was not funded. MCH continues to network with counties that are addressing Fetal Alcohol Spectrum Disorder (FASD). //2005//

//2005/ There are 159 hospitals certified and participating in the Newborn Hearing Screening Program as of March 31, 2004, up from 138 one year ago. It is expected that by the end of August 2004, all 179 CCS-approved hospitals will be certified. During CY 2003, over 304,000 infants received hearing screening prior to hospital discharge. 473 infants were identified with hearing loss, an incidence rate of 2 per 1000. Among NICU infants, the incidence of hearing loss was 6 per 1000. Only 5 percent of infants who needed additional evaluation after hospital discharge were lost to follow-up (compared to 30-50 percent in other states). //2005//

//2005/ The Genetic Disease Branch (GDB) of DHS provides newborn screening for primary hypothyroidism, phenylketonuria (PKU), galactosemia and several hemoglobinopathies to 99 percent of the newborn population. A state-mandated pilot project to evaluate expanded genetic disease testing utilizing Tandem Mass Spectrometry (MS/MS) ended in June 2003. In the pilot project, over 320,000 infants were tested, over 425 newborns were referred for follow-up at one of the CCS-approved Metabolic SCCs, and 52 infants were diagnosed with a metabolic disorder. Laboratory, follow-up, diagnosis, treatment and outcome data are being collected as part of a three-year evaluation process supported by HRSA. Guidelines are being developed for diagnostic follow-up and treatment of the most frequently identified disorders.//2005//

Preventive and Primary Care for Children

Access to care:

Medi-Cal and HF provide 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 up to 133 percent of FPL, children and adolescents ages 6 up to 19 at up to 100 percent of FPL, and young adults ages 19 to 21 at up to 86-92 percent of FPL. HF covers 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. There were 683,787 children enrolled in HF as of December 30, 2003. This is a 7 percent increase from March 2003 and a 22 percent increase from March 2002.

The CMS Branch administers the screening and preventive component of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) entitled the CHDP program. CHDP provides preventive services, including health assessments, immunizations, screening tests, dental screening, anticipatory guidance, health education, 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.

//2005/ In FY 2001-02, 2,087,243 children received screening and health assessments through the CHDP program, a 4.8 percent decrease from FY 2000-01. There was an increase in the number of children receiving services enrolled in MCMC plans through which they receive health assessments. Of the nearly 2.1 million children receiving CHDP services, 55 percent were funded by Medi-Cal and 45 percent were funded through state funds, representing a 5.8

percent increase in Medi-Cal funded services. Of the Medi-Cal recipients, 34 percent received services through fee-for-service Medi-Cal and 66 percent through the MCMC plans. //2005//

//2005/The CHDP Gateway, implemented on July 1, 2003, has pre-enrolled 671,557 children through June 2004, and of this number, 563,345 (80 percent) have requested a joint Medi-Cal/HF application. The number of applications returned and the extension of eligibility has averaged 12 percent. DHS has modified (effective June 1, 2004) the pre-enrollment process that allows the Gateway transaction to identify and "deem" certain infants less than one year of age as eligible for ongoing, full-scope, no cost Medi-Cal at the time of a CHDP health assessment. The families of these infants do not have to complete a Medi-Cal application. Through this process, 5,802 infants were enrolled in Medi-Cal in June. Information about the Gateway is available at <http://www.dhs.ca.gov/pcfh/cms/chdp/chdpgateway.htm>. //2005//

Childhood/adolescent health promotion:

Injuries are the leading cause of mortality among children and youth. To reduce injury-related mortality and morbidity among children and adolescents, MCH's Childhood Injury Prevention Program contracts with the Center for Injury Prevention Policy and Practice (CIPPP) at SDSU.

//2005/ CIPPP provides technical assistance and training for local MCAH programs through the annual Childhood Injury Prevention Conference, bi-monthly teleconferences, injury prevention list serve, and weekly literature reviews of the latest published injury prevention research. The Center has produced a CD-Rom with resources and educational materials on injury prevention issues to be used by local jurisdictions for their injury prevention efforts. The MCH Branch continues to fund five local MCAH jurisdictions to increase injury prevention capacity within their community. Each jurisdiction receives \$45,000 annually for three years. The new cycle starts with FY 2004-05. Plumas, Sacramento, Siskiyou, Stanislaus, and Ventura Counties were awarded funding for this cycle. //2005//

//2005/ As a part of the California Initiative to Improve Adolescent Health by the Year 2010, NAHIC continues to provide support to local jurisdictions interested in adolescent health. During this fiscal year, the Guide to Adolescent Health Data Sources was produced to assist locals who were interested in adolescent health to better assess the needs of the youth in their community. In order to increase capacity of local programs during tight budget times, NAHIC is providing technical assistance to assist programs in developing a grant application template that they can use for future applications to foundations and federal agencies interested in adolescent health. The California Adolescent Health Collaborative continues to be a vital forum for local MCAH programs, community programs and providers and state agencies. The Collaborative shares information on important adolescent health activities and provides up-to-date training on specific issues. Mental Health financing and services were highlighted at several of the meetings during 2003-04. //2005//

//2005/ The MCH Branch applied for a System Capacity for Adolescent Health Technical Assistance Grant from the Association of Maternal and Child Health Programs (AMCHP), but did not receive one. In spite of this, California hopes to continue to assess and improve adolescent health system capacity in the State. //2005//

//2005/ The MCH Branch participates in the multi-agency California Coalition for Youth Development. The coalition serves to improve youth development throughout California through the annual Youth Development Summit and other projects. Participants include the Attorney General's Office, CDE, 4-H Center for Youth Development, Friday Night Live, Alcohol and Drug Program, and DMH.

//2005/ The MCH Branch participates in UCSF's Childcare Health Program Advisory Committee. This organization is dedicated to enhancing the quality of child care for California's children by

initiating and strengthening linkages between health, safety, and child care communities and the families they serve. This program receives the Healthy Child Care America Grant.

/2005/ The MCH Branch received a two-year planning grant for fiscal years 2003-05 from HRSA for the State Early Childhood Comprehensive Systems (SECCS) project. The goal is to provide state-level leadership for early childhood health programs to help California's children be emotionally, socially, and physically healthy and ready for kindergarten. The two-year planning grant will culminate in the completion of a statewide needs assessment and strategic plan. The assessment and plan will address and coordinate critical components of early childhood health care systems. These include access to medical homes, mental and social health, childcare education, parent education, family support, and safety in out-of-home care. The project will coordinate various health-related programs at the state and local levels, including: DHS, DMH, DSS, CDE, Department of Developmental Services (DDS), First Five California, and MRMIB. It also includes organizations such as the American Academy of Pediatrics, Family Voices of California, March of Dimes, Easter Seals, Interagency Coordinating Council for Children with Disabilities; and representatives of faith-based organizations (e.g. California Council of Churches). //2005//

/2005/ The CMS Branch continues to participate in the Childhood Asthma Initiative. The CAI Asthma Treatment Services Project, administered by the CMS Branch, is being discontinued but the CAI CHDP project, consisting of asthma education, trainings, resource development, and implementation of Asthma Assessment Guidelines for CHDP providers, will continue. Some local CHDP programs have established or become active in local asthma coalitions, and other programs have expanded their asthma community outreach as a direct result of the CAI CHDP project. //2005//

/2005/ The MCH and CMS Branches continue to participate in the California Interagency Asthma Interest Workgroup, a collaborative that includes DHS, CDE, First Five California, and California Environmental Protection Agency. This group serves as a forum for collaboration in addressing asthma in California. //2005//

Services for Children with Special Health Care Needs (CSHCN):

The CMS Branch administers the CCS program that provides case management and payment of services for CSHCN. The program authorizes medical and dental services related to the CCS eligible condition. Additionally, it establishes standards for providers, hospitals, and SCCs 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 CCS Medical Therapy Program (MTP) provides physical and occupational therapy services to children with CCS MTP eligible conditions. There is no financial eligibility requirement. In 2003, there were 104 Medical Therapy Units (MTUs) located on public school campuses throughout California. Over 22 new MTUs or therapy satellites in Southern California began remodeling, new construction, or new design in 2004. The facility expansion is necessary to accommodate the overcrowding at existing MTUs and to extend outpatient services to communities with new school construction.

/2005/ The estimated caseload for CCS in FFY 2002-03 was 172,340. This is a 4.0 percent increase from the prior year. Approximately 75 percent of these children were enrolled in Medi-Cal and 10 percent in HF. CHDP providers continue to facilitate referrals to CCS of children with CCS eligible medical conditions or potentially CCS eligible conditions. //2005//

The CCS program is responsible for case managing the CCS eligible condition for Medi-Cal beneficiaries 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 HF. Through a system of CCS-approved SCCs, CCS provides access to quality specialty and subspecialty providers for CSHCN. The SCCs are located in the outpatient departments of tertiary care hospitals and use multidisciplinary teams to address health needs and provide coordinated care for CCS beneficiaries.

//2005/ In the past, 31 "independent" counties fully administered their own CCS programs, while 27 "dependent" counties shared the administrative and case management activities with CMS Branch Regional Offices. The lack of adequate state Regional Office resources to perform case management activities for dependent counties, coupled with the difficulty of maintaining efficiency in a dual system, has led to the modification of dependent county program operations. The Case Management Improvement Project has encouraged dependent counties to assume case management functions historically done by state Regional Office staff. In turn, the function of the Regional Offices is shifting from primarily direct case management to training, monitoring, and oversight of the case management activities of the dependent counties and providing backup for the more technically challenging cases. //2005//

The CCS Program has structured a system of regional affiliation among the 114 CCS-approved NICUs to assure that infants have access to appropriate specialty consultation and intensive care services throughout the state. CCS-approved NICUs are designated as Intermediate, Community, and Regional NICUS. NICUs that provide basic level intensive care services to infants in their communities are required to have established affiliations with NICUs that provide more extensive services, to facilitate obtaining consultation and needed patient transfers. The CCS approval process denotes the level of patient care provided in each NICU and verifies that the cooperative agreements are in place. In June 2001 the CPQCC initiated annual NICU data reporting to CCS for the first cohort of participating nurseries. Annual NICU reporting is required for continuing CCS approval and reporting through the CPQCC facilitates data submission and analysis and improves reporting accuracy. In February 2003, the CMS Branch instructed all CCS-approved hospitals that CCS NICU annual data submission through CPQCC is mandatory beginning in January 2004.

//2005/ For 2002, 26 NICUs reported their data through CPQCC. The CPQCC web-based report for 2002 has been completed and is available on-line. //2005//

//2005/ The CMS Branch has two programs that address the needs of high-risk infants. The first allows infants that are discharged from CCS-approved NICUs to be followed in NICU High Risk Infant Follow-up clinics. Three multidisciplinary outpatient visits are authorized by CCS during the first three 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. The second program, the Medically Vulnerable Infant Program (MVIP), 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. Infants are eligible for the MVIP program if they have required medical care in a CCS-approved NICU, are at risk of developing a CCS eligible condition, and were premature or had a defined, serious neonatal health problem. Twelve contractors, including hospitals, community-based organizations and universities, have contracts until June 30, 2005. As of March 1, 2004, 3,540 infants have been enrolled in the program and 40,437 home visits have been made since program inception July 2000. Also, as of March 1, 2004, there were 1,432 active cases and 99 percent of these infants had medical homes. //2005//

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 program enrollees 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.

/2005/ There are currently 1,690 clients enrolled in GHPP. Hemophilia is the most common diagnosis followed by cystic fibrosis, sickle cell disease, Huntington's Disease, and Friedreich's Ataxia. //2005//

Rehabilitation services to Supplemental Security Income (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. If physical and/or occupational therapy are needed, they can be provided in the CCS MTP. Children receiving SSI who have mental or developmental conditions are served by DMH, DDS, and CDE.

/2005/ During FY 2002-03, CCS received 1,632 referrals of SSI beneficiaries, and, of these, approximately half were medically eligible for CCS. //2005//

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

SCCs 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 (FCC). 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 SCC, the CMS Branch sends a follow-up report to the facility with FCC recommendations.

The CCS Program has a longstanding history of facilitating FCC and services for families of CSHCN. County CCS programs cover M and T expenses for CSHCN and their families. County CCS programs also work with hospitals and community agencies that contribute to expenses for family M and T.

/2005/ The CMS Branch issued instructions to county CCS programs in February 2004 for approving M and T benefits and procedural guidelines for reimbursement for M and T costs. CCS staffing standards allow a parent liaison position in each county CCS program.

/2005/ The CMS Branch has been collaborating with Family Voices in a two-phase project to revise CCS letters/documents to make them more family-centered. Drafts of 64 letters were reviewed. Both phases of this collaborative process have been completed; however, due to budgetary constraints, the contracted work for translating the letters, documents, and materials into DHS's threshold languages has not occurred.

/2005/ CRISS (Children's Regional Integrated Service System), which is a collaboration of family support organizations, pediatric provider institutions and organizations, and county CCS programs in the 14-county area of Northern California, as well as Family Voices of California and three statewide pediatric organizations, sponsors major conferences on family centered care for children with special health care needs and provides technical assistance to support local efforts promoting family centeredness, including transition planning, in CCS programs. CRISS sponsored a fall 2003 workshop on family-centered communications. 120 CCS staff from 15 Bay Area counties attended. Family support agency staff and parent leaders also attended, as well as staff from Regional Centers, Special Education, and other agencies in Northern California.

Approximately 15 CCS counties have sent out family satisfaction surveys in 2003-04, and many more counties are developing family satisfaction surveys for 2005. Approximately 16 counties have parent liaisons. San Mateo County is planning to develop a multicultural parent task force. San Diego County is a model for the state with six parent liaisons, two of which are Spanish-speaking. Family members are participating on advisory committees or task forces in

many counties, and they are becoming involved in in-service training of CCS staff and providers.

The Medical Therapy Programs have been targeted for many FCC activities because they provide direct services. Some MTUs have made computers available to families for web searches. Collaborative workshops for families have been held in MTUs on topics such as Positioning and Play, Grief and Loss, the IEP, and Feeding and Nutrition. Treatment materials are available to families in many languages. San Francisco County recently sponsored "A Day in the Life" workshop where families shared their daily routines.

Provide transitioning services to CSHCN:

The CMS Branch recognizes the importance of transitioning care for CSHCN from pediatric to adult services. Standards for beginning transition services at age 14 years will be added to the standards for the outpatient SCCs when they are revised. During site reviews of new SCCs and county CCS programs, transition issues are emphasized as important for the future delivery of medical care and services to the CSHCN. During both types of reviews, staff are advised of the availability of transitioning resources.

Several counties are making special efforts with regard to transition planning services. CCS programs in several Bay Area counties have participated in transition trainings. CCS staff in Southern California regularly attend and participate with the Special Education Local Planning Areas (SELPA) Interagency Coordinating Transition Council. In Santa Barbara County, there is a Transition Committee of CCS staff. They receive input from CCS parents, young adult clients, and the Family Support Center to assess and develop ways to infuse the concept of transition into all CCS services and functions.

//2005/ Counties utilize transition committees, clinics, checklists, packets of information, and questionnaires to address transition issues. The CMS Branch is currently forming a workgroup for developing policy and guidelines. The group includes county CCS physicians, nurses (one of whom is also a parent of a child with special needs), social workers, and therapists, as well as a physician from a MCMC plan, a community advocate, two physicians from UCLA with interest and expertise in transitional care, a representative from the Healthy and Ready to Work Program, several parents (including the Parent Liaison from LA County CCS), and a young adult who is transitioning out of CCS. //2005//

C. ORGANIZATIONAL STRUCTURE

Please see attachment containing updated organizational charts. See below for url links to our Primary Care and Family Health Division (PCFH) and California Executive Branch (CA EXEC) organizational charts:

PCFC

<http://admin.int.dhs.ca.gov/orgcharts/pdf/pcfhd.pdf>

CA EXEC

http://www.cold.ca.gov/Ca_State_Gov_Orgchart.pdf

//2005/ In November of 2003 Arnold Schwarzenegger was elected Governor of California, replacing Gray Davis. Shortly thereafter S. Kimberly Belshe replaced Grantland Johnson as the Secretary for the Health and Human Services Agency, which is a cabinet-level position reporting directly to the Governor. In March 2004 Sandra L. Shewry replaced Diana Bonta, RN, DrPH as Director of DHS. //2005//

The MCH and CMS Branches have joint responsibility for carrying out the Title V functions. MCH and CMS are located in DHS, which is one of 13 departments within the California Health and Human Services Agency (HHS). 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 (OFP); WIC; GDB; and Primary and Rural Health Care Systems.

//2005/ The Deputy Director of PCFH is Catherine Camacho, who replaced Tameron Mitchell, RD, MPH in February, 2003. The Chief of the MCH Branch is Susann J. Steinberg, MD, and the Acting Chief of the CMS Branch is Marian Dalsey, MD, MPH. //2005//

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 (GHPP), which provides services to individuals with certain genetic conditions, is authorized by the Health and Safety Code Division 106, Part 5, Chapter 2, Article 1, Sections 125125-125180. The CHDP program, California's preventive healthcare program for children, is authorized by the Health and Safety Code Division 106, Part 2, Chapter 3, Article 6, Sections 124025-124110 and by Division 103, Part 3, Chapter 1, Article 1, Section 104395.

D. OTHER MCH CAPACITY

Maternal and Child Health Branch

//2005/ Susann Steinberg, MD was appointed Chief of the MCH Branch in March 2003, after having been Acting Chief for four months. Dr. Steinberg is Board Certified in Family Practice as well as Preventive Medicine and has an MBA. She is also Chief of the Programs and Policy Section in the MCH Branch and Acting Chief of the Office of Family Planning. //2005//

Les Newman is the Assistant Chief of the MCH Branch, a position he has held since February 2001. He has over twenty years working in leadership positions in California government and was previously Operation Section Chief within the MCH Branch.

The MCH Branch staff includes senior consultants in a variety of clinical, public health, and scientific disciplines. Emeterio Gonzalez, MD is a Board Certified Obstetrician and Gynecologist who serves as a medical consultant to the Branch. Eileen Yamada, MD, MPH is a board-certified Pediatrician and serves as the MCH Pediatric Consultant, Coordinator for the Childhood Injury Prevention Program, and State Adolescent Health Coordinator.

//2005/ In 2003-04 several key positions in the MCH Branch became vacant due to retirement of staff. One of them was Robert Bates, MD, MPH, who retired from a part-time Medical Consultant position (Pediatrics). Redirection of staff has been accomplished, but due to a hiring freeze, replacement of staff is challenging at this time. The half-time Public Health Nutritionist position is also vacant. //2005//

Holly Huffer, PhD was the Title V Principal Author in 2003, and prior to that, Rhonda Sarnoff, DrPH was the Title V Coordinator. Prior to 2003, Katherine Heck, MPH, a Health Statistician with CDC, and Sharon Dourousseau, MD, MPH, an Epidemic Intelligence Service Officer with CDC, also worked on the Title V report.

//2005/ Lori Llewelyn, MPP joined MCH in February 2004 as Title V Principal Author. Mike Curtis, PhD and Eugene Takahashi, PhD oversee the compilation of state statistics for the Title V report. Gretchen Caspary, PhD, MBA, who joined MCH in March 2003, is the Coordinator for the Title V Five-Year Needs Assessment. This Title V team works under the direction of Shabbir

Ahmad, DVM, MS, PhD, Chief of the Epidemiology and Evaluation Section of MCH. //2005//

The MCH Branch is divided into three sections: Programs and Policy; Epidemiology and Evaluation; and Operations. Domestic Violence (DV) and School Health Connections (SHC), which were formerly separate sections, were consolidated into the Programs and Policy Section in 2003.

Epidemiology and Evaluation Section:

The Epidemiology and Evaluation Section provides program information for monitoring MCH program implementation, evaluating program effectiveness, and policy development. Program and population-based data are analyzed to support California's application for Federal Title V Grant Funds and Needs Assessment. They also provide assessment and surveillance information for use in program related research, program policy planning, and allocation of resources. The section is organized into two research units comprised of 21 research and support staff.

//2005/ Shabbir Ahmad, DVM, MS, PhD, was appointed Chief of the Epidemiology and Evaluation Section in May 2004, after having served as Acting Chief for twelve months. Ellen Stein, MD, MPH, was Section Chief in 2002, and Gwen Nakagawa was Acting Chief in 2001. //2005//

The Epidemiology and Evaluation Section consists of two units: Surveillance and Program Evaluation; and Epidemiology. The Acting Chief of the Surveillance and Program Evaluation Unit is Mike Curtis, PhD. The Chief of the Epidemiology Unit is Eugene Takahashi, PhD.

Operations Section:

The Operations Section assumes the administrative functions for the branch, including fiscal forecasting, budget related work, 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. The section has two units: the Contract Management and Policy Unit (12 staff) and the Contract and Fiscal Management Unit (14 staff).

Nancy Smith has been the Chief of the Operations Section since 2001. Prior to Ms. Smith's tenure, Les Newman was Section Chief.

Programs and Policy Section:

The Programs and Policy Section of MCH coordinates the implementation of standards of care for pregnant women under the CPSP, RPPC, FIMR, SIDS, CDAPP, BIH, and AFLP. Program consultants develop standards and provide consultation and technical assistance to local MCH jurisdictions and other organizations.

Susann Steinberg, MD is the Chief for the Programs and Policy Section (as well as being the Branch Chief), a position she has held since 2002. Prior to Dr. Steinberg, the Section Chief was Willie Parker, MD, and, prior to him, Terrence Smith, MD.

//2005/ The Programs and Policy Section consists of five program units: two Perinatal Health Units, the Child and Adolescent Health Unit, the DV Program, and SHC. //2005//

//2005/ The Perinatal Health Units are supervised by Chris Carson, RN, MSN and Leona Shields, MS, CNP, Nurse Consultant Supervisors, and consist of a staff of 15. The Perinatal Health Units provide technical assistance and consultation to 61 health jurisdictions regarding their MCH allocation, BIH, Breastfeeding Support Programs, SIDS and FIMR programs. This unit

also has responsibility for the perinatal quality improvement contracts with the RPPC, CDAPP and the Perinatal Transport Program as well as CPSP. //2005//

//2005/ The Child and Adolescent Health Unit, with three staff members, is supervised by Chris Carson, RN, MSN, who also supervises one of the Perinatal Health Units. The Child and Adolescent Health Unit has responsibility for the provision of consultation and technical assistance to the 43 agencies that provide AFLP services, 18 of which also provide ASPPP services. //2005//

//2005/ The DV Program has a staff of six, and Ellen Buchanan, Health Program Specialist II, is the acting manager. Previous program managers were Suzie Fatheree, RN (2002-2003), Joseph Perez (2001-2002), and Carol Motylewski-Link (2001). //2005//

//2005/ The DV Program has suffered from state budget reductions. The Program currently has 145 grants, down from 155 two years ago. The DV program will have 97 grants as a result of consolidating the prevention/prevention planning and unserved/underserved grants into the direct shelter service grants and one technical assistance grant. State budget reductions have also reduced statewide technical assistance and training contracts from ten to one. //2005//

//2005/ The SHC Program, with a staff of one, is under the leadership of Ellen Buchanan, Health Program Specialist II and Acting Manager of the Domestic Violence Program. Previous program managers were Suzie Fatheree, RN (2003) and Nancy Gelbard, MS, RD (2001-2002). //2005//

SHC did not receive continued CDC funding, and the 25 contracts for HF/Medi-Cal school outreach ended June 30, 2002 due to lack of State funds. The remaining six foundation-funded contracts were completed on June 30, 2003. The number of staff is down from eight in 2002 to one in 2004.

Children's Medical Services (CMS) Branch

//2005/ Maridee A. Gregory, MD, Branch Chief, retired in April 2004 after 24 years of service in DHS. Marian Dalsey, MD, MPH was appointed Acting Branch Chief in April 2004. Dr. Dalsey is a board certified pediatrician. She has held positions in healthcare administration and policy development at the local level in California and Illinois and with Medi-Cal and CMS at DHS. //2005//

Elisabeth H. Lyman, MPH, was Assistant Branch Chief until 2003 when she left CMS to become the Assistant Deputy Director for the PCFH Division.

//2005/ The Assistant Branch Chief position has been eliminated due to budget constraints. //2005//

The CMS Branch is composed of five sections: Program Standards and Quality Assurance, Program Operations, Program Case Management, Program Support, and Information Technology.

Program Standards and Quality Assurance (PSQA) Section:

The PSQA section is responsible for the development of regulations, program policies and procedures, and provider standards for both the CHDP and CCS programs; development and maintenance of the NHSP; development of policies and procedures to implement Medi-Cal managed care, the HFP, the Health Care Program for Children in Foster Care and the Children's Asthma Program; provision of pediatric consultation to the Medi-Cal program and other DHS programs. The Section also reviews and approves all requests for organ transplants for children funded by CCS and Medi-Cal.

//2005/ PSQA is divided into Medical Program and Policy Standards with seven staff and Program Planning and Development with eight staff. The number of staff are down from eight and ten, respectively, two years ago. The Children's Asthma Program reports directly to the CMS Branch Chief. //2005//

Marian Dalsey, M.D., M.P.H., board certified pediatrician, resumed the position of section chief of PSQA in 2002, a position which she had held until 1999.

Program Operations Section (POS):

The POS is responsible for planning, implementing, and monitoring the 58 county CCS and 61 local CHDP programs. Professional staff provide pediatric medical expertise and consultation in medicine, nursing, Physical Therapy/Occupational Therapy (PT/OT), dentistry, nutrition, audiology, public health social work, and educate providers, State and local agencies, and the public. POS is responsible for oversight and monitoring of the MTP. POS has responsibility for review and approval of hospitals and SCCs. The POS is implementing the Health Care Program for Children in Foster Care (HCPCFC).

The positions in POS are divided between the central office in Sacramento and three regional offices. Each regional office has a 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.

//2005/ This section has 39 positions, down from 45 four years ago.

//2005/ The POS Section Chief position is currently vacant. Dr. Maridee Gregory, who was Acting Chief of POS (in addition to Branch Chief) in 2003-2004, retired in April 2004. Jean Whittiker, P.H.N., B.S.N., M.S., was Section Chief from 1996 until her retirement in 2003. //2005//

Program Case Management Section:

The Program Case Management Section is composed of three units. The Case Management Unit, also known as the CCS Sacramento Regional Office (SRO), provides CCS case management and technical assistance for 21 dependent counties. The GHPP Unit provides medical and administrative case management for GHPP clients. The Provider Services Unit is responsible for the enrollment of CCS, GHPP, and CHDP program providers; approving CCS paneled providers; maintaining records of CCS/GHPP approved facilities and SCCs; and working with providers, CCS and GHPP SCCs, and hospitals in resolving reimbursement issues.

//2005/This section has 48.5 positions, down from 60.5 in 2002. //2005//

The position of Chief of the Case Management Section is currently vacant. Karlette Winters, M.D., was Chief from 2002 until her retirement in April 2004.

Program Support Section (PSS):

The PSS has responsibility for budget planning and fiscal management of CMS funds; supervising and prioritizing expenditure of funds; data analysis and research; negotiating and preparing contracts and grants; personnel and position management; business services; and clerical support. PSS is organized into three units: Data Analysis, Research, and Evaluation (DARE); Clerical Support; and Administration.

//2005/ There are currently 16 positions in this Section, down from 25.5 in 2001. //2005//

The Section Chief of PSS is Erin M. Whitsell; prior to 2003, Irvin B. White was the Section Chief.

Information Technology Section (ITS):

//2005/ITS is responsible for all aspects of information technology support for the CMS Branch and for the CMS case management and data system (CMS Net). The section is divided into two units: Information Systems, with 16 positions, and IT Support, with 5 positions. These positions include 10 state staff and 11 contract positions. Six contract positions are for E47 and will end June 30, 2004. William White has been the section chief since 2003. //2005//

E. STATE AGENCY COORDINATION

//2005/ The lead on Title V programs in California is taken by the MCH and CMS Branches of the PCFH Division of the DHS in HHS. The MCH and CMS Branches coordinate with several other departments and offices, both within and outside of HHS, on programs related to Title V. In addition, MCH and CMS work with various universities and professional organizations on programs and projects related to Title V. //2005//

Inter and intra agency collaboration is vital for meeting the needs of all children and particularly CSHCN. MCH and CMS have numerous 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, coalitions and children's advocacy groups.

//2005/ CPQCC is a cooperative effort of public and private obstetric and neonatal providers, insurers, public health professionals (including MCH, CMS, and other branches of DHS), and business groups. It is working to develop an effective perinatal and neonatal quality improvement infrastructure at state, regional, and hospital levels.//2005//

//2005/ The MCH Branch has received a two-year planning grant for 2003-2005 from HRSA for the SECCS project, which focuses on interagency collaboration and coordination. The goal is to provide state-level leadership for early childhood health programs to help California's children be emotionally, socially, and physically healthy and ready for kindergarten. The project will coordinate a myriad of health-related programs at the state and local levels, including: DHS, DMH, DSS, CDE, DDS, First Five California, MRMIB; organizations such as the American Academy of Pediatrics, Family Voices of California, March of Dimes, Easter Seals, Interagency Coordinating Council for Children with Disabilities; and representatives of faith-based organizations (e.g. California Council of Churches). The two-year planning grant will culminate in the completion of a statewide needs assessment and strategic plan that addresses and coordinates critical components of early childhood health care systems related to access to medical homes, mental and social health, childcare education, parent education, family support, and safety in out-of-home care. //2005//

Department of Education (CDE)

The MCH Branch works closely with CDE on the SHC Program. The two organizations collaborated to develop the infrastructure to support coordinated school health.

//2005/ The MCH Branch continues to work closely with CDE to develop the infrastructure to support coordinated school health. In addition, MCH SHC is working collaboratively with the Project Coordinator of the SECCS grant to ensure a coordinated approach to early childhood health programs to help California's children be healthy and ready for school. //2005//

/2005/ The MCH Branch is represented on CDE's Content Review Panel for K-8 health instructional materials for 2004. MCH also collaborates with CDE and the STD Control Branch in improving HIV/STD/Teen Pregnancy Integration. In 2003 representatives from MCH, CDE, and the STD Control Branch attended regional meetings with other states jointly sponsored by the Society of State Directors of Health, Physical Education, and Recreation; AMCHP; the National Alliance of State and Territorial AIDS Directors; the National Coalition of STD Directors; and the National Conference of State Legislatures. California was successful in obtaining a \$1000 technical assistance grant to continue activities at the state level to bring together additional stakeholders. //2005//

/2005/The CMS Branch is working with CDE (1) to assure that all infants with hearing loss identified through the NHSP are referred to Early Start and (2) in partnership on the Maternal and Child Health Bureau (MCHB) grant for improving services for early identification and intervention of hearing loss. //2005//

/2005/The CCS MTP is working with CDE on structuring the school and the school-based Medical Therapy Unit (MTU) together prior to the onset of new school construction, rather than trying to fit the MTU into the school after it has been constructed. //2005//

Department of Developmental Services (DDS)

CCS and Medi-Cal provide medical services to eligible infants and toddlers in the Early Start Program. Through CMS participation on the Interagency Coordinating Council and Health Services Committee, CMS maintains ongoing communication with DDS.

/2005/The CMS Branch is collaborating with the MCMC Division and DDS to finalize an interagency agreement between the Early Start Program and DHS to establish a common set of working guidelines and procedures in coordinating early intervention services for children aged 0-3 years. //2005//

Department of Social Service (DSS)/Children in Foster Care

The Health Care Program for Children in Foster Care (HCPCFC), implemented in January 2000, is a collaboration between DSS and CMS to improve access to and oversight of health care for children and youth in foster care settings.

/2005/ The HCPCFC, administered locally by the CHDP program, continues to work very closely with local foster care programs to coordinate preventive and specialty health services for children and youth in out-of-home placement. The CMS Branch has initiated a performance measure to evaluate the effectiveness of HCPCFC case management. //2005//

/2005/For the past year, two MCH staff have participated with DSS staff in meetings to develop a statewide Peer Quality Case Review System as a part of an outcome and accountability system to improve the foster care system. //2005//

/2005/ The CMS Branch Chief and the Medi-Cal Policy Division Medi-Cal Eligibility Branch Chief are representing DHS on the State Interagency Child Welfare Team. Branch Chiefs from DSS, CDE, DMH, and the Department of Drug and Alcohol Programs are the other team members with the Foundation Consortium. The Team promotes shared responsibility and accountability for the welfare of children and families.

DHS Environmental Health Investigations Branch

//2005/ The Environmental Health Investigations Branch is partnering with the MCH and WIC Branches to conduct a survey of fish consumption among pregnant women in San Joaquin County. This county borders the California Delta where there is concern about mercury contamination in the fish supply. //2005//

DHS Childhood Lead Poisoning Prevention Branch (CLPP)

The CMS Branch, through CHDP, provides lead screenings for children. The CCS program 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, the CHDP program 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.

//2005/ The MCH and CMS Branches participate in the statewide planning process led by CLPP to eliminate childhood lead poisoning in order to meet the Healthy People 2010 goal. By 2010, the goal is to eliminate blood lead levels of concern in young children. Strategic planning meetings have begun with a goal of implementation of a plan for FY 2004-05. //2005//

DHS Immunization Branch (IZ)

The CMS Branch collaborates with the IZ Branch and its Vaccines For Children (VFC) program by providing vaccinations through the CHDP program.

//2005/ The CMS Branch collaborates with the IZ Branch with representation on the Statewide Immunization Information System (SIIS) Executive Consultative Committee. This committee provides oversight and support for California's statewide immunization registry network. The CMS and IZ Branches collaborated in the past year in several areas including developing policy to provide influenza vaccine to healthy infants 6 to 24 months of age and ensuring that there was sufficient influenza vaccine for high risk children in CHDP provider practices. //2005//

DHS STD Control Branch

//2005/ The MCH Branch collaborates with the STD Control Branch in a project to better integrate HIV/STD/Teen Pregnancy Prevention. //2005//

DHS Medi-Cal Managed Care Division (MMCD)

Memoranda of Understanding (MOUs) between county health plans, CHDP and CCS are mandated by DHS. Each local program coordinates with the plans and maps out a procedure for working together. At the state level, CCS and MRMIB rotate quarterly meetings throughout the state for medical plans. A separate meeting is held for dental plans as CCS dental and orthodontic services are carved out. Ad hoc subcommittees composed of members from CCS, MRMIB, and the MCMC plans have successfully worked together on provider training and solving program issues.

//2005/ Liaison activity continues with individual plans and with MMCD on system, policy, care coordination, and education issues. Due to state travel restrictions and budget constraints, the quarterly meetings have not been held for the past year. //2005//

//2005/ The MCH Branch collaborates with the MCMC Division on their project to improve the rate of preventive health care visits by adolescents. The MCH Branch also collaborates with MCMC on their Interagency Work Group for the Behavioral, Emotional, and Social Screening

and Treatment for Primary Care Providers in MCMC (BEST-PCP) Project. BEST-PCP focuses first on a discrete set of policy and structural issues at the state and county levels that must be addressed to facilitate meaningful change at the practice level. The project then aims to develop and implement a model for changing provider practice as the basis for broader collaborative quality improvement efforts. //2005//

DHS Epidemiology and Prevention for Injury Control (EPIC) Branch

//2005/ The MCH Branch collaborates with the EPIC Branch on injury prevention activities, including local training programs. The two Branches have had several meetings on areas of joint interest, including SIDS, CDRT, and review of applications for local MCAH program funding. Other areas of collaboration include: SAFE-KIDS California Advisory Committee, the California Strategic Traffic Safety Planning Coalition, and BWSP. //2005//

DHS Birth Defects Monitoring Program

Coordination with the California Birth Defects Monitoring Program (CBDMP) is essential in DHS's efforts to reduce birth defects. CBDMP is recognized worldwide for the quality and scope of its birth defects surveillance data and for the quality of its research to identify causes of birth defects. For example, CBDMP discovered that folic acid taken at the time of conception prevents several types of birth defects. This finding, consistent with other research results, was the basis for the federal Food and Drug Administration's decision to fortify grains with folic acid. Recently, CBDMP found that tobacco smoking during pregnancy is associated with development of cleft lip and palate. This finding has been used by First Five in their smoking cessation campaigns. The annual cost savings from the folic acid and smoking cessation strategies is estimated at \$100 million. Title V funds are used to partially fund birth defects surveillance in Los Angeles, Orange, San Diego, San Francisco, and Santa Clara Counties. Additionally, Title V funds are supporting the development and on-going maintenance of the CBDMP website, which has been a fundamental tool for communicating the results of birth defects research and raising awareness about the issue of birth defects and the importance of research in identifying causes of birth defects.

DHS Office of Audits and Investigations

//2005/ The MCH Branch works closely with the DHS Audits and Investigations Division to ensure the integrity of MCH programs. //2005//

DHS Primary Care and Family Health Division (PCFH)

In addition to the MCH and CMS Branches, there are four other branches in the PCFH Division of DHS: GDB, OFP, Primary and Rural Health Care Systems Branch (including the Indian Health Program), and WIC. MCH and CMS work closely with all of these offices.

Genetic Disease Branch (GDB)

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

GDB services are provided by private providers under contract for newborn, prenatal, and Tay Sachs screenings. GDB enforces quality standards via contract requirements or by regulations; in addition to

the screening program, GDB also monitors quality standards for Rh testing, genetic counseling and mandated laboratory reporting of cytogenetics. GDB also engages in research projects to develop new or improved tests.

In September 2000, Governor Davis signed into law Assembly Bill 2427 which required DHS to conduct a pilot project on the feasibility of expanding California's newborn screening program utilizing MS/MS. The CMS Branch has ensured that infants with potentially abnormal screening results received diagnostic or treatment services in any one of the 14 CCS-approved Metabolic SCCs around the state. Over 425 infants were referred to SCCs.

//2005/ Though the MS/MS project has ended, CCS has continued to collaborate with GDB in facilitating treatment services for those infants whose results were still pending at the conclusion of the project. //2005//

Office of Family Planning (OFP)

MCH and OFP work together to promote the goal of teen pregnancy prevention. In addition to MCH's AFLP and ASPPP programs, OFP programs include Family PACT, the Community Challenge Grant Program, the Male Involvement Program, and information and education projects. The Family PACT Program provides clinical contraceptive and reproductive health services to low-income California residents, including adolescents. The Community Challenge Grant Program promotes community-based partnerships for the development of effective local teen pregnancy prevention programs and to promote responsible parenting and the involvement of the father in the economic, social, and emotional support of his children. The Male Involvement Program promotes the involvement of young men in the prevention of teen pregnancy and unintended fatherhood.

Women, Infants & Children (WIC) Supplemental Nutrition Branch

The MCH and CMS Branches collaborate with WIC in a variety of areas including: the improvement of prenatal care, linkages between MCH and WIC data files, obesity prevention, oral health, childhood injury prevention, and breastfeeding.

//2005/ Staff from the MCH, CMS, and WIC Branches come together quarterly for nutrition coordination meetings. The CMS Branch ensures that the PEDNSS data are available to WIC local agencies and assists WIC agencies with data interpretation. //2005//

Universities

//2005/ The MCH and CMS Branches work closely with public health and other departments of several campuses of the University of California and other universities in California. These include the National Adolescent Health Information Center and the Center for Reproductive Health Research & Policy at UCSF, Stanford University (on CPQCC issues), and the Center for Injury Prevention Policy and Practice at SDSU. The MCH Branch contracts with the UCSF Family Health Outcomes Project to provide consultation and training to local MCAH jurisdictions in monitoring and updating of their local five year plan, data collection, identification of data sources, data analysis and survey development. The MCH Branch also collaborates with UCSF to conduct, analyze, and report on the Maternal and Infant Health Assessment Survey.

Through the Advanced Practice Nursing Program, the MCH Branch provides funds to nine universities in California to maintain accredited advanced and midlevel nursing programs. These programs assist MCH to meet Title V objectives by improving access to quality health care services to a diverse population through appropriately trained health care providers.

Participating universities provide clinical preceptorships in medically underserved areas and provide the MCH Branch with program evaluation data.

California District of the American Academy of Pediatrics (AAP)

The CMS Branch has collaborated with the AAP in developing 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 for CSHCN. The AAP has worked with the CMS Branch in development of the CHDP program as a gateway to Medi-Cal and HF enrollment. The AAP has been involved in planning and implementing the NHSP, and has partnered with the CMS Branch in physician education and outreach for the NHSP.

//2005/Four AAP Chapter Champions for Newborn Hearing Screening participate in local and statewide forums and conferences educating hospitals, pediatricians, families, and service providers about newborn hearing screening and the need for linkage with a medical home. The AAP advisory group continues to provide input on the CHDP Gateway. In 2004 CMS began working with the AAP in dissemination of the Primary Care Bioterrorism Needs Assessment and the development of training materials.//2005//

California Association of Neonatologists (CAN), and Stanford University

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). CCS has also provided technical assistance to CAN on issues related to patient CCS eligibility, provider claiming, NICU services, and the NHSP.

//2005/The CMS Branch Chief recently presented E47 to members of the CAN Executive Board. Through representation by CAN members on the CMS NICU Technical Advisory Committee, there is ongoing communication with the CMS Branch on issues of concern. //2005//

California Medical Association (CMA) and California Health Care Association (CHCA)

The CMS Branch interacts with these key health care provider organizations on issues concerning services for the CSHCN population and CHDP services, including procedures for service authorizations, claims adjudication, provider reimbursement, and provider enrollment and credentialing.

//2005/ The CMA and CHCA continue to participate in implementation of the Gateway and a CMA representative is on the CHDP Gateway Advisory Group. //2005//

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

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

//2005/CHEAC and CCLHO participate in the CHDP Gateway and are actively involved in issues affecting CMS programs such as cost containment proposals, administrative allocations, and program funding. //2005//

California Children's Hospital Association (CCHA)

The Children's Hospitals are important major providers of services to children in the CCS program. CMS has collaborated with CCHA on multiple issues including trainings on compensation, a "Best Practices Seminar", and other technical assistance.

/2005/ The CMS Branch works with the hospitals to increase efficiency by streamlining CCS referral, authorization, and billing processes and accelerating payment. The CMS Branch has collaborated with CCHA and the California Medical Assistance Commission (CMAC) on developing hospital payment and policy for inhaled nitric oxide therapy in neonates. //2005//

Other Professional Organizations

The CMS Branch collaborates with the California Association of Orthodontists, the California Orthopedic Surgeons Association, the California Association of Home Health Agencies, and the Hemophilia Foundations to improve working relationships and recruitment of providers.

/2005/ The CMS Branch has sought the input of the above agencies as E47 is being developed and implemented. The system enhancements will facilitate the authorization process and permit direct electronic billing to the State's fiscal intermediaries. //2005//

Managed Care Plans

The California HealthCare Foundation, Family Voices and the Children's Regional Integrated Service System (CRISS), have been working with CMS on a major effort to provide medical homes to CSHCN.

/2005/ There is ongoing collaboration on the medical home project and on statewide operational problems that occur with the carve-out of CCS services in Medi-Cal and HF managed care plans. //2005//

F. HEALTH SYSTEMS CAPACITY INDICATORS

Health Status Capacity Indicator #1

/2005/ Health System Capacity Indicator #1 (HSCI-1) is the rate per 10,000 for asthma hospitalizations among children less than five years old. The child asthma hospitalization rate increased from 23.9 per 10,000 in 1998 to 31.5 in 2000, then dropped to 29.5 in 2001, and was 30.6 in 2002. This is consistent with national increases in asthma prevalence between 1980 and 2000 [19] but contrary to the Healthy People 2010 objective to reduce the rate to no more than 25 per 10,000. //2005//

The California Asthma Initiative (CAI), First Five-funded through June 30, 2004, targets children with asthma from birth to 5 years of age. There are two CMS CAI components: the Asthma Treatment Services (ATS) Project and the CHDP Asthma project. ATS provides outpatient visits, medications, medication administrative devices, and patient/parent education in three communities. Initial findings are that quality of life has improved and the number of hospitalizations, acute care visits, and emergency room visits related to asthma for enrolled children has decreased. In the CHDP Asthma Project, the CMS Branch provided training to over 5,200 pediatric providers in asthma management. This project has resulted in CHDP providers including asthma assessments in their periodic health assessments for 1.3 million CHDP children under the age of five years.

/2005/ The ATS component of the CAI is being discontinued due to insufficient funding, but the

CMS Branch has received approximately \$1 million for the coming fiscal year to continue to train and provide educational support on asthma for CHDP providers, and to develop and provide education materials for children and parents.//2005//

Health Status Capacity Indicator #2

Health Systems Capacity Indicator #2 (HSCI-2) (formerly Core Health Status Indicator CHSI #02A) is the percent of Medi-Cal enrolled children less than one year of age who received at least one CHDP health assessment in the reporting year. In FY 2000-01, 73.9 percent of Medi-Cal enrolled children under one year of age received care; an increase from 71.3 percent for FY 1999-00. This is probably an under-estimate since an increasing number of children are enrolled in MCMC plans, and there is under-reporting of data from these plans as the PM 160 is an "information only" form.

//2005/ The percentage of Medi-Cal enrolled children under one year of age receiving at least one initial periodic screen for FY 2001-02 (the most current year for which there is data) is 66.2 percent. There was a large increase in the Medi-Cal population for FY 2001-02, compared with prior years, and this was reflected in the under one year of age enrollment. The numerator for this indicator continues to be under-reported because there is no incentive for MCMC plans to submit their data. In addition, the methodology for determining the denominator of this indicator was changed for FY 2001-02 to be more inclusive. Using this same methodology for the prior two fiscal years would have resulted in Medi-Cal enrollments of 439,994 (instead of 407,496) for FY 1999-00, and 444,404 (instead of 425,521) for FY 2000-01; and the indicators would have been 66 percent and 70.8 percent respectively.//2005//

Current HSCI #2 activities include the continuation of Memoranda of Understanding between MCMC plans and local CHDP programs. Each local CHDP program coordinates with MCMC plans to develop a procedure for working together. DHS provides technical assistance to local CHDP programs and MCMC plans to resolve problem areas. The CHDP program provides outreach to providers and children and their families (such as Health Fairs). The CMS Branch has been collaborating with the California Medical Home Project and the LA Medical Home Project. A policy is being drafted for a CCS Medical Home Pilot Project; LA County CCS is working with LA Care MCMC Plan for better coordination of care by the medical home.

//2005/ DHS continues to provide technical assistance to local CHDP programs and MCMC plans to resolve problems. Budget constraints have ended the quarterly meetings between DHS and the plans, diminishing communication. The CMS Branch has participated in MCMC planning meetings in an effort to coordinate work on Facility and Medical Record Review Tools that are being updated by MCMC plans and the CHDP program. There is provider concern about multiple site visits and reviews by several entities because of the impact on the provider and staff time. There is ongoing collaboration with MCMC plans on the medical home project and on statewide operational problems that occur with the carve-out of CCS services in Medi-Cal and HF managed care plans. //2005//

Health Status Capacity Indicator #3

//2005/ Health Systems Capacity Indicator (HSCI-3) (formerly Core Health Status Indicator CHSI #02B) is the indicator for the percent of HF enrollees under one year of age who received at least one CHDP health assessment. As in prior years, this data was again not available for FY 2002-03. The HF plans do not conduct CHDP health assessments, but instead perform preventive examinations based on the AAP guidelines. The HF program relies on the Health Plan Employer Data and Information Set (HEDIS) to determine the performance of the health plans. //2005//

Health Status Capacity Indicator #4

//2005/ Health Systems Capacity Indicator #4 (HSCI-4) is the percent of women (ages 15 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index. The Kotelchuck Index is a measure of prenatal care utilization that includes both the mother's timing of initiation of prenatal care and the number of prenatal care visits compared to those recommended by the American College of Obstetricians and Gynecologists.

There were steady improvements in adequate prenatal care utilization in California from 1989 through 1999, but since then rates have leveled off. Using the Kotelchuck Index, 76.2 percent of California women received adequate prenatal care in 1999, up from 58.7 percent in 1989.[20] In 2002, the rate was 77.8 percent. This is still considerably lower than the national Healthy People 2010 goal of 90 percent.

Several strategies have been used in California to improve prenatal care utilization including expansion of MediCal eligibility criteria, improved access to MediCal through presumptive and continuous eligibility, a waived assets test, and reduced application paperwork. These were accomplished in California in the late 1980s, and the improvements in the rates in the 1990s are probably at least partly attributable to these changes. Also, several state programs support improvements in adequate prenatal care through direct and indirect delivery of services and support; these include CPSP, AFLP, ASPPP, WIC, BIH, and the American Indian Infant Health Initiative (AIIHI). //2005//

Health Status Capacity Indicator #5

//2005/ Health Systems Capacity Indicator # 5 (HSCI-5) compares Medicaid and non-Medicaid in the following four areas:

> HSCI-5a: Percent of low birth weight (<2,500 grams)

> HSCI-5b: Infant death rate

> HSCI-5c: First trimester prenatal care

> HSCI-5d: Percent of women with adequate prenatal care (Kotelchuck Index)

Payment source data are obtained from birth certificates. Non-Medicaid payment source includes private insurance, self-pay, no charge, other government programs, and medically indigent. In California, Medicaid is called Medi-Cal.

HSCI-5a, the percent of low birth weight (<2,500 grams), was quite similar for Medi-Cal and non-Medi-Cal in 2002: 6.4 percent and 6.3 percent, respectively. This is similar to the previous year. Neither payment source reached the Healthy People 2010 target of 5.0 percent.

HSCI-5b, the infant death rate, was higher among Medi-Cal births (6.0 per 1,000) than among non-Medi-Cal births (4.6 per 1,000) for 2001 (most current data available). Both rates are slightly lower than the previous year (6.3 and 4.8, respectively). Neither the Medi-Cal population nor the non-Medi-Cal population has achieved the Healthy People 2010 goal of 4.5, but the rate in the non-Medi-Cal population is very close.

HSCI-5c, the percent of women entering prenatal care in the first trimester, was lower for Medi-Cal births (80.8 percent) than for non-Medi-Cal births (90.6 percent). The non-Medi-Cal population achieved the Healthy People 2010 goal of 90 percent. This is the first year this goal has been met in California; HSCI 5c for the non-Medi-Cal population in the previous year was 89.6 percent. In the Medi-Cal population, first trimester prenatal care improved by 1.6 percentage points, up from 79.2 percent in 2001.

HSCI-5d is a comparison for Medi-Cal and non-Medi-Cal of the percent of live births in which the woman had adequate prenatal visits. The adequacy of prenatal care is measured, as in

HSCI 4, as the percent of women (ages 15 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index. By this measure, 74.6 percent of Medi-Cal women and 80.1 percent of non-Medi-Cal women had adequate prenatal care in 2002. Both groups are lower than the national Healthy People 2010 goal of 90 percent.

One of the reasons that utilization of prenatal care in the first trimester is lower than optimal is that the number of unintended pregnancies remains high. Among low-income women surveyed in the 1995 National Survey of Family Growth, 61 percent classified their pregnancies as unintended, compared with 41 percent of women whose incomes exceeded 200 percent of the FPL. [21]

Medi-Cal eligibility increases prenatal visits, but Medi-Cal's beneficial effects are limited by the program's inability to encourage women to seek care earlier in their pregnancy. MCH programs are critical in identifying women in need of prenatal care at early stages in the pregnancy through community connections, community outreach, hotlines, and similar interventions; they are also critical in providing social support services, case management and client follow-up. //2005//

Health Systems Capacity Indicator #6

//2005/ Health Systems Capacity Indicator #6 (HSCI-6) compares the income eligibility requirements for 2002 for Medicaid and the State Children's Health Insurance Program (SCHIP) for the following three populations:

> HSCI 6a: Infants (ages 0 to 1)

> HSCI 6b: Children ages 1 to 19

> HSCI 6c: Pregnant women

In California, the SCHIP program is called Healthy Families (HF).

HSCI 6a: Infants (ages 0 to 1). Infants are eligible for Medi-Cal if the family income is at or below 200 percent of the FPL. HF is more inclusive, using an eligibility level of at or below 250 percent of FPL.

HSCI 6b: Children ages 1 to 19. Children age 1-5 are eligible for Medi-Cal if the family income is at or below 133 percent of FPL; for children age 6-19, the eligibility level is 100 percent of FPL. HF has an eligibility level of 250 percent of FPL for children age 1 - 19.

HSCI 6c: Pregnant women. Pregnant women are eligible for Medi-Cal if the family income is at or below 200 percent of the FPL. Pregnant women are not eligible for HF.

There were no changes in the income eligibility requirements for these three groups in 2001-2002.

In June 2004, the U.S. Department of Health and Human Services approved a plan to raise the HF eligibility income level to 300 percent of FPL in four selected counties: Alameda, San Francisco, San Mateo, and Santa Clara. California hopes to enroll nearly 33,000 children in these county children's health insurance programs (C-CHIP). C-CHIP also will raise the income level statewide to 300 percent of FPL for children up to age 2 whose mothers are enrolled in the Access for Infants and Mothers (AIM) program; this change is expected to add nearly 5,000 AIM-eligible children to C-CHIP.

//2005//

Health Systems Capacity Indicator #7

Health Systems Capacity Indicator #7 (HSCI-7) (formerly DHSI #04) is the percent of EPSDT eligible children (CHDP in California) aged 6 through 9 years who received any dental services during the year. The goal of this indicator is to increase dental health services to Medi-Cal eligible children at an important stage of dental development. In FY 2001-02, 45.5 percent of eligible children received at least one dental referral during the year, an increase from 44.6 percent in FY 2000-01. The methodology for calculating this indicator changed in FY 2001-02. Applying this methodology to 1999-00 data yielded 43.8 percent of children receiving a dental referral. It is anticipated there will be higher rates of referral in future years.

//2005/ In FY 2002-03, 48.1 percent of CHDP eligible children 6 through 9 years of age received at least one dental service during the year. This represented another increase in the number of children receiving services. It is anticipated that new CHDP tools such as the two-sided full color laminated "PM 160 Dental Guide" that was distributed in 2003 to all CHDP providers will improve the quality of dental screenings and facilitate more precise referrals to a dentist. Also, the CHDP program is making CHDP providers aware of the MCH website, www.mchoralhealth.org/PediatricOH/index.htm, that includes seven oral health teaching modules for pediatricians; this instruction should make screening providers more cognizant of the importance of dental referrals and particularly timeliness of these referrals.

Current activities related to this indicator include: the CHDP Gateway covers dental services for pre-enrolled children for up to two months and has increased access to dental services for this group of children; the CHDP Gateway offers the opportunity for children to apply for permanent enrollment in Medi-Cal or HF with dental services as benefits; the Dental Subcommittee of the CHDP Executive Committee continues to work on dental updates and revisions to the CHDP HAGs and other CMS publications to broaden the knowledge-base of providers, local program staff, families, and communities. //2005//

Health Systems Capacity Indicator #8

Health Systems Capacity Indicator #8 (HSCI-8) is the percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program. In the past, the numerator for this measure has been an estimate of the children who have received rehabilitation services, based on the number of children in the CCS program who had at least one rehabilitative service resulting in a claim paid by the Medi-Cal program. This method overestimates the numerator. The method used for FY 2002-03 is the number of children in the CMS Net system with eligibility aid codes of 20 or 60 (disabled children with SSI), most of whom will be receiving MTP services. The number from CMS Net is then extrapolated to all counties. This percentage will improve when all counties are on CMS Net. Also, CCS will have the capability in the future to retrieve data for particular age groups. Current data are for all children under 21 years of age.

The denominator used in the past for HSCI #8 was the unduplicated count of Medi-Cal enrolled children age 15 and under with aid codes 20 and 60. For FY 2002-03, the denominator is from the Social Security Administration Office of Policy, Children Receiving SSI for December 2002 (for children under 16 years). With these changes, the performance indicator is 23.0 percent, lower than in the past, but a more accurate estimate of the percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State CSHCN Program. Since the numerator and denominator were derived differently for FY 2002, comparisons will be made with future years. However, the applicability of this performance measure for California is again questioned. Many children receiving SSI with mental health and developmental disabilities or delays are not medically eligible for CCS but are eligible for other state-funded services such as regional center services.

//2005/ The annual indicator for HSCI #8 for FY 2003-04 is 22.6 percent, similar to the prior year. The numerator, 20,940, is the number of children under 21 years of age in the CMS Net system with aid codes 20 and 60, extrapolated for all counties. Since it is anticipated that all counties

will be using CMS Net next year, the numerator should be more accurate next year and the CMS Branch will be able to report this measure as it is intended, i.e., for children under 16 years of age.

The denominator has been determined using the same method as for 2002. For 2003, there were 92,790 SSI beneficiaries under 18 years of age. The number for 2002, misstated in the 2004 narrative, was also for children under 18 years of age. Once the CMS Branch can report the numerator for children less than 16 years of age, the denominator will also be reported for children less than 16 years of age, as this data is available from the Social Security Administration.

The CCS MTP provides physical therapy, occupational therapy, and Medical Therapy Conference (MTC) services to children who meet specific medical eligibility criteria. The majority of children have cerebral palsy. The children eligible for the MTP do not have to meet the CCS financial requirement to receive therapy or conference services through the MTP. Services are provided in a Medical Therapy Unit (MTU), an outpatient clinic setting that is located on a public school site. Coordination of services in the MTU is under the medical management of a physician/therapy team. It is estimated from current data that approximately 75 percent of children in the MTP are SSI beneficiaries. As in past years, the CMS Branch notes that many children who are SSI beneficiaries have mental health and developmental disabilities or delays and are not medically eligible for CCS but are eligible for other state-funded services such as regional center services; the applicability of this indicator to California is again questioned. //2005//

Health Systems Capacity Indicator # 9

//2005/ Health Systems Capacity Indicator # 9 (HSCI-9) describes MCH data capacity in the following three areas:

- > HSCI 9a: General**
- > HSCI 9b: Adolescent tobacco use**
- > HSCI 9c: Obesity/overweight**

HSCI 9a is general MCH data capacity. There are many sources of MCH data in California, including data from birth and death certificates; hospital discharge data; several statewide surveys, including the Maternal and Infant Health Assessment Survey (MIHA), the California Women's Health Survey (CWHS), the California Healthy Kids' Survey (CHKS), and the California Health Interview Survey (CHIS); and program data.

The MCH Branch has maintained linked files of infant birth and death certificates for all deliveries in California since 1965. These data are used for a variety of research endeavors including the assessment of fetal and infant mortality rates across the state and over time. These data are provided (confidentially) to hospitals annually and are one of the primary tools for reducing fetal and infant mortality rates and improving quality of care.

MCH also has access to hospital discharge data through the California Office of Statewide Health Planning and Development (OSHPD). OSHPD has administrative and clinical data from all licensed hospitals in California, including data on population demographics, hospital/clinic characteristics, payor source, births and deliveries, and other conditions, procedures, and injuries.

MCH has access to linked birth, hospital discharge, and death files, for surveillance of maternal mortality and morbidity and indicators of maternal quality of care.

MCH has the capacity to link birth certificate data and WIC eligibility files, as was done in 1999. Because of budgetary constraints, it has not been done in the past three years, but it is

anticipated that this linkage can be resumed within the next year or two.

Although the MCH Branch does not currently have the ability to link birth certificate and newborn screening files, plans are underway for MCH to work with the GDB to accomplish this. DHS does have the capacity to link birth certificate files with Medicaid files.

MCH's MIHA survey is an annual survey of women delivering live infants in California. The survey is modeled after CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) and is self-administered 10-14 weeks after birth to a stratified, random sample of approximately 3,500 women. Strata are by maternal region of residence, race/ethnicity, and education. Surveys are available in English and Spanish. The first year of data collection was completed in 1999. Covered issues include demographics, intendedness of pregnancy, utilization of health care, breastfeeding, and risk behaviors before and during pregnancy, including use of folic acid supplementation. Birth outcomes are provided through linkage with birth certificate data. Questions may be rotated into and out of MIHA depending on data needs and emerging issues. The administration of this survey is contracted out to UCSF, and UCSF staff collaborate with MCH staff on analysis and reporting of survey results.

CWHS, conducted under the auspices of the California Office of Women's Health, is an annual, computer-assisted telephone survey in which 200 questions are answered by approximately 4,000 randomly-selected women. The survey is anonymous and is conducted in English and Spanish. Covered issues include health insurance status, family planning, sexually transmitted infections, pregnancy (including knowledge and use of folic acid), mental health, and lifestyle issues such as food/nutrition and exercise. MCH staff sit on the CWHS advisory group, contribute questions to the survey, and prepare and present findings.

CHIS is a collaborative project of DHS, the UCLA Center for Health Policy Research, and the Public Health Institute. CHIS is a bi-annual telephone survey of adults, adolescents, and children from all parts of the state. The 2001 and 2003 surveys each covered 42,000 - 55,000 households, enough to allow for statewide and some local level analysis. Covered issues include health insurance coverage, alcohol and tobacco use, asthma, diabetes, mental health, oral health, overweight and obesity, and lifestyle issues, including food/nutrition and exercise. MCH staff sit on several CHIS Technical Advisory Groups, helping to develop topic areas and survey questions, and participating in the analysis of survey data.

The MCH Branch also collects and maintains data on its various programs, including AFLP, ASPPP, BIH, BWSP, CDAPP, CPSP, FIMR, and SIDS. Data elements vary by program, but generally cover number of clients served, client sociodemographics, number of home visits, and utilization of services. Program files can usually be linked to birth and/or death files.

HSCI 9b is data capacity for adolescent tobacco use. Developed by CDC in 1990, the Youth Risk Behavior Survey (YRBS) was established to monitor priority health risks including tobacco use. Conducted every two years, the YRBS includes national, state, and local school-based surveys of representative samples of 9th through 12th grade students. 1999 was the last year the YRBS was administered in California. The California Healthy Kids Survey (CHKS), administered by CDE, replaced the YRBS.

Data on adolescent tobacco use in California come from CHKS and the California Student Survey (CSS). Questions on these two surveys are coordinated, so that the combination yields one comprehensive, integrated local and state health behavior data collection system, which serves the needs of multiple agencies and programs. CHKS is a modular, voluntary data collection system that is supported by CDE and available to all California schools. It is targeted to grades 5-12. CHKS tobacco-related data has been collected from more than 700 schools in 300 school districts. The 2001-2002 CSS was administered to approximately 8,400 students in grades 7, 9, and 11 attending a randomly selected sample of 112 schools

representative of California schools as a whole.

HSCI 9c is data capacity for obesity/overweight. The PedNSS, administered through CDC, provides a valuable framework for tabulating and interpreting state-specific information on the nutritional characteristics of low-income children. California submits data from all CHDP health assessments to PedNSS, including length/height, weight, birthweight, hemoglobin/hematocrit, ethnicity/race, and gender. CDC uses this data and data from other sources to produce multiple tables for growth and anemia in children from birth to 20 years of age.

CHKS contains questions drawn primarily from the national YRBS, including questions pertaining to obesity among children. //2005//

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

Performance Reporting

California's Title V performance reporting includes a total of twenty-seven measures: eighteen national performances measures (NPM) mandated by HRSA and nine additional measures chosen by the state. Based on input from each of the 61 MCH jurisdictions (58 counties and 3 cities), the State of California prepared a Five Year Needs Assessment in 2000. From this Needs Assessment, the State developed a set of priority needs, and the nine State Performance Measures (SPM) were developed to reflect the priority needs:

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

SPM 2: The percent of low-income children who are above the 95th percentile of weight-for-height, or overweight.

SPM 3: The rate of deaths per 100,000 children aged 1 through 4 years caused by drowning in swimming pools.

SPM 4 : The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by homicide.

SPM 5: The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries.

SPM 6: The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System.

SPM 7: The percent of CCS enrolled children registered in CMS Net, the statewide automated case management and data collection system for CCS.

SPM 8: The percent of women 18 years or older reporting intimate partner physical abuse in the past 12 months.

SPM 9: The percent of youth aged 12-17 years who report smoking cigarettes in the past 30 days.

The national and state performance measures cover the four levels of the MCH pyramid: Direct Health Care Services, Enabling Services, Population-Based Services, and Infrastructure Building Services. For a discussion of specific programs associated with each performance measure, please refer to Sections IV C (NPMs) and IV D (SPMs). Figures 4a and 4b (Performance Measures Summary Sheet) show where the state's many activities fit on the MCH pyramid.

Data on performance measures are included in two parts of this report - on the data forms and in the narrative. The most recent data available for most performance measures is for 2002. Where the forms require data for 2003 that are currently unavailable, estimates are made based on data from 2002.

Please refer to the Attachment for information on the development of the annual objectives for the performance measures.

/2005/

Update on the FFY 2006-2010 Needs Assessment

California is unique among the states in terms of its size and diversity of population, geography, and MCH needs. Therefore, the MCH Branch depends on receiving input from all of its 61 local MCAH jurisdictions in order to produce a comprehensive analysis that describes the State's various public health issues and unmet needs, some of which may be specific to a given area.

The MCH Branch has an ongoing working relationship with FHOP at UCSF to design and implement the Five Year Needs Assessment. In August 2003 the MCH Branch and FHOP released a set of Needs Assessment instructions called the "California MCH Five Year Needs Assessment Guidelines & Indicator List for MCAH Jurisdictions," referred to as "the Guidelines." The Guidelines included a detailed description of the outline to be used for each jurisdiction's report. The outline included suggested page lengths for each section in order to encourage the preparation of succinct and focused reports of no more than 32 pages in total length.

The outline described in the Guidelines includes seven sections:

- 1) Summary/Executive Report;**
- 2) Description of the MCH Community Health Assessment Process -- local jurisdictions are required to obtain public input into their MCH assessments, including input from citizens and other stakeholders;**
- 3) MCH Planning Mission Statement and Goals -- each MCH jurisdiction's needs assessment planning group should review any previous mission and goals and establish the current MCH mission and goals to guide the work of the assessment;**
- 4) MCH Community Assessment -- this should include indicators of the overall population's socio-demographic status, health status, health risk factors, and access to health and social services;**
- 5) Priority MCH Problems/Needs in the Jurisdictions -- set priorities among identified health problems;**
- 6) Preliminary Problem Analysis for the Identified Local Priority Problems; and**
- 7) Appendices.**

The Guidelines also list 27 indicators for which the MCH Branch and FHOP have provided the numerators and denominators. MCAH jurisdictions are provided with templates designed by FHOP into which they can enter their local numbers in order to calculate rates and compare local rates to standards such as Healthy People 2010 or State averages. Having each jurisdiction work with the reporting forms in this way enables local MCAH programs to see the numbers behind the rates for each indicator, and encourages them to think further about the health care needs of their communities.

FHOP is monitoring and working with MCAH jurisdictions to assure that all will have correctly completed and submitted Five Year Needs Assessment reports by August 2004. The MCH Branch will then evaluate needs, assets, and challenges of the local jurisdictions, conduct further statewide data analyses, and compile a comprehensive Needs Assessment that represents the State of California as a whole.

//2005//

B. STATE PRIORITIES

State Priorities

The five-year needs assessment for FFY 2001-05 identified ten priorities for maternal and child health in California. The priorities encompass all levels of the MCH health services pyramid and in some cases span pyramid levels. The ten priorities for Title V activities in California are:

- 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 CSHCN.
- 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 DV.
- Improve coordination and outreach with other health programs to facilitate delivery of health care services to CSHCN.
- 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.

Relationship of Priorities, Performance Measures, and Capacity

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, particularly CSHCN. The two primary programs serving children, CHDP and CCS, are the core "safety net" for children's health care in the state. Performance Measures associated with Direct Services include NPM 1 and 2 and SPM 1.

A number of priority needs that relate to Enabling Services were identified. The major needs in this area include racial and ethnic disparities in infant health and mortality; 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 community, family and DV. Performance Measures associated with Enabling Services include NPM 3 and SPM 8.

Priority needs relating to Population-Based Services include the need to reduce the large number of adolescents giving birth; the need to increase the low breastfeeding rates; and the need to reduce the high rates of intentional and non-intentional injury. Other population-based concerns include the need for promotion of healthy lifestyle practices for children and adolescents and the need for outreach through health programs to aid CSHCN. Performance Measures associated with Population-based Services include NPMs 4-10 and SPMs 2-6 and 9.

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 CMS Net. Performance Measures associated with Infrastructure Services include NPMs 11-18 and SPM 7.

Emerging, New Priority: Mental Health

In California and across the country there is increasing recognition of the importance of promoting mental health and of early detection and treatment of mental health problems. According to a recent report from the U.S. Surgeon General, one in ten children and adolescents suffers from mental illness, but less than 20 percent of them receive needed treatment.[22] The report also indicated that minorities are less likely to be diagnosed, or diagnosed correctly, or to receive treatment.

California's MCH Branch is working to address the mental health needs of infants, children, adolescents, and mothers. MCH programs play an important role in identifying needs, intervening before mental health problems become debilitating, and facilitating access to integrated, comprehensive treatment. In addition to direct services to clients, MCH programs provide guidelines and training for healthcare providers. The MCH Branch also participates in statewide efforts to bring together various state agencies and other stakeholders to plan and implement coordinated needs assessments, programs, and services.

The following MCH programs include a mental health component: CPSP, BIH, AFLP, ASPPP, DV, CDAPP, and local MCAH programs. All include assessment and referral, and some include treatment as well.

CPSP provides Medi-Cal eligible women with comprehensive perinatal services, including psychosocial, health education, and nutrition support services. Services include psychosocial assessment and reassessment each trimester and postpartum, development of a care plan, and client follow-up. In addition to mental health status, all women are assessed and served or referred for related concerns, including substance abuse, financial need, and material need (food, clothing, housing).

BIH identifies pregnant and parenting African-American women who are at risk for poor birth outcomes and provides them assistance in accessing and maintaining appropriate health care and other supportive services. On enrollment in BIH, all clients are administered the BIH screening tool to assess for psychosocial risk factors. For women identified as at-risk psychosocially, referrals are made to community resources.

AFLP utilizes a case management and mentoring model to assess and address the risks and resources of adolescent clients and their children and to enhance the psychosocial and economic well-being of the adolescent family. ASPPP utilizes a similar model working with non-pregnant, non-parenting siblings of clients of the AFLP Program. AFLP and ASPPP case management includes mental health needs assessment, development of individual service plans, and referral to appropriate providers. The mental health assessment includes related areas such as substance abuse, domestic abuse, school support, parenting education, and suicide risk.

State and local AFLP and ASPPP staff have been working since fall 2002 to revise and improve the tool that is used statewide to assess the health and psychosocial needs of its adolescent clients. Statewide training on mental health issues, including infant mental health, was provided in May 2003, prior to the elimination of the AFLP/ASPPP training program due to budget cuts.

CDAPP promotes improved pregnancy outcomes for high-risk pregnant women who have diabetes and women who develop diabetes while pregnant. CDAPP provides comprehensive individualized services, including psychosocial services, to pre-pregnant and pregnant women with diabetes. Psychosocial assessment is required for all participants. Care plans include identification of stressors and planned interventions. Interventions may include counseling for

an individual, family or group, and may address psychiatric illness, marital and family problems, alcohol and substance abuse, smoking cessation, depression, eating disorders, etc.

The DV Program provides comprehensive shelter-based services for battered women and their children. Counseling for both adults and children is one of its required core services. All agency staff are trained on mental health issues and in counseling. Some agencies also do therapeutic counseling with a licensed mental health professional. All agencies give mental health referrals to clients who indicate the need or desire and/or based on staff observation and judgment.

State and local MCH staff are working with the California Women's Mental Health Policy Council and DMH to develop a curriculum for training local staff to work with women experiencing DV in addition to mental health and/or substance abuse issues. This curriculum will include a mental health screening tool.

Based on their local five-year needs assessments for Title V, local MCAH programs select one area in which to focus. Several counties have chosen to focus on substance abuse among pregnant and parenting women for their 2004 MCAH plans. Many are following the Dr. Ira Chasnoff model which encourages health care providers to help substance-abusing women by learning to ask questions that break down the secrecy barrier. The primary prenatal care provider is responsible for screening for substance use in pregnant women by asking about past and present alcohol use, along with whether drinking has ever been a problem for them, their partner, or for either of their parents. MCAH programs work with the community to mobilize as many perinatal providers as possible.

The MCH Branch also participates in statewide efforts to bring together various state agencies and other stakeholders to plan and implement coordinated mental health services. Four such efforts currently underway are the Behavioral, Emotional, and Social Screening and Treatment for Primary Care Providers (BEST-PCP) Project; the State Early Childhood Comprehensive Systems (SECCS); the School Readiness Initiative (SRI); and a joint effort of MCH, the NAHIC, and the AHC.

An MCMC Task Force on CSHCN assembled representatives from multiple state agencies (including the MCH and CMS Branches), family advocacy groups, providers and health care plans to develop recommendations for improving access to services promoting children's healthy mental development. The BEST-PCP Project was then undertaken to implement several of the key Task Force recommendations. BEST-PCP brings together agencies and stakeholders to agree on the roles and boundaries of each agency, to identify barriers to accessing existing resources, to develop policies to optimize use of resources, and to engage primary care providers in the work of improving screening and referrals for children at risk or with emerging developmental or behavioral problems. The target population is 0-3 year-olds.

The MCH Branch has received a federal grant for the SECCS project. The goal is to provide state-level leadership for early childhood health programs to help California's children be emotionally, socially, and physically healthy and ready for kindergarten. The two-year planning grant will culminate in the completion of a statewide needs assessment and strategic plan. The plan will address and coordinate critical components of early childhood health care systems, including mental and social health, parent education, and family support. The project will coordinate various health-related programs of state and local government; organizations such as the AAP, March of Dimes, and Easter Seals; and representatives of faith-based organizations.

The School Readiness Initiative (SRI) is the signature initiative of First Five. Mental health counseling is one of the five "essential and coordinated elements" of SRI. The SECCS grant will strengthen the health component of the SRI.

Another First Five effort is the Infant, Preschool and Family Mental Health Initiative, which funds eight counties to develop new mental health services for young children and their families.

California is also looking at ways to improve adolescent mental health. AHC, a broad-based, statewide group with representatives of the public and private sectors, identified the need for a comprehensive plan for addressing the health and developmental needs of California's adolescents. In response to this need, the California MCH Branch contracted with NAHIC to develop a strategic plan to address adolescent health.

The MCH Branch, NAHIC, and AHC held a meeting in 2002 to begin to develop the capacity for increased coordination between primary care, mental health, and schools. The meeting focused on adolescent mental health issues related to prevention and early intervention. A follow-up meeting occurred to share best practices and provide training on mental health financing to interested stakeholders in California so that they could learn about ideas that could be implemented in their organization or community.

Emerging, New Priority: Fetal Alcohol Syndrome

Another issue that has received increasing attention is Fetal Alcohol Syndrome Disorder (FASD). An estimated 260 to 1,050 babies with FASD are born each year in California and another 4,200 to 5,000 babies are born with related disorders. [23, 24] The estimated lifetime costs associated with FASD range from \$1.4 million to \$5 million per affected person, excluding the cost of incarceration. [25, 26, 27, 28]

DHS, through community-based prevention programs in MCH, aims at improving prenatal care and birth outcomes for women at risk of alcohol use/abuse, including referrals for prevention and treatment services. The following MCH programs provide pregnant women with information about FASD, identify women at high risk, and refer them for mental health and social support services: CPSP, BIH, AFLP, ASPPP, DV, and CDAPP.

Many local health jurisdictions are also active in FASD prevention. The Ventura County Health Care Agency's Ambulatory Care Division recently screened pregnant women receiving prenatal care at publicly funded clinics and found 13 percent to be actively consuming alcohol during their pregnancy. Ventura County MCH is developing an outreach program on alcohol use during pre-pregnancy and pregnancy for physicians in private practice; it encourages routine screening of all pregnant women for alcohol and other drug use. The March of Dimes has undertaken a FASD awareness/education campaign in Los Angeles, Kern, and San Bernardino Counties.

Dr. Ira Chasnoff, a nationally known expert on FASD, has worked with several California MCAH jurisdictions to combat FASD, including Fresno, Ventura, Madera, and Alameda Counties. Dr. Chasnoff and his team of researchers at Children's Research Triangle have developed a screening methodology that identifies pregnant women at risk for alcohol and illicit drugs. Their five-question screen, which takes less than one minute to complete, can be integrated into initial prenatal visits to quickly identify patients in need of more in-depth assessment. Fresno and Ventura Counties have instituted screening with Dr. Chasnoff's screening tool and have worked with Dr. Chasnoff and his team to develop strategies to expand and improve utilization of the tool by prenatal providers.

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C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

Newborn screening for genetic metabolic and hematologic disorders (formerly Federal Performance Measure 4) has been monitored in California for many years. Between 1998 and 2000, between 98.8 and 99.0 percent of newborns received at least one genetic screening for each of the specified conditions. Near universal coverage of these newborn screening tests has been achieved.

In FFY 2003-04 Federal Performance Measure 4 was replaced by NPM 1, and the definition was changed to the percent of infants with positive screens who received appropriate follow-up as defined by their State. In 2002, of the overall confirmed cases of the abnormalities for which screening tests were performed, 98.7 percent (376/381) received appropriate follow-up treatment. This is up from 98.4 percent in the previous year. The annual objective of 99 percent was almost achieved. One of the reasons that follow-up may not reach 100 percent is the inability to track all affected children who relocate.

The annual objective of 99 percent was achieved for three of the four conditions for which screening tests were performed. The percent receiving appropriate follow-up was 100 percent for PKU (21/21); 99.6 percent for congenital hypothyroidism (256/257); and 100 percent for galactosemia (6/6). These rates are all similar to the previous year. The percent receiving appropriate follow-up for sickle cell disease was 95.9 percent (93/97), compared to 94.0 percent (94/100) in 2001.

The GDB conducts two large screening programs for the prevention and detection of neonatal and prenatal disorders. 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 pregnant women (prenatal screening) and newborns (newborn screening). The testing panel for newborns include primary screening for phenylketonuria (PKU), hypothyroidism, galactosemia, and hemoglobinopathies. The program follows the infant until a confirmatory diagnosis is received and the infant's treatment is established with a health care provider. The expanded alpha fetoprotein program is a prenatal screening program for the detection of neural tube defects (spina bifida, anencephaly, encephalocele), abdominal wall defects, and trisomy 21, 18, 13, and other chromosomal abnormalities. Women with positive screening tests are referred to pre

b. Current Activities

The GDB screens for genetic and congenital disorders, including testing, follow-up and early diagnosis of disorders to prevent adverse outcomes or minimize the clinical effects. The GDB ensures quality of analytical test results and program services by developing standards and quality assurance procedures and monitoring compliance with them. The GDB fosters informed participation in its programs through a combination of patient, professional, and public education, and accurate and up-to-date information and counseling.

In 2001, Governor Gray Davis signed into law AB 2427, which authorized a pilot project to screen newborns for metabolic conditions using Tandem Mass Spectrometry (MS/MS) technology. The CMS Branch worked with GDB to ensure that infants with potentially abnormal results from MS/MS testing received diagnostic evaluations at one of the CCS approved Metabolic SCCs in the state. The county CCS programs expedited these referrals so that those with metabolic illness could be identified and treated promptly, thereby preventing premature death and/or serious disabilities.

The pilot project to evaluate the use of MS/MS for newborn screening ended in June 2003. In the pilot project, over 320,000 infants were tested, over 425 newborns were referred for follow-up at one of the CCS-approved Metabolic SCCs, and 52 infants were diagnosed with a metabolic disorder. Laboratory, follow-up, diagnosis, treatment and outcome data are being collected as part of a three-year evaluation process supported by HRSA. Guidelines are being developed for diagnostic follow-up and treatment of the most frequently identified disorders.

c. Plan for the Coming Year

GDB will continue to provide newborn screening for primary hypothyroidism, PKU, galactosemia and several hemoglobinopathies. GDB will also continue services related to patient counseling, public information and professional education. California is looking at opportunities to expand its newborn screening program.

Performance Measure 02: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

a. Last Year's Accomplishments

NPM 2 is one of five measures (see also NPM 3,4,5, and 6) taken from the National Survey of CSHCN. The Special Population Surveys Branch of the CDC National Center for Health Statistics conducted the telephone survey from October 2000 to April 2002 and identified approximately 750 children with special needs in each state. Based on this survey, 47.6 percent of CSHCN age 0 to 18 have families partnering in decision making at all levels and are satisfied with the services they receive. The next survey will be conducted January 2005 through December 2006.

Accomplishments related to this measure over the past year include: 1) County CCS programs are beginning to add a parent liaison to their staff. 2) The Children's Regional Integrated Service Systems (CRISS) which comprises 14 CCS county programs has a Family-Centered Care (FCC) Work Group that has been meeting bimonthly. 3) The Work Group hosted a conference November 7, 2003, that included reinforcing skills for transitioning activities, instructions on teaching parents to advocate for their children, and instructions on conveying difficult information in a more culturally competent and sensitive way. 120 CCS staff from 15 Bay Area counties attended. Family support agency staff and parent leaders also attended, as well as staff from Regional Centers, Special Education, and other agencies in Northern California. 4) The CMS Branch has established a performance measure for family participation in the CCS program. Over the past year counties evaluated their programs using this performance measure.

b. Current Activities

Current activities around this measure include: 1) CISS (Community Integrated Services System) Grant Family Centered Survey data analysis. 2) The CRISS FCC Work Group meets bimonthly and county member representatives report on their FCC activities, share ideas and resources, and coordinate conferences, trainings and activities. 3) The FCC Work Group monitors FCC and transition activities, parent liaison services, and medical home projects. 4) More county CCS programs are hiring a parent liaison while others have parents from strong family support organizations sitting on their CCS advisory committees. Approximately 30 percent of the counties now have parent liaisons. 5) The FCC Work Group is providing technical assistance for CCS administrators for hiring or contracting a parent liaison. 6) County

CCS programs are reporting on family participation in the CCS program. 7) Many counties are sending out or planning to send out family satisfaction surveys. 8) There is much collaboration among counties and among counties and agencies to provide workshops, resource fairs, and conferences for families; these collaborations include parents and families in their planning and development. 9)CRISS continues to sponsor major conferences on FCC for CSHCN and provides technical assistance for transition planning in CCS programs. 10) San Mateo County is currently planning and developing a multicultural parent task force. 11) Family members are participating on advisory committees or task forces in many counties, and are becoming involved in in-service training of CCS staff and providers.

c. Plan for the Coming Year

Plans for the coming year include: 1) County CCS programs will continue hiring a parent liaison. 2) The CISS Grant Family Centered Survey data analysis will continue. 3) The FCC Work Group will continue to meet bimonthly, monitoring FCC and transition activities, parent liaison services, and medical home projects, as well as providing resources and support for all counties in attaining parent liaison services. 4) The FCC Work Group will host another conference this year that focuses on FCC communications. 5) County CCS programs will continue to evaluate their programs for family participation in the CCS program. 6) More family members will be participating on advisory committees, task forces, and in-service trainings of CCS staff and providers. 7) Medical therapy programs will continue to be targeted for FCC activities. 8) Collaborative workshops, conferences, and resource fairs will continue to occur.

Performance Measure 03: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

a. Last Year's Accomplishments

NPM 3 is from the National CSHCN Survey. Based on this survey, 44.7 percent of the CSHCN in California receive coordinated, ongoing, comprehensive care within a medical home. Last year's accomplishments related to this measure included: 1) The CMS Branch is collaborating with the California Medical Home Project and the LA Medical Home Project. 2) A policy is being drafted for a CCS Medical Home Pilot Project. 3) LA County CCS is working with LA Care Plan for better coordination of care by the medical home. 4) The CMS Branch has established a performance measure to evaluate whether CMS programs provide effective case management to eligible children. Within this measure is an assessment of whether children in the CCS program have a documented medical home. County CCS programs have been evaluating this over the past year. 5) The CMS Branch participated in the AAP sponsored medical home training in Southern California in 2003.

b. Current Activities

Current activities include: 1) Collaboration with California Medical Home Project on Improving Care Delivery for CSHCN sponsored by the California HealthCare Foundation with CCS eligible children as the target population. 2) CMS state and county staff involvement in the LA Medical Home Project with web site and Medical Home Assessment Survey for Physicians as two of many activities. 3) LA Care and Health Net MCMC partnering with LA County CCS in developing and implementing a plan to eliminate the barrier for primary care physicians' knowledge of their patients' participation in the CCS program. 4) Development of a draft policy for a CCS medical home pilot project. 5) Information sharing between LA CCS Automated Case Management System and LA Care MCMC Plan for better coordination of care by the medical home. 6) County CCS programs are assessing whether CCS eligible children have a documented medical home and looking at ways to improve this.

c. Plan for the Coming Year

Plans for the coming year include: 1) Continued collaboration with the California Medical Home Project. 2) Continued involvement with the LA Medical Home Project. 3) Continued work on a draft policy for a CCS medical home. 4) Continued evaluation by county CCS programs of whether children in the CCS program have a medical home and how to improve on this part of a performance measure regarding effective case management.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

a. Last Year's Accomplishments

NPM 4 is from the CSHCN Survey and is related to population-based services. For the survey period, October 2000 to April 2002, 59.3 percent of families of CSHCN age 0 to 18 years in California had adequate private and/or public insurance to pay for the services they needed. Both for FY 2000-01 and FY 2001-02, the CMS Branch has estimated that 97 percent of CSHCN have health coverage. The survey introduces the words, "adequate to pay for services" to the new measure, which may have contributed to the difference in results. CMS activities to increase third party coverage for children have included 1) development and implementation of the CHDP Gateway and 2) continuation of the CAI's Asthma Treatment Services Project.

Implementation of the CHDP Gateway has been a major activity for DHS. Prior to the Gateway, approximately 1.1 million children receiving CHDP services were not enrolled in Medi-Cal or HF although it was estimated that approximately 760,000 children receiving CHDP services were eligible for comprehensive coverage through Medi-Cal or HF. Children enrolled in CHDP, who are identified with CCS eligible conditions (CSHCN), now have access to Medi-Cal or HF coverage through the CHDP Gateway.

b. Current Activities

Current activities revolve around E47. One component of the E47 system activated on July 1, 2004, is connectivity to DHS' Other Health Coverage (OHC) file. This will enable the CMS Branch to determine whether CCS eligible children have access to private health coverage. When the CMS Branch learns that a child has coverage not shown on the OHC file, it can add this information to the file. This component is now available for services received on or after July 1, 2004.

DHS has modified the pre-enrollment process to allow the Gateway transaction to identify and "deem" certain infants under one year of age as eligible for ongoing, full-scope, no cost Medi-Cal at the time of a CHDP Health Assessment.

Through its liaison activities with HF, Branch staff are assisting with questions relating to changes in the AIM program that just became effective July 1, 2004. The AIM program is being transitioned to a new administrative vendor, Maximus, which is also the HF administrative vendor. The new vendor will improve coordination of coverage for babies born to mothers enrolled in AIM on or after July 1, 2004, as they will automatically be eligible for enrollment in the HF.

c. Plan for the Coming Year

The OHC file will be used to determine whether CCS eligible children have third party coverage. The CMS Branch will continue to work with HF and the AIM program to facilitate enrollment of eligible infants into HF.

Performance Measure 05: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

a. Last Year's Accomplishments

NPM 5 is a National CSHCN Survey measure and is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily. For California, this result was 65.9 percent. The CMS Branch is developing policy to instruct counties on methods to collaborate with families and community organizations in the provision of services and assisting CCS approved hospitals and SCCs with implementation of FCC. The CMS Branch continues collaboration with Family Voices, parent representatives, and diverse parent groups through the Interagency Coordinating Council for Early Start. In addition, the CCS program has continued to facilitate FCC and services for CSHCN and their families when needed through reimbursing for lodging, meals, and travel for SCC visits and hospitalizations and making medical appointments including clustering appointments on one to two days.

b. Current Activities

Current activities include: 1) Development of CCS program policy letter for FCC instructing county CCS programs to collaborate with families and community organizations in the provision of services. 2) Reviewing CCS-approved hospitals, Neonatal Intensive Care Units (NICUs), Pediatric Intensive Care Units (PICUs), and SCCs for implementation of FCC. 3) Family members are participating on CCS advisory committees and task forces. 4) CHDP, HCPCFC, and CCS programs are reporting on a performance measure demonstrating that they provide effective case management. 5) Counties are sending out family satisfaction surveys. 6) Family members are providing in-services to CCS staff and providers.

c. Plan for the Coming Year

Plans for the coming year include: 1) Continued development of CCS program policy letter for FCC instructing Counties to collaborate with families and community organizations in the provision of services. 2) Family members will continue participating on CCS advisory committees and task forces. 4) CHDP, HCPCFC, and CCS programs will continue reporting on a performance measure demonstrating that they provide effective case management. Results will be compared with future years. 5) The CMS Branch is also evaluating collaborative relationships with other departments, agencies, and organizations. 6) The FCC Work Group will continue meeting bimonthly, and county member representatives will report on their FCC activities, share ideas and resources, and coordinate conferences, trainings and activities. 7) Counties will continue to develop family satisfaction surveys. 8) more counties will involve families in in-services of CCS staff.

Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

a. Last Year's Accomplishments

NPM 6 is a National CSHCN Survey measure and is the percentage of youth who received the

services necessary to make transitions to all aspects of adult life. Due to small sample sizes, the relative standard error for every state except Maine was greater than 30 percent, so the national average is reported which is 5.8 percent.

A few county CCS programs in California have been aggressively tackling transitional services for CSHCN, but most counties need to develop and implement plans of action. Within the past year, there has been a training on transition services for the Bay Area Counties that included representatives from hospitals and community agencies such as Support for Families. Alameda County has a very active transition planning process that was presented at the training.

There have also been transition-planning activities in Southern California. Seven county CCS programs are ensuring at a minimum that all identified needs, supplies, surgeries, and insurance eligibility are addressed before the age of 21. MTP staff in Ventura County regularly attend and participate with the Special Education Local Planning Areas (SELPA) Interagency Coordinating Transition Council, and there is coordinated SELPA training on the process of transitioning to adulthood. Each MTU in Ventura County sent a representative to the October 2003 training. In Kern County, the MTP Physiatry Clinic emphasizes referral for transitioning services for older children who have sustained spinal cord injuries, traumatic brain injuries, vascular accidents and related disabilities. In Santa Barbara County, a Transition Committee of CCS staff receives input from CCS parents, young adult clients, and the Family Support Center to assess and develop ways to infuse the concept of transition into all CCS services and functions. The committee organizes in-service training and presentations for CCS staff. Current and former CCS clients attend meetings to share their experiences.

b. Current Activities

Current activities include: 1) The CMS Branch is forming a Transition Work Group to develop written policy and guidelines for transition planning for adolescents. The group includes county CCS physicians, nurses (one of whom is also a parent of a child with special needs), social workers, and therapists; a physician from a MCMC plan; a community advocate; two physicians from UCLA with interest and expertise in transitional care; a representative from the Healthy and Ready to Work Program; several parents (including the Parent Liaison from LA County CCS); and a young adult who is transitioning out of CCS. 2) At the bimonthly meetings of the FCC Work Group, county CCS programs report on transition activities. A matrix of transition activities of each of the 14 counties represented is maintained and updated. 3) CCS social work consultants have quarterly meetings and discuss transition issues. 4) Some county CCS programs have transition committees, clinics and workshops. 5) State CCS staff instruct CCS-approved SCCs and those newly applying for approval on the importance and methods of integrating transition planning into patient care beginning at age 14 years.

c. Plan for the Coming Year

Plans for the coming year include: 1) The Transition Work Group will begin developing written policy and guidelines for transition planning for adolescents. 2) The FCC Work Group will continue to monitor transition activities in the 14 CRISS counties. 3) CCS social work consultants will continue to meet on transition issues. 4) More counties will become involved in planning and implementing transition strategies. 5) State CCS staff will continue to instruct CCS-approved SCCs and those newly applying for approval on the importance and methods of integrating transition planning into patient care beginning at age 14 years.

a. Last Year's Accomplishments

In 2002, the percentage of 19 to 35 month olds in California who completed the full schedule of age-appropriate immunizations was 75.8 percent, similar to previous years. (NPM 7 has been steady, between 74.9 and 75.9 percent, for 1998 to 2002.) The annual objective of 75.4 percent was achieved. The Healthy People 2010 objective is 80%.

A full schedule of immunizations 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 influenza type b vaccine (Hib).

To promote childhood immunization, the CHDP program assures access to vaccines that are required for school entry and has issued provider information notices that contain updated information on the vaccines covered by the CHDP program. CHDP also maintains access to vaccines that are indicated in some high risk children, reimbursing medical providers for vaccine purchase when these vaccines are not supplied by the federal Vaccines for Children program.

Efforts to improve immunization rates have also been made through CHDP, Medi-Cal, HF, Healthy Start, the Health Insurance Plan of California (HIPC), AIM, and the IZ Branch of DHS.

California has worked on improving regional immunization registries, creating a state hub to link all the regions, and unifying the statewide system for identifying pockets of need and developing adequate interventions. As of 2001, nine regions had been established, covering 40 California counties and reaching nearly 85 percent of the state's population. Efforts were made to improve the electronic exchange of information on patients moving between regions and jurisdictions and also on allowing schools, childcare centers, Medi-Cal, WIC, and Cal-WORKS to link into regional registries.

The CMS and IZ Branches collaborated in the past year on a policy to provide influenza vaccine to healthy infants 6 to 24 months of age. The Branches worked together to attempt to ensure that there was sufficient influenza vaccine for high risk children in CHDP provider practices and that providers would be reimbursed if there were no free vaccine available through the Vaccines for Children Program.

Because of a concern that providers holding immunization clinics might not get reimbursed for immunizations due to changes with the CHDP Gateway, the CMS and IZ Branches worked together to inform providers holding immunization clinics that they had to have the ability to electronically pre-enroll children, not already in Medi-Cal, through the Gateway process.

b. Current Activities

The CMS Branch and Medi-Cal are expending great efforts to ensure the success of the CHDP Gateway and are encouraging providers to deliver needed services during the pre-enrollment period, particularly immunizations.

The MCH and CMS Branches continue advocating for families to enroll in Medi-Cal or HF. With more children having access to primary and preventive care, the number of children receiving immunizations should increase. Local MCH programs, including AFLP, ASPPP, and BIH, continue to assess the immunization status of adolescent clients and their children on a periodic schedule, and to promote the importance of maintaining up-to-date immunizations by assisting program clients to access ongoing preventive care.

The CMS Branch has been collaborating with the IZ Branch on informing providers of the current Pneumococcal Conjugate Vaccine shortage and the CDC recommendation to suspend third and fourth doses for healthy children.

c. Plan for the Coming Year

The National Advisory Committee on Immunization Practices (ACIP) is recommending that healthy infants 6-24 months as well as their siblings and household contacts receive influenza vaccine. CHDP will determine if the program will be able to reimburse providers for the CHDP-eligible siblings and household contacts.

The CMS and IZ Branches will work together to make providers aware of vaccine shortages as they occur and any other immunization-related communications that need to reach providers. Through the CMS Branch and the CHDP Executive Committee, local CHDP programs will be kept informed of all immunization issues.

The CMS Branch will continue to collaborate with the IZ Branch with representation on the Statewide Immunization Information System (SIIS) Executive Consultative Committee and its work on California's statewide immunization registry.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

a. Last Year's Accomplishments

Reducing the adolescent birth rate is one of California's highest health priorities. Between 1987 and 1994, the birth rate among 15-17 year olds increased from 34 to 45 births per 1,000 women. Since 1994, the rate has fallen steadily, down to 32.6 in 1998, and down further to 22.9 in 2002. The annual objective of 23.5 for 2002 was achieved.

A decrease in teen birth rates was observed among all racial/ethnic groups. However, racial and ethnic differences in the adolescent birth rate persist. In 2002, Asian/Pacific Islander adolescents had the lowest birth rate for women 15-17 years old (6.8 births per 1,000 women), followed by non-Hispanic Whites (7.9). Other groups had substantially higher rates. The rate for American Indians was somewhat lower than the rate for African-Americans (20.7 and 24.7, respectively). Hispanic women had an adolescent birth rate of 46.3, almost double the African-American rate and nearly 6 times higher than the rate for Whites.

DHS supports teen pregnancy prevention efforts through programs within the MCH Branch and OFP. MCH's AFLP utilizes a case management and mentoring model to assess and address the risks and resources of adolescent clients and their children related to pregnancy prevention, birth outcomes, child health and safety, access to health insurance, appropriate utilization of health care, and enhancing the psychosocial and economic well-being of the adolescent family.

MCH's ASPPP works with non-pregnant, non-parenting siblings of clients of the AFLP Program or the Cal-Learn Program. ASPPP is designed to promote adolescent health and development, educational achievement, positive relationships with family and peers, and prevent early and unplanned pregnancies among this high-risk population.

OFP programs include the Family Planning Access Care and Treatment Program (Family PACT), the Teen Smart Education (TSE) Program, the Community Challenge Grant (CCG) Program, the Male Involvement Program (MIP), and Information and Education projects (I&E).

DHS undertook an "It's Up to Me" pregnancy prevention media campaign from 2000 through 2003. "It's Up to Me" addressed teen pregnancy by involving teens, promoting responsible fatherhood, increasing awareness of Family PACT, and encouraging communication between adults and teens.

In addition to the DHS teen pregnancy prevention programs, DSS operates the Cal Learn program, and CDE funds 140 school districts and county offices of education to operate the California School Age Families Education (Cal-SAFE) program. Cal Learn assists pregnant/parenting teens to attend and graduate from high school. Cal-SAFE is designed to increase the availability of support services necessary for enrolled expectant/parenting students to improve academic achievement and parenting skills.

b. Current Activities

AFLP and ASPPP provide case management services to pregnant and/or parenting teens and their siblings. AFLP provides services to about 18,000 teens a year, and the ASPPP to about 2,750 teens a year. The budget for both programs was reduced by \$1.6 million for FY 2003-2004. Some caseloads in local agencies were reduced for an anticipated total reduction of about 1,000 clients per year, and the ASPPP was eliminated in 16 of 34 agencies.

The Family PACT Program provides clinical contraceptive and reproductive health services to more than 200,000 adolescents annually. The TSE Program offers in-depth counseling related to sexual and contraceptive concerns of adolescent Family PACT clients. OFP contracts with the UCSF Center for Reproductive Health Research & Policy for Family PACT and TSE program monitoring and evaluation services. Family PACT undertakes ongoing efforts in the areas of client outreach; provider recruitment, training, and technical assistance; and the addition of new FDA-approved contraceptive methods to the benefits package.

CCG promotes community-based partnerships to develop effective local teen pregnancy prevention programs, to promote responsible parenting, and to involve the father in the economic, social, and emotional support of his children. CCG funds approximately 130 community agencies and serves approximately 120,000 teens annually.

MIP promotes the involvement of young men in the prevention of teen pregnancy and unintended fatherhood. MIP funds 25 agencies and serves roughly 30,000 adolescent boys and young adult males annually. OFP Information and Education (I&E) projects operate in 30 community agencies and serve approximately 75,000 youth in grades 6 through 12 annually.

Funding for most of the OFP programs, including Family PACT, TSE, CCG, MIP, and I&E, has been stable. Funding for the "It's Up to Me" media campaign was eliminated in 2003.

MCH is also collaborating with CDE and the STD Control Branch in improving HIV/STD/teen pregnancy prevention integration. Representatives from the MCH Branch, CDE, and the STD Control Branch attended regional meetings with other states during 2003 sponsored by the Society of State Directors of Health, Physical Education, and Recreation, AMCHP, National Alliance of State and Territorial AIDS Directors, and the National Coalition of STD Directors, and the National Conference of State Legislatures.

c. Plan for the Coming Year

Teen pregnancy prevention will continue to be a major issue for California in spite of the considerable success in the reduction of teen birth rates in recent years, given the changing demographics of California's youth population. By 2008, the annual number of teen births in California is projected to exceed 66,000--a projected 23 percent increase from 2001 teen births.

AFLP, ASPPP, Family PACT, TSE, CCG, and I&E will continue their teen pregnancy prevention efforts.

California was successful in receiving a small \$1000 technical assistance grant to continue activities to better coordinate efforts in the prevention of sexually transmitted diseases (STD), HIV, and teen pregnancy. Key stakeholders participating in this effort will include the MCH Branch, OFP, STD Control Branch, Office of AIDS and CDE.

Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

a. Last Year's Accomplishments

Children's access to preventive dental services is assessed in relation to the percent of third grade children who have received protective sealants on at least one permanent molar tooth. In 1998, 17.6 percent of third graders had a protective sealant, and the 1998 objective of 10.6 percent was achieved. In 2002, the percent with sealant in California increased to 19.7 percent, and the annual objective of 19.5 percent was achieved. The Healthy People 2010 objective is 50 percent.

The MCH Branch has an oral health policy consultant to provide technical assistance on oral health issues at the state and local levels. However, the MCH Branch has not had funds to collect surveillance data on sealant prevalence. The data currently reported for Performance Measure 09 are based on estimates made by the DHS Medical Care Statistics Section and Delta Dental Plan of California.

A significant improvement in oral health is the slow but steady progress in community water fluoridation in the last five years. In 1998, only 17 percent of Californians had access to fluoridated drinking water. As of June 2003, almost 30 percent of Californians had access to fluoridated drinking water. The Metropolitan Water District of Southern California voted to fluoridate their five treatment plants in 2003, and this will move California to approximately 60 percent of residents having fluoridated water.

Medi-Cal and HF provide access to a comprehensive package of primary and preventive services, including dental care, for California's low-income children. CHDP provides dental screenings for over 1.7 million children a year. Also, through the CHDP Gateway, providers are helping to get pre-enrolled children into dental services.

Increased enrollment in HF and Medi-Cal, which provide coverage of dental services, is expected to contribute to increased access to preventive dental services in the future. However, a significant impediment to increased access is the limited number of dentists who will accept children with Medi-Cal.

The California Conference of Local Directors of Maternal, Child and Adolescent Health (CCLDMCAH) has also included oral health as one of its priorities. The local directors address oral health needs in their strategic planning and in an oral health workgroup.

b. Current Activities

The DHS Office of Oral Health (OOH) contracts with the UCSF School of Dentistry to oversee the California Children's Dental Disease Prevention Program (CDDPP), which serves more than 300,000 preschool and elementary school children annually. The CDDPP includes the screening/application of dental sealants as well as oral health education in the classroom,

parent education, and other activities. The program has been focusing on dental sealants for 2nd and 5th graders, but will include 3rd and 4th graders beginning in FY 2004-05. The parent oral health/nutrition education component was implemented in 2002; its purpose is to provide training to the parents of children in OOH's school-based program about oral disease prevention strategies and the importance of nutrition to health, including oral health.

The CMS Branch is undertaking activities to encourage orthodontists and dentists to accept more CCS children into their orthodontic and dental practices. The CCS program is implementing electronic billing and other associated CCS program revisions that will result in (1) rapid provider reimbursement for dental/orthodontic services with claims sent directly to Denti-Cal, (2) preservation and expansion of the dental/orthodontic provider network, (3) decreasing the length of time for a CCS client to get an orthodontic screening, and (4) increasing access to dental/orthodontic care for CCS clients.

The Dental Subcommittee of the CHDP Executive Committee has been revising the CHDP Dental Periodicity Schedule to recommend dental referrals beginning at one year of age. In addition to the full-color laminated CHDP "PM 160 Dental Guide" distributed last year to all CHDP providers, the CHDP program is developing a training packet for CHDP providers that contains instruction on performing dental examinations on young children.

The WIC and MCH Branches jointly purchase toothbrushes and toothpaste that are distributed to participants in local WIC and MCH programs as education and incentive tools. The Nutrition Network funded the development of a brochure and a poster to inform MCH program providers about oral health and nutrition.

The MCH oral health policy consultant continues to convene the DHS Dental Workgroup that was created several years ago to bring together all oral health staff at the state level to foster collaboration and partnerships in oral health. In addition to the state oral health staff, this group includes representatives of key private organizations such as the California Dental Association, the California Dental Association Foundation, and the First Five Commission.

Several counties have allocated First Five funds for services related to oral health. First Five has listed oral health as one of its five priorities. These initiatives are indicative of the State's commitment to combating dental illness in the MCH population through prevention and improved access to care

c. Plan for the Coming Year

The first statewide oral health needs assessment was conducted in 1993-1994, and plans are currently underway for a follow-up needs assessment to be conducted in 2004-2005. OOH is partnering with the MCH Branch and the Dental Health Foundation to conduct the study, which is funded by HRSA and the California Dental Association Foundation.

State and county programs will continue to promote oral health, but the State will not be able to fully address NPM 09 until appropriate funds are allocated for sealant promotion, placement, and continuous surveillance of prevalence.

Efforts to increase fluoridation of the State water supply will continue. California expects to reach the Healthy People 2010 fluoridation objective of 75% by 2006.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

a. Last Year's Accomplishments

California motor vehicle death rates for children aged 0-14 showed a statistically significant downward trend between 1990 and 1998, from 5.4 deaths per 100,000 in 1990 to 2.8 in 1998. Between 1998 and 2001, the rate in California was relatively stable, fluctuating between 2.7 and 2.9. The 2002 rate declined to 2.6, and the annual objective of 2.8 was achieved. (Caution should be applied in comparing mortality-related measures for 1999 and subsequent years to prior years' rates because of the uncertainty regarding the comparability of data resulting from the shift in codes used through 1998 to the ICD10 codes used in 1999 and subsequent years).

Some of the activities which have contributed to progress on NPM 10 in California include: Increased enforcement of drinking and driving laws; passenger restraint laws; graduated driver licensing; public education campaigns addressing the risks of drinking while driving; and vehicle safety improvements.

CIPPP at SDSU serves as a resource center on child and adolescent injury prevention and provides technical assistance in the development, implementation and evaluation of injury prevention programs. CIPPP works with the MCH Branch to organize the annual childhood injury prevention conference. CIPPP also produces Safety Literature updates with weekly references of current injury prevention articles.

The MCH Branch funds local childhood injury prevention programs in five counties (through June 2004): Alameda, Kern, Humboldt, San Mateo, and Sonoma. In 2002, CIPPP, in collaboration with the MCH Branch, started a bi-monthly injury prevention teleconference with injury prevention professionals in the five counties; regular teleconferencing enables statewide networking, joint planning, and skill development. This group then expanded to include other interested MCAH programs and other injury prevention stakeholders in 2003. In addition, an injury prevention list serve was started with the five funded programs and expanded to include a total of 23 MCAH jurisdictions. The list serve will be used to give updates, alert programs of funding sources, and share information.

Other local MCAH programs are also implementing motor vehicle injury prevention activities. Shasta County has been involved in a campaign working with teens on driving smart, driving sober, and the effects of riding with someone who is under the influence. Many local MCAH programs are also participating in the SAFE KIDS Coalitions, child passenger safety checks, child passenger safety seat distribution, and bicycle helmet education programs.

b. Current Activities

The MCH Branch funds local childhood injury prevention programs in five counties in three-year cycles. The funding cycle for the current counties ended June 30, 2004. Plumas, Siskiyou, Sacramento, Stanislaus, and Ventura Counties will receive funding for three years beginning July 1, 2004.

The MCH Branch has held several meetings this year with the EPIC Branch to coordinate activities and collaborate to address joint areas of interest. The MCH Branch participates in the SAFE KIDS California Advisory Committee and the California Traffic Safety Coalition and works with members of the Child Death Review Team Council. The CIPPP in collaboration with the MCH Branch continues to coordinate the list serve, injury prevention teleconferences, and weekly injury prevention literature reviews.

California's Vehicle Occupant Safety Program (VOSP) works to prevent unnecessary death and disability to California's children by helping to strengthen and expand California's child passenger safety infrastructure. VOSP promotes resource sharing and capacity building among California's state and local Child Passenger Safety agencies and provides professional development opportunities, technical assistance and training resources. An updated statewide

list of current locally operated child passenger safety seat programs for use by traffic courts, community agencies, hospitals and clinics is available online at <http://www.dhs.ca.gov/ps/cdic/epic>.

To raise funds to support child injury and abuse prevention programs, the State sells personalized auto license plates, called "Kid's Plates". Kid's Plates feature a heart, hand, star, or plus sign. The proceeds fund child injury prevention efforts, including bicycle safety, motor vehicle occupant protection, and pedestrian safety, as well as other child injury and abuse prevention programs. The Kid's Plates Program provides a wide range of technical assistance to help foster effective regional and local injury prevention efforts and funds grants for training and equipment. Between 1998 and 2003, over 200 grants were awarded to community-based organizations, local health departments, and other organizations. CIPPP is the Kid's Plate program administrator for the EPIC Branch.

c. Plan for the Coming Year

The 18th annual Childhood Injury Prevention Conference will be held September 27-29, 2004 in San Francisco to provide the latest information on practices and research in injury prevention and to provide in-depth training in specific areas. The MCH Branch, in collaboration with the CIPPP, is planning an orientation teleconference and in-person meeting for the five newly funded local jurisdictions, to be held in conjunction with the CIPPP conference. CIPPP will be working with the local jurisdictions to provide technical assistance on data analysis, program planning, and evaluation.

The MCH Branch plans to continue and expand its list serve and teleconference to meet local jurisdictions' needs. The MCH Branch will continue to work with SAFE KIDS California Advisory Committee, California Traffic Safety Commission, and the Child Death Review Council. A Prevention Subcommittee of the Child Death Review Council focusing on vehicle occupant safety is planned to begin during 2004, and the MCH Branch will be participating on this subcommittee. CIPPP, in collaboration with the MCH Branch, is working with MCH programs to better incorporate injury prevention into their programs. CIPPP plans to update educational materials for CPSP and plans to meet more in-depth with AFLP, DV, and BIH to determine their specific needs and to develop a plan to better address injury prevention within their programs.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

Increasing the proportion of mothers who breastfeed their infants is a Title V priority for the period 2001-2005. The percent of mothers who were breastfeeding at the time of hospital discharge in California in 1998 was 43.5 percent. Since 1998, California's rate has declined slightly, to 41.8 percent in 2002, short of the annual objective of 43.1 percent for the year. (Performance Measure 11 examines the percent of women who report exclusive breastfeeding, which is defined as the infant receiving breast milk, and no other fluids or solids, with the exception of vitamins, minerals, water, juice, or cultural foods given infrequently.)

There remain disparities between racial and ethnic groups in the proportion of mothers who were breastfeeding at the time of hospital discharge. In 2002 white women had the highest percentage of mothers who breastfed (63.7 percent), followed by American Indian mothers (47.7 percent). Other groups were below the state rate: 40.2 percent of Asian/Pacific Islander mothers, 30.4 percent of African American mothers, and 29.6 percent of Hispanic mothers were breastfeeding at hospital discharge.

Assembly Bill 1025, signed into law in 2001, facilitates breastfeeding among women who return to work after childbirth by requiring all California employers to provide a reasonable amount of break time to accommodate an employee wishing to express breast milk, and to make a reasonable effort to provide a room for expressing milk in close proximity to the work area.

DHS holds statewide Public Health Grand Rounds sessions once a month, and in August of each year, the focus is on breastfeeding promotion. In 2002, the topic was "Breastfeeding and the Law that Helps" and in 2003, "The Impact of Infant Feeding on Obesity and Diabetes." These sessions on breastfeeding have been well-attended, with more than 150 participants. Local health department staff and other interested parties are able to participate via videoconferencing.

BIH promotes breastfeeding among African American women. Based on findings that African American women are less likely to initiate or sustain breastfeeding than most other race/ethnic groups, strategies for BIH program collaboration with local breastfeeding coalitions have been promoted and adopted in several counties.

CDAPP promotes breastfeeding as beneficial for both mother and child in reducing the risk for diabetes. CDAPP has added a chapter on breastfeeding to its Guidelines for Care for women with gestational diabetes, as well as for those who take insulin and breastfeed.

Working with AFLP, CalSAFE, and CalLEARN, DHS is insuring that teen pregnancy programs effectively promote breastfeeding among this age group of mothers that is less likely to breastfeed.

b. Current Activities

The MCH and CMS Branches are participating on the new DHS Nutrition and Physical Activity Action Team. Breastfeeding promotion is one of the main interventions for childhood obesity prevention.

The California Breastfeeding Promotion Advisory Committee consists of representatives of hospital administrators, medical groups (such as the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics), state agencies (including MCH, WIC, BIH, CMS, and AFLP), advocacy groups, and academia. Meetings were formerly held up to four times a year, but, due to budget constraints, there was only one meeting in FY 2003-2004.

The California Breastfeeding Promotion Advisory Committee is working to revise its Model Hospital Policies that provide information and guidance to perinatal professionals. The Committee has been successful in its recent efforts to get the Medi-Cal program to improve reimbursement for lactation services and lactations aids, such as breast pumps.

The MCH Branch helps promote local breastfeeding coalitions, including working with a planning team from UC Davis to organize an annual Statewide Breastfeeding Coalition Conference. The first Coalition Conference was held in December 2003; planning for the 2004 Coalition Conference is now underway.

The Local Health Officers are interested in the Baby Friendly Hospital Initiative (BFHI) and have been provided a short presentation on the subject. The designation of "baby-friendly hospital" is bestowed, after an on-site evaluation, on hospitals and birth centers that have taken steps to provide an optimal environment for the promotion, protection and support of breastfeeding.

CPQCC has recently released a new quality improvement toolkit, "Nutritional Support of the Very Low Birth Weight Infant". As the survival rate for preterm infants and neonatal intensive

care unit patients improves, more attention is being focused on improving the quality of survival through optimal nutritional management. Current research indicates that human milk (with appropriate fortification for very low birth weight infants) is the standard of care for preterm nutrition, as well as term infant nutrition.

The MCH Branch collaborates with WIC on many breastfeeding promotion activities. Current efforts are focused through the Breastfeeding Promotion Advisory Committee. The MCH and WIC Branches also share data on breastfeeding among perinatal populations.

BIH, CDAPP, AFLP, CalSAFE, and CalLEARN continue to promote exclusive breastfeeding among their constituencies and through informational materials and professional organizations and meetings. The breastfeeding page of the MCH website, which contains information about advocacy groups, sources of data, and other resources, is continually updated. The website contains hospital-specific data on the percentage of mothers who breastfeed their infants at discharge.

c. Plan for the Coming Year

The WIC Branch has tallied the results of the Infant Feeding Policies and Practices Survey distributed to all hospitals in California. The survey results identify labor and delivery policies and practices associated with higher exclusive breastfeeding rates. The results of the survey will be distributed to hospitals and appropriate MCH programs, such as the RPPC, where they will be used to work with the hospitals on becoming more breastfeeding friendly.

The theme of the next breastfeeding Grand Rounds in August 2004 is "Exclusive Breastfeeding: Achieving the Gold Standard."

The next meeting of the California Breastfeeding Promotion Advisory Committee will be in July 2004. The meeting will focus on increasing initiation and duration of breastfeeding. The MCH and CMS Branches will continue their participation on this Committee and will provide consultative input as needed.

An executive subcommittee of the California Conference of Local Health Officers has endorsed the Baby Friendly Hospital Initiative and will promote the concept to the full Conference.

The MCH Branch is the lead for authoring the Infant Feeding Section of the California Daily Food Guide.

Performance Measure 12: Percentage of newborns who have been screened for hearing before hospital discharge.

a. Last Year's Accomplishments

NPM 12 relates to population-based services for pregnant women, mothers and infants and is the percent of newborns who have been screened for hearing impairment before hospital discharge. For FY 2001-02, based on birth records from hospitals known to be performing universal screening and those that were certified to participate in the NHSP, it is estimated that 114,166 infants or 21.6 percent received hearing screening prior to hospital discharge. Data regarding newborn hearing screening is estimated using birth records and Hearing Coordination Center (HCC) reports. This number was an increase of 58 percent from FY 2000-01 and well over the objective of 15 percent. The annual performance objectives have been increased to reflect the anticipated numbers of hospitals screening infants in the coming years.

Based on information reported by the individual HCCs, 276,646 infants, or 52.2 percent of all California newborns, received newborn hearing screening prior to hospital discharge in FY 2002-03. This was an increase of 142 percent from FY 2001-02 and well above the objective of 40 percent. California legislation only provides authority to implement the NHSP in the 179 hospitals approved by the CCS program. The infants screened in FY 2002-03 comprise 78 percent of the target population. DHS only receives aggregate data reports from HCCs on a quarterly basis; this has affected the program's ability to accurately report the number of infants who receive screening, those who need follow-up, those identified with hearing loss, and those who have entered early intervention services.

Accomplishments in the past year include: 1) A CMS contract has been executed with the National Center for Hearing Assessment and Management (NCHAM) to train community audiologists in performing infant diagnostic evaluations. Three training sessions were held in 2003 and over 50 audiologists completed the three-part course, which included a practicum component. 2) Educational programs were provided for primary care providers regarding their role as a medical home in the NHSP. 3) CMS Branch participated on the Deaf and Hard of Hearing Early Intervention Workgroup to research and recommend statewide standards for parent-infant curriculum and methodology-neutral language assessment for use in the Early Start programs. 4) The CMS Branch provided technical assistance and consultation support to the HCCs. These HCCs are in turn providing assistance to hospitals in the development and maintenance of their screening programs and tracking and monitoring infants needing outpatient follow-up, diagnostic evaluations, and early intervention.

b. Current Activities

Current activities include: 1) Activities taking place as part of the MCH Bureau grant include training sessions for community audiologists in performing infant diagnostic evaluations with another session planned for the spring/summer of 2004; and development of primary care physician education on newborn hearing screening. 2) The CMS Branch continues its participation and collaboration with the Early Start program. 3) A contract is being executed with Sonoma State University for evaluation of the NHSP. A Parent Satisfaction Survey is being utilized. 4) Technical assistance and consultation support to HCCs continues.

c. Plan for the Coming Year

Plans for the coming year include: 1) A two-part training on intervention and amplification for infants with hearing loss is expected to be presented in two sessions during the winter of 2004-05. 2) The CMS Branch continues its participation and collaboration with the Early Start program. 3) Evaluation of the NHSP will continue. 4) Technical assistance and consultation support to HCCs continues. 5) Program evaluation site visits with the HCC contractors will be scheduled and implemented. 6) PCP trainings will be planned for 2005, and an educational activity at the AAP annual conference in San Francisco in October 2004 is being planned.

Performance Measure 13: *Percent of children without health insurance.*

a. Last Year's Accomplishments

The percent of children in California aged 0-18 who were uninsured declined from 21.0 percent in 1998 to 14.3 percent in 2002. The annual objective of 16.7 percent for 2002 was achieved. While the trend is in the right direction, the number of uninsured children is still high - about 1.5 million in 2002. The Healthy People 2010 objective is 0% uninsured.

California's data for NPM 13 are for children ages 0-18 and are based on the U.S. Current Population Survey. Estimates derived from the California Health Interview Survey (CHIS) cover a slightly different age cohort (ages 0-17), but the results are similar. According to CHIS, 1.3 million children (14.3 percent) lacked health insurance coverage or experienced gaps in coverage in 2001. [29]

CHIS data on health coverage are available by race/ethnicity and immigration status and show notable disparities. Of race/ethnic groups, Hispanic and American Indian children have the highest rates of uninsurance, at 24 percent and 17 percent, respectively. The rates were 9 percent for Asians, 8 percent for Whites, and 6 percent for African Americans. [30] The rate of uninsurance was also very high (25 percent) for children whose parents (one or both) were undocumented.[31]

Insurance coverage rates depend largely on three sources of coverage: job-based insurance, Medi-Cal and HF. There is considerable variation in patterns of coverage by race/ethnicity. The children with the highest rates of coverage through Medi-Cal are African American (40 percent) and Hispanic (34 percent), with lower rates of coverage for Asian/Pacific Islander (19 percent) and White (11 percent). The children with the highest rates of coverage through HF are Hispanic (8 percent) and Asian/Pacific Islander (6 percent), with lower rates of coverage for African American (2 percent) and White (2 percent). The children with the highest rates of job-based coverage are White (77 percent) and Asian/Pacific Islander (65 percent), with lower rates of coverage for African American (53 percent) and Hispanic (36 percent). [32]

In an effort to decrease the number of uninsured children, DHS and MRMIB (administrator of HF) have developed a comprehensive outreach and education campaign to increase enrollment in Medi-Cal and HF. Efforts to reduce administrative barriers to enrollment included a shortened joint application for both Medi-Cal and HF, the elimination of quarterly status reports under Medi-Cal, and an online enrollment system.

California also employed and trained certified application assisters (CAAs) who work with families in clinics, community centers, schools, and homes. Many CAAs are bilingual or multilingual. CAAs receive \$50 for each application that results in a successful enrollment. CAAs help families navigate the complex eligibility structures of Medi-Cal and HF, under which one child in a family may be eligible for Medi-Cal and another for HF or another state program.

b. Current Activities

The number of uninsured children in California could be reduced by two-thirds if all children eligible for public insurance programs were enrolled. [33] MCH programs, including AFLP, ASPPP, BIH, BWSP, and CPSP, encourage and facilitate enrollment in Medi-Cal and HF. Other efforts to enroll eligible children into Medi-Cal and HF, including public awareness media campaigns and other community education efforts, are ongoing.

A collaborative initiative between the California Health Care Foundation and the State of California led to the development of Health-e-APP, a web-based HF application. Health-e-App became available in 2003 and has improved speed, accuracy, and consumer satisfaction with the application process. The DHS Medi-Cal Eligibility Branch, in collaboration with MRMIB, operates and maintains the Health-e-App system.

Through the CHDP Gateway, any child under 19 years old with family income at or below 200 percent FPL (and not already in the MEDS system) is "presumed eligible" for Medi-Cal or HF and is given a temporary Medi-Cal Benefits Identification Card. With this BIC card, a child has access to no-cost, full-scope fee-for-service Medi-Cal benefits for up to 60 days. From July 2003 through March 2004, 473,208 children were pre-enrolled in the Gateway, and 368,528

(78 percent) requested a joint application for Medi-Cal and HF.

The CHDP Gateway was implemented in July 2003, and since then the CMS Branch has been fine-tuning the Gateway Program. There are ongoing Gateway Advisory Committee meetings involving all the partners and teleconferences with local CHDP programs to discuss implementation issues. Local CHDP programs inform new providers about the Gateway and direct these providers to CHDP Gateway resources.

The CMS Branch made modifications to the Gateway pre-enrollment process that allow the Gateway transaction to identify and "deem" certain infants under one year of age as eligible for ongoing, full scope, no cost Medi-Cal at the time of a CHDP assessment. These modifications were effective June 1, 2004.

Due to the state budget crisis, state funding for the CAAs was terminated as of July 1, 2003. Some CAAs continue working on a county-funded or volunteer basis, and the State continues to provide CAA trainings.

c. Plan for the Coming Year

MCH programs, including AFLP, ASPPP, BIH, BWSP, and CPSP, will continue to encourage and facilitate enrollment in Medi-Cal and HF.

CHDP Gateway Advisory Committee meetings and teleconferences with local CHDP programs will continue. The CMS Branch will work with EDS to initiate a CHDP Gateway module as part of their routine training of providers.

CMS Branch will continue to analyze CHDP Gateway data reports to monitor program operations and the needs of CHDP local programs and CHDP providers.

Performance Measure 14: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

a. Last Year's Accomplishments

Performance Measure 14 was stable in the years 1999-2001, between 60.8 and 61.3 percent. In 2002, it was 61.7 percent, up from 60.9 percent in 2001. The annual objective for 2002, 60.3 percent, was achieved. (The methodology used to calculate the measure changed in 1999, and figures for 1999 and later years are not comparable to previous years.) The number of children in California who received a service paid by Medi-Cal in 2002 was 2.87 million.

The State has made a strong commitment to reducing the number of uninsured children in California and ensuring access to healthcare services. Activities have included: 1) support of streamlined Medi-Cal eligibility processes that encourage continuous coverage; 2) support for client case management by MCH programs such as the AFLP and BIH to screen and assess children and adolescents for Medi-Cal eligibility and assist them in obtaining services needed; 3) public education media campaigns and other community education efforts to encourage eligible families to obtain medical services, such as family planning, well child care, prenatal care, childhood immunizations, and dental care ; and 4) facilitation of the provision of Medi-Cal paid prenatal care services to adolescents by providing financial incentives to prenatal care providers.

In 2003 the CHDP Gateway was successfully implemented. Prior to and after launching the Gateway, many changes in policies and procedures at the state, local, and provider level have occurred. A Provider Manual and a draft Local Program Guidance Manual have been

distributed and are now undergoing revision. The Provider Manual is online and the first updates were made in December 2003 regarding CHDP payment reductions. Informational materials, with frequently asked questions and answers, were produced and placed on the CHDP Gateway website, along with introductory materials about the Gateway. A Gateway Internet Step-by-Step User Guide and Point-of-Service Device User Guide were developed and placed on the Medi-Cal website.

b. Current Activities

MCH programs, including AFLP, ASPPP, BIH, BWSP, and CPSP, continue to screen and assess children and adolescents for Medi-Cal eligibility and assist them in obtaining services needed.

Work continues on revisions to the CHDP Provider Manual and Local Program Guidance Manual. The CHDP local program staff serve an important role in recruiting and enrolling new providers, and assisting and encouraging established providers about the CHDP program, including the Gateway. The guidance manual ensures that there is uniformity among all local programs in daily functions and the Provider Manual is an up-to-date resource for enrollment, billing, the Gateway, and all program responsibilities.

c. Plan for the Coming Year

MCH programs, including AFLP, ASPPP, BIH, BWSP, and CPSP, will continue to screen and assess children and adolescents for Medi-Cal eligibility and assist them in obtaining services needed.

Refer to NPM 13 for more activities related to the Gateway. The revised Local Program Guidance Manual is anticipated to be issued late summer 2004. The CHDP Provider Manual (online) has been revised with updated pages and it is anticipated that the manual will need further updates as the year unfolds. Updates will be reported in the CHDP Bulletin (found on the Medi-Cal website under Publications, CHDP program).

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

NPM 15, the percent of very low birth weight (VLBW) infants among all live births, has been stable in California for the period 1998-2002, between 1.1 and 1.2 percent. In 2002, it was 1.2 percent, and the annual objective of 1.1 percent was not met. The Healthy People 2010 objective is 0.9 percent.

Stable rates since 1998 have coincided with strong programmatic efforts throughout California to focus on early prenatal care and adequate delivery for expectant at-risk mothers. There are currently more than 1,500 Medi-Cal obstetrical providers approved to provide CPSP services and approximately 165,000 women served annually.

African American infants remained twice as likely as other infants to be born at VLBW in California. While other racial and ethnic groups had 1.0 to 1.1 percent of VLBW infants among all live births in 2002, 2.8 percent of African American infants were VLBW. The infant mortality rate for African Americans is also more than twice as high as for all Californians.

BIH provided services to more than 14,000 pregnant and parenting African American women, infants, and children in 2003. BIH is active in the 17 local health jurisdictions where 94 percent of African American infant births and infant deaths occur. BIH identifies pregnant and parenting

African American women at risk for poor birth outcomes and provides them assistance in accessing and maintaining appropriate health care and other supportive services. The Program assures that appropriate pediatric and preventive baby care is available and accessible to all children in the family through the first two years of life.

The USDA Nutrition Network funded the production of "Preventing Iron-Deficiency Anemia", educational materials targeted at the African American community. Materials were provided to local BIH, CHDP, WIC and MCH Branch programs.

Pregnant adolescents, particularly young adolescents, are also at increased risk of delivering low birthweight infants. A primary goal of AFLP is to improve the birth outcomes for babies born to its adolescent clients. AFLP assists and encourages pregnant adolescents to access prenatal and other necessary health care early in their pregnancy, provides nutritional counseling and works with teens to eliminate behaviors such as smoking and alcohol use which could contribute to poor birth outcomes.

The MCH and CMS Branches collaborate with the CPQCC, which advocates for performance improvements in perinatal and neonatal outcomes. CPQCC has more than 80 member hospitals, which account for most of the newborns requiring critical care in California.

b. Current Activities

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.

CPSP works to decrease the incidence of low birth weight infants by providing Medi-Cal eligible women with comprehensive services including prenatal care, health education, and psychosocial and nutrition support services. Assessments, care plans, and interventions are provided.

The MCH Branch has partnered with the CPSP coordinators to better address the needs of local practitioners and CPSP clients. MCH continues to initiate, support and develop opportunities to make particular programs more culturally relevant.

AFLP providers work in partnership with their adolescent clients toward improving the birth outcomes for at-risk teens through prenatal education and counseling as well as appropriate referrals for medical care.

BIH programs continue to identify at-risk pregnant African American women and provide education and support. State and county BIH programs are also collaborating with the March of Dimes Prematurity Prevention Campaign to increase awareness about preventing prematurity in the African American community.

The MCH and CMS Branches are collaborating with the March of Dimes on its 5-year Prematurity Campaign (2003-2007). The goal of this \$75 million campaign is to invest in research, education and community programs in order to identify the causes of prematurity and develop strategies to improve birth outcomes. The five aims of the Prematurity Campaign are to: 1) raise public awareness; 2) educate pregnant women about the signs of preterm labor; 3) assist practitioners with risk reduction tools; 4) invest in research into the causes of preterm birth; and 5) increase women's and children's access to health insurance.

The MCH and CMS Branches are also collaborating on the March of Dimes Alcohol and Pregnancy Campaign, which aims to increase knowledge and awareness about the

consequences of substance use during pregnancy. Alcohol and drug use during pregnancy continue to be a major cause of negative birth outcomes

The CMS Branch is working closely with CPQCC on reviewing and determining data elements that need to be collected for CCS-approved NICUs, and the CMS Branch is requiring all CCS-approved NICUs to submit their data through CPQCC beginning with CY 2004.

The fourteen RPPC assure access to risk-appropriate perinatal care while providing quality improvement activities at delivery hospitals and working to connect agencies, providers, and individuals. The RPPCs work to match the needs of high risk perinatal patients with the appropriate type of care by developing a multi-tiered network of care providers and facilities within specific geographic areas.

c. Plan for the Coming Year

CPSP, AFLP, and BIH will continue to work to decrease the incidence of low birth weight infants by providing Medi-Cal eligible women with comprehensive services including prenatal care, education, and psychosocial support.

The CMS Branch and CPQCC will continue to work on data element selections and CMS will continue to review quarterly and annual CPQCC data reports of CCS-approved NICU/hospitals. The CMS Branch and CPQCC will continue to work on increasing CPQCC membership. MCH and CMS will continue to participate on the Perinatal Quality Improvement Panel. All these efforts are intended to help improve the quality of neonatal and perinatal care statewide.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

a. Last Year's Accomplishments

The rate of suicide deaths among California youth declined between 1990 and 1998, from 9.2 to 6.3 per 100,000 youth. Between 1999 and 2002, the rate fluctuated around 5.0. In 2002, the rate was 4.8, and the annual objective of 5.4 was met. (Rates for years before 1999 are not directly comparable to rates for 1999 and later years because of the change from ICD9 to ICD10 codes in calculating mortality rates.)

Suicide is one of the leading causes of death among American youth, and California is looking at ways to improve adolescent mental health. The AHC, a broad-based, statewide group with representatives of the public and private sectors, identified the need for a comprehensive plan for addressing the health and developmental needs of California's adolescents. In response to this need, the MCH Branch contracted with staff of NAHIC to develop a strategic plan to address adolescent health in 2001. The document provided background information and recommendations for future directions for the local adolescent health programs in California.

The MCH Branch, NAHIC, and AHC met in December 2002 to begin to develop the capacity for increased coordination between primary care, mental health, and schools. The meeting focused on adolescent mental health issues related to prevention and early intervention. A follow-up meeting occurred to share best practices and provide training on mental health financing to interested stakeholders in California so that they could learn about ideas that could be implemented in their organization or community.

The State Adolescent Health Coordinator has been working with the MCMC Division, UCSF, and the Adolescent Health Working Group on a quality improvement project to improve preventive services for adolescents.

State and local AFLP and ASPPP staff have also been working since fall of 2002 to revise and improve the tool that is used statewide to assess the health and psychosocial needs, including suicide risk, of its adolescent clients. Statewide training on this and other mental health issues, including infant mental health, was provided in May 2003, prior to elimination of the AFLP/ASPPP training program due to budget cuts. Though the need for mental health services is very prevalent in the AFLP and ASPPP client population, appropriate local services are typically insufficient to meet the demand.

b. Current Activities

The MCH Branch collaborates with the MCMC Division on their Interagency Work Group for BEST-PCP Project. BEST-PCP focuses first on a discrete set of policy and structural issues at the state and county levels that must be addressed to facilitate meaningful change at the practice level. The project then aims to develop and implement a model for changing provider practice, as the basis for broader collaborative quality improvement efforts. The target population for this project is age 0-3 years. By addressing the behavioral, emotional, and social health of very young children, this model also has the potential for improvements in social, emotional, and mental health of children as they get older.

The MCH Branch also participates in the multi-agency California Coalition for Youth Development. The coalition serves to promote positive youth development throughout California through the annual Youth Development Summit and other projects. Participants include the Attorney General's Office, CDE, 4-H Center for Youth Development, Friday Night Live, Alcohol and Drug Program, and DMH.

c. Plan for the Coming Year

Collaborations with MCMC and DMH on the BEST-PCP project will continue in order to better understand, coordinate, and implement change to improve the screening and treatment of behavioral, emotional, and social needs of our young children. The MCH Branch will continue to look for opportunities to incorporate positive youth development into its programs and coordinate with others in the State to work to increase the assets of our youth. The MCH Branch will continue to work with AHC and others to promote best practices in mental health and to investigate best practices in suicide prevention.

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

a. Last Year's Accomplishments

NPM 17, the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates, was relatively stable in California for the period 1998-2001, between 64.6 and 65.9 percent. In 2002, it was 68.7 percent, and the annual objective of 66.6 percent was achieved. However, California is still far short of the Healthy People 2010 objective of 90 percent.

The California figures are 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 have included: 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 RPPCs to encourage appropriate referrals.

California's fourteen RPPCs provide regional planning and coordination and ensure that the needs of high-risk patients are matched with the appropriate level of care. RPPCs develop communication networks among agencies, providers, and individuals, and they disseminate education materials and produce a statewide newsletter. RPPCs assist hospitals with data collection and quality improvement activities. They also provide resource directories, referral services, and hospital linkages to the two California Perinatal Transport Systems (CPTS).

CPTS assists health care professionals in the referral of high-risk pregnant women and newborn infants. Bed availability status for regional neonatal intensive care units, updated daily, is available on the CPTS website (www.perinatal.org). CPTS also provides collection and analysis of perinatal and neonatal transport data for regional planning, outreach program development, and outcome analysis; the information is reported back to the participating hospitals.

In an effort to provide data for perinatal quality improvement efforts in California, the MCH Branch undertook two complementary projects: the Improved Perinatal Outcome Data Reports (IPODR) and California Perinatal Profiles. Their websites are <http://datamch.berkeley.edu/> and <http://perinatalprofiles.berkeley.edu>, respectively. The IPODR are intended to provide information on which to base health planning and allocation decisions, and evaluation of these decisions. The IPODR website includes an annual county profile report based on California Birth/Death Vital Statistics and Hospital Discharge Data aggregated to the ZIP code level. The California Perinatal Profiles website provides both public (state and regional) information, as well as confidential (hospital specific) information, with the goal of providing data for quality improvement to all the maternity hospitals in California.

b. Current Activities

The RPPC and CPTS continue their work in the areas of regional planning and coordination, matching high-risk patients with the appropriate level of care, and assisting hospitals with data collection and quality improvement activities. CPTS is currently training hospitals to self report their bed availability on the CPTS web site.

The RPPC, in collaboration with CPTS, is conducting a survey of all California hospitals to identify current practices in perinatal regional cooperation. The survey is intended to assess policies and procedures, standards and contracts regarding maternal-fetal and neonatal transport, collaborative education, consultation and quality improvement. Statewide quality improvement activities will be developed based on the survey results.

The MCH Branch is developing the Maternal Quality Improvement (MQI) Project, a collaborative effort between CPQCC and UCLA's Maternal Quality Indicators group. The MQI Leadership Council will include members from CCS and MCH Branches, Medi-Cal Managed Care, and Medi-Cal Policy Division. MQI will direct statewide maternal quality improvement activities utilizing the methodology developed by the CPQCC. MQI will measure maternal quality of care in California, beginning with the use of linked OSHPD data sets to determine hospital-level outcomes for maternal/neonatal infections and postpartum hemorrhage.

The CMS Branch is collaborating with CPQCC in retrieval and analysis of NICU data for CCS approved NICUs. This collaboration offers CCS a useful and uniform reporting scheme for comparative assessment of hospitals on level of care for neonates. As of May 2004 there were more than 80 hospitals/NICUs enrolled in CPQCC. As of January 2004, CCS is requiring all CCS-approved NICUs to submit data on an annual basis to CPQCC; because of this new requirement, the number of CPQCC member hospitals is expected to increase to 90-100 by the end of 2004. (For more information about CPQCC, see National Performance Measure 15.)

The CMS Branch and CPQCC are responding to questions about CPQCC membership and NICU data reporting from hospitals that are new members or about to become new members. CMS and CPQCC are reviewing data element selection in an effort to decrease any unnecessary data collection for hospitals. The CMS Branch is analyzing CPQCC annual data reports for CCS-approved NICUs for 2002.

c. Plan for the Coming Year

The RPPC and CPTS will continue their work in the areas of regional planning and coordination, matching high-risk patients with the appropriate level of care, and assisting hospitals with data collection and quality improvement activities.

The MCH Branch will continue its work on the development of the MQI Project.

The CMS Branch and CPQCC will continue to 1) respond to CPQCC membership questions, and 2) review data element selection in an effort to decrease any unnecessary data element collection for hospitals. The CMS Branch will continue to analyze CPQCC data reports for CCS-approved NICUs, addressing outliers and concerns about quality of care. The MCH and CMS Branches will continue participation on the CPQCC Executive Committee and the Perinatal Quality Improvement Panel (PQIP). (The PQIP is an executive subcommittee of CPQCC which oversees data analysis and quality improvement efforts.)

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

a. Last Year's Accomplishments

Improving access to first trimester prenatal care has been a long-term MCH priority. California has made steady progress on NPM 18, with the rate increasing about one percentage point a year between 1998 and 2002. NPM 18 was 86.5 percent in 2002, up from 85.4 percent in 2001. The 2002 annual objective of 85.9 percent was achieved. The Healthy People 2010 objective is 90 percent.

Women in two race/ethnic groups exceeded the statewide annual objective for 2002, while other groups did not. White and Asian/Pacific Islander women were more likely to receive prenatal care in the first trimester (89.5 percent and 86.5 percent, respectively) than women who were Hispanic, African American, or American Indian/Aleut (82.2, 80.9, and 74.5 percent, respectively.)

Several strategies have been used in California to improve prenatal care utilization. One was the expansion of Medi-Cal eligibility criteria, improved access to Medi-Cal through presumptive and continuous eligibility, a waived assets test, and reduced application paperwork. These were accomplished in California in the late 1980s, and the improvements in the rates in the 1990s are at least partly attributable to these changes.

Several state programs support improvements in adequate prenatal care through direct and indirect delivery of services and support; these include CPSP, AFLP, WIC, BIH, and AIIHI. The programs provide case management services and linkages to medical care for their target populations.

The MCH Branch works to provide ethnically diverse staff for recruiting clients into care, and local MCH jurisdictions employ a variety of methods to target diverse populations. The MCH program in Orange County works with Latino Health Access, a local non-profit organization, to operate the Promotores Program. Promotores are highly trained community health workers

who provide wellness education and act as role models for their peers. They are recruited and hired from the communities where they live. Promotores, in conjunction with public health professionals, work with pregnant Hispanic women and their families to promote early prenatal care and access to other appropriate healthcare services.

In spite of efforts to increase the number of women who receive prenatal care in the first trimester, the following obstacles remain: delays due to lack of awareness of Medi-Cal Presumptive Eligibility, delays due to the Medi-Cal enrollment process, and high rates of unintended pregnancy.

b. Current Activities

CPSP, AFLP, WIC, BIH, and AIIHI continue to provide case management services and linkages to medical care for their target populations.

CPSP provides perinatal support services to 165,000 women a year, and reimbursement to the 1500 active CPSP providers is more than \$88 million/year.

The MCH Branch is working on consolidating data (beneficiaries, paid claims, birth outcomes, and hospital discharge data) to develop baseline data on the efficacy of CPSP services. These data are not currently available in DHS or in the public health literature, and they can have significant value in program evaluation. The data will be used to assess the cost-effectiveness of CPSP services and to identify the savings to the State in reduced poor birth outcomes and reduced neonatal intensive care unit days. Dissemination of program data to providers will help support providers' quality improvement and utilization management efforts.

In California an estimated 44 percent of all births are unintended. [34] California's Family PACT Program provides no-cost family planning services to all California residents with incomes at or below 200 percent of FPL, and, insofar as these services help to reduce the rate of unintended pregnancy, they also contribute indirectly to increased utilization of prenatal care.

c. Plan for the Coming Year

CPSP, AFLP, WIC, BIH, and AIIHI will continue to provide case management services and linkages to medical care for their target populations.

Plans for the coming year for CPSP include continued provider recruitment; provider and practitioner training, including documentation training; material development; and development of evaluative reports on the efficacy of services. These activities are undertaken in an effort to ensure the availability and effectiveness of CPSP services, even in this era of budget constraints, and to achieve improvements in first trimester entry into prenatal care.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

NATIONAL PERFORMANCE MEASURE		Pyramid Level of Service			
		DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed					

with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. The GDB screens for genetic and congenital disorders, including testing, follow-up and early diagnosis of disorders to prevent adverse outcomes or minimize the clinical effects.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The GDB ensures quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance with them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. The GDB fosters informed participation in its programs through a combination of patient, professional, and public education, and accurate and up-to-date information and counseling.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Laboratory, follow-up, diagnosis, treatment and outcome data are being collected as part of a three-year evaluation of a pilot project to address expanded genetic disease testing utilizing MS/MS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. CISS Grant Family-Centered Survey data analysis continues.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Development of CCS program policy letter for FCC for county programs continues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. CRISS FCC Work Group from 14 CCS county programs plans FCC trainings, conferences, monitors activities, shares resources.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Counties are implementing CCS Staffing Standards for inclusion of a parent liaison.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Counties are including parents on their CCS advisory committees.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. CCS counties are evaluating their programs using a performance measure for family participation in the CCS program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. FCC Work Group provides technical assistance for CCS administrators for hiring or contracting a parent liaison.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. There is collaboration with California Medical Home Project targeting CCS children.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. CMS state and county staff are involved in the LA Medical Home Project and its activities.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. LA Care and Health Net MCMC Plans are partnering with LA County CCS to develop plan to eliminate barrier for PCP not knowing child is enrolled in CCS.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Drafting policy for a CCS medical home project continues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Counties are evaluating their programs for documentation of a medical home for each client.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Information sharing between LA CCS Automated Case Management System and LA Care MCMC Plan for better coordination of care by the medical home continues.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Connectivity to other health coverage file through E47 and updating file.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Post implementation of modified pre-enrollment Gateway process for infants.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Liaison activities with HF to facilitate AIM transitioning for babies.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Development of CCS program policy letter for FCC continues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2. Counties are implementing the outpatient mental health CCS program policy letter.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. The CMS Branch is reviewing CCS approved facilities for implementation of FCC.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. There is collaboration with Family Voices, parent representatives, and parent groups through the Interagency Coordinating Council for Early Start.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. There is CMS Branch support for local CCS program innovative projects to coordinate FCC services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Family members are participating on CCS advisory committees and task forces.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. CHDP, HCPCFC, and CCS programs are evaluating the effectiveness of their case management through a performance measure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. CRISS FCC Work Group meets bimonthly and reports are shared on FCC activities and resources; FCC trainings and conferences are planned.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. The CMS Branch is forming a transition work group with wide representation to develop and implement written policy and guidelines for transitioning care for adolescents.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. The CMS Branch is reviewing CCS approved facilities for implementation of transition care planning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. County CCS representatives report on transition activities at the FCC Work Group and a matrix of activities is maintained and updated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. CCS social work consultants discuss transition issues at quarterly meetings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Counties continue to form transition committees, clinics and plan workshops.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				

1. The MCH and CMS Branches advocate for eligible children to join Medi-Cal or HF, both of which cover immunization.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Healthy Start (HS), the Health Insurance Plan of California (HIPC), and AIM provide health care access, including immunizations, for children.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Health promotion for adequate immunizations is also done through the CHDP Gateway and the BIH program, AFLP, ASPPP, and CPSP.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Nine regional immunization registries, covering about 85 percent of the state's population, exchange immunization data.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Based on data from the regional immunization registries, pockets of need are identified, and interventions are developed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. The CMS Branch and the IZ Branch are informing providers of the current Pneumococcal Conjugate Vaccine shortage and the CDC recommendation to suspend third and fourth doses for healthy children.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. The AFLP and the ASPPP provide case management services to pregnant and/or parenting teens and their siblings to improve birth outcomes and prevent additional pregnancies.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The Family PACT Program provides comprehensive clinical contraceptive and reproductive health services for adolescents at more than 2,000 provider sites throughout California.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The CCG Program funds approximately 130 community agencies and serves approximately 120,000 teens annually.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The TSE program does outreach to teens and offers in-depth counseling related to sexual and contraceptive concerns of adolescents who access family planning services through the Family PACT program.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The I and E program provides community-based educational services on teen pregnancy prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. The MIP provides community-based educational services which promote the involvement of young men in the prevention of teen pregnancy and unintended fatherhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. The Cal-SAFE program, which operates in 140 school districts, promotes teen pregnancy prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. MCH is working with other key stakeholders at the state level, including the CDE and the STD Control Branch, to better coordinate efforts in HIV, STD, and teen pregnancy prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Medi-Cal and HF provide access to a comprehensive package of primary and preventive services, including dental care, for California's low-income children.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. CHDP provides dental screening for children up to 21 years of age.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The CMS Branch is undertaking activities to encourage orthodontists and dentists to accept more CCS children into their practices, including more rapid reimbursement.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. WIC and MCH provide toothbrushes and toothpaste to program participants.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. DHS continues efforts to increase fluoridation of State water supply.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. MCH Oral Health Policy Consultant convenes the DHS Dental Workgroup to bring together oral health staff at the state level and provides technical assistance to the Branch.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. CDDPP serves more than 300,000 school children annually, including dental sealants screening/application and oral health education in the classroom.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. CDDPP includes a parent education component, which provides training to the parents of children in the OOH's school-based program about oral disease prevention strategies and the importance of nutrition to health, including oral health.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. The MCH Branch funds local CIPPs in five local health jurisdictions in three-year cycles.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. The CIPPP at San Diego State University provides data and technical assistance in the development, implementation and evaluation of injury prevention programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. MCH and CIPPP organize an annual childhood injury prevention conference.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. CIPPP creates linkages between agencies, researchers, and advocates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. To raise funds to support child injury and abuse prevention programs, the State sells special car license plates, called Kid's Plates.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The EPIC Branch maintains an up-to-date statewide list of current locally operated child passenger safety seat programs for use by traffic courts, community agencies, hospitals and clinics.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. The AFLP promotes breastfeeding among adolescent mothers, an age group that is less likely to breastfeed.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The CDAPP promotes breastfeeding as beneficial for both mother and child in reducing the risk for diabetes.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The BIH program promotes breastfeeding among African American women.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The MCH and CMS Branches are participating on the new DHS Nutrition and Physical Activity Action Team; breastfeeding promotion is one of the interventions for childhood obesity prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. The MCH Branch staff helps promote local breastfeeding coalitions, including working with a team from UCD to organize an annual Statewide Breastfeeding Coalition Conference.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. The Statewide Breastfeeding Promotion Advisory Committee is revising its Model Hospital Policies and has been successful in getting the Medi-Cal program to improve reimbursement for lactation services and aids.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. DHS annually holds a statewide Public Health Grand Rounds session on breastfeeding promotion.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. There are trainings on infant diagnostic audiology evaluations for community audiologists.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. There are educational programs for primary care providers on their role as medical home in NHSP.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Participation by the CMS Branch on the Deaf and Hard of Hearing Early Intervention Work Group continues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. HCCs assist hospitals and track and monitor infants needing follow-up/evaluation/intervention.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. CMS Branch staff provide technical assistance and consultation support to the NHSP HCCs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Two-part training for community audiologists on intervention and amplification for infants with hearing loss is being planned and developed for the winter of 2004-05.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. MCH programs encourage and facilitate enrollment in Medi-Cal and HF via education and assistance efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. The CMS Branch works to maximize the effectiveness of the Gateway for enrolling eligible children in Medi-Cal or HF.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. CHDP provides information and materials in multiple languages for the Gateway.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. DHS and MRMIB continue to implement and support improvements in the process of eligibility determination and enrollment for Medi-Cal and HF.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. MCH programs provide client case management services including assisting families in obtaining health services for children.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. MCH programs provide community education efforts related to families getting medical services.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. MCH programs facilitate provision of adolescent prenatal care services by Medi-Cal providers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The CMS Branch continues to work on improving relations with Medi-Cal providers in order to maintain existing providers and encourage new provider enrollment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				

1. The CPSP provides Medi-Cal eligible women with prenatal care, health education, and psychosocial and nutrition support services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The AFLP assists and encourages pregnant adolescents to access early prenatal care and works with teens to eliminate behaviors such as smoking and alcohol use which could contribute to poor birth outcomes.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The BIH program identifies pregnant and parenting African American women who are at risk for poor birth outcomes and provides them assistance in accessing and maintaining appropriate health care and other supportive services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. BIH educates women on how to recognize the signs and symptoms of preterm labor and advises women on helpful hints to prevent preterm labor.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The MCH and CMS Branches are collaborating with the March of Dimes on their Prematurity Prevention Campaign and their Alcohol and Pregnancy Campaign.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. The Regional Perinatal Programs of California (RPPCs) match the needs of high risk perinatal patients with the appropriate type of care by developing a multi-tiered network of care providers and facilities within specific geographic areas.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. The CPQCC collects data from over 80 member hospitals, recommends quality indicators and performance improvement objectives, and assists providers in translating the data into improved patient care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. The CMS Branch is working closely with CPQCC on determining data elements that need to be collected for NICUs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. MCH collaborates with MCMC on their Interagency Work Group for BEST-PCP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. MCH participates in the multi-agency California Coalition for Youth Development, which promotes positive youth development through the annual Youth Development Summit and other projects.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At the local level, the AFLP and ASPPP providers routinely assess all adolescent clients for suicide risk and other mental health needs on an ongoing basis.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. AFLP and ASPPP case management strategies include both youth development and risk reduction activities and services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. The fourteen RPPCs provide regional planning and coordination and ensure that the needs of high-risk patients are matched with the appropriate level of care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. CPTS assists in the referral of high-risk pregnant women and newborn infants by providing bed availability status for regional CCS approved NICUs, updated daily, on the CPTS website.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. RPPC and CPTS assist hospitals with data collection and quality improvement activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. The CPQCC reports on neonatal care for hospital/NICU members of CPQCC, providing CCS a useful and uniform reporting scheme for comparative assessment of hospitals on level of care for neonates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. The IPODR, which include county profiles and other reports, are intended to provide information on which to base health planning and allocation decisions, and evaluation of these decisions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. The California Perinatal Profiles website provides both public (state and regional) information, as well as confidential (hospital specific) information with the goal of providing data for continuous quality improvement to all maternity hospitals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. The CPSP provides Medi-Cal eligible women with prenatal care, health education, and support services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The BIH program identifies pregnant and parenting African American women who are at risk for poor birth outcomes and provides them assistance in accessing and maintaining health care and other support services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The AFLP provides case management services to pregnant adolescents at risk of poor birth outcomes; services include nutritional and prenatal counseling and assisted referral for prenatal and other medical services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The AIHI serves prenatal and parenting American Indian women with direct health care services and case management services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The MCH Branch works to provide ethnically diverse staff for recruiting clients into care, and local MCH jurisdictions employ a variety of methods to target diverse populations.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. MCH Branch is working on consolidating data on CPSP (beneficiaries, paid claims, birth outcomes, and hospital discharge data) in order to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

assess the efficacy of CPSP services.				
7. The Family PACT Program provides no-cost family planning services to all low-income residents; insofar as these services help to reduce the rate of unintended pregnancy, they also contribute indirectly to increased utilization of prenatal care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 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.*

a. Last Year's Accomplishments

SPM 1 addresses the utilization of preventive medical exams by children whose family income is below 200 percent of the FPL. CHDP data is used to calculate this measure. In FY 2000-01, an estimated 4,412,824 children with family incomes under 200 percent of the FPL were the target population for the CHDP program. Of these children, 1,812,655 or 41.1 percent, received CHDP health assessments. For FY 2001-02, of an estimated 4,558,136 target population, 1,744,626 children, or 38.3 percent, received CHDP health assessments. This was a decrease of 6.8 percent from the prior year and below the target of 45 percent. This decline may have been in part attributable to 1) children being transferred to other health care programs such as HF, or 2) under-reporting of complete or partial CHDP preventive health assessments provided by MCMC plans.

HF provides services to children from eligible families up to 250 percent of the FPL. The data for preventive medical examinations received by children enrolled in HF are not reported to the CMS Branch. This lack of reporting will continue to negatively impact this performance measure, particularly as the number of HF clients continues to increase.

The CHDP "Information Only" PM 160 is used to report health assessment services rendered to Medi-Cal children enrolled in MCMC plans. Because they are not used as a billing form, the "Information-Only" PM 160's are not edited, and therefore the data from these forms may be less reliable than data reported on the other PM 160 forms. This potential under-reporting becomes more significant as increasing numbers of children are transitioning from Medi-Cal fee-for-service to MCMC plans.

In addition to under-reporting, the target population for this measure increased 5.2 percent from FY 1999-00 to FY 2001-02.

Activities over the past year related to this measure have focused on implementation of the CHDP Gateway to enroll eligible children into Medi-Cal and HF. Local CHDP programs continue to work with providers in their counties to encourage provider participation in CHDP and to encourage provision of preventive services for children from families with incomes at or below 200 percent of the FPL.

b. Current Activities

Current activities related to this performance measure include: 1) Continuing the CHDP Gateway implementation; 2) Outreach efforts of the local CHDP programs and collaboration

with the schools and Head Start to assist more low-income children to receive preventive exams; 3) Local health departments assisting children and their families to access preventive health examinations through health fairs and interagency agreements with WIC and Head Start; 4) Local CHDP staff participating on the Head Start Advisory Board; 5) CHDP working with school districts to have the first grade exam on record and to complete the CHDP Annual School Report; 6) Local CHDP programs continuing to work with providers in their counties to encourage provision of preventive services for children from families with incomes at or below 200 percent of the FPL; and 7) In areas where access is limited, local CHDP staff working to recruit providers to participate in the CHDP program.

c. Plan for the Coming Year

Plans for the coming year include: 1) Continuing the CHDP Gateway process; 2) Continuing CHDP collaboration with schools, Head Start and providers in order to assist more low-income children to receive preventive exams; 3) Continuing to provide health fairs in communities and to participate on the Head Start Advisory Board; 4) Continuing working with school districts to have the first grade exam on record and to complete the CHDP Annual School Report; 5) Local CHDP staff continuing to work toward recruiting providers to participate in the CHDP program.

State Performance Measure 2: The percent of low-income children who are above the 95th percentile of weight-for-length (less than 2 years) or BMI-for-age (2-12 years), or overweight.

a. Last Year's Accomplishments

SPM 2 is the percent of low-income children 0 -12 years who are above the 95th percentile of weight-for-length (<2 years) or BMI-for-age (2-12 years), or overweight. Starting with the year 2000, the data used for this report from the PEDNSS have been updated to utilize the 2000 CDC growth chart percentiles. CDC has also unduplicated the data for FY 2001-02 and this has improved accuracy and resulted in smaller numbers for both the numerator and the denominator. The percentage of overweight children for FY 2002-03 was 16.1 percent. This is still above the target of 14 percent, but a decrease from FY 2001-02, which was 17.2 percent. The percentage of overweight children was 14.9 percent in FY 2000-01.

In the age group of 0 -12 years, American Indian/Alaskan Native have the highest prevalence for overweight (20 percent), followed by Hispanic (18.8 percent), and African American (15.2 percent). The trends for overweight within every ethnic group have shown marked increases over the past ten years. For example, in the 5 to <20 years age group, the Asian/Pacific Islanders have shown an increase in overweight of 118 percent, from 6.5 percent overweight in FY 1993-94 to 14.2 percent overweight in FY 2002-03. In response to these trends, childhood obesity prevention has become a major statewide initiative.

The three CDC priority areas (increased physical activity, reduced television viewing, and breast feeding promotion) and the two promising areas (energy balance and five fruits and vegetables per day) for programs for reducing obesity have been assimilated into existing MCH and CMS programs. The MCH, CMS, and WIC Branches, and the UC Berkeley Center for Weight and Health collaboratively hosted the biannual California Childhood Obesity Prevention Conference in January 2003 for 11,000 participants from all states and five nations. The MCH and CMS Branches have been involved with program planning, implementation and evaluation in the CDC funded California Obesity Prevention Initiative (COPI). The MCH and CMS Branches have actively participated in the DHS Physical Activity and Nutrition Coordinating Committee (PANCC).

A special project funded by the Nutrition Network was the purchase and distribution of "Go, Glow, Grow" booklets to CHDP providers. These booklets were given to families at the CHDP health assessment to educate them on the importance of consuming fruits and vegetables, a well-balanced diet, and participating in physical activity. The booklets provided parents with a unique opportunity to not only read to their children, but to learn more about the importance of diet and activity. Through another special project funded by the Nutrition Network, older children and adolescents participating in the CHDP program received color brochures of "Food, Activity, and You" (printed in various languages) to educate them about healthy eating, physical activity, and weight management.

b. Current Activities

In 2004, the Nutrition Network funded five CHDP Nutrition Special Projects in Merced, Sonoma, Yolo, San Bernardino, and San Francisco Counties. All the projects have a focus of nutrition and physical activity. Another ongoing activity for the CMS Branch is the collection of data from CHDP nutrition assessments by CHDP providers for infants, children, and adolescents. The data is forwarded to CDC for entry into PEDNSS. CDC prepares multiple informative tables from this data. In another ongoing activity, state and local CHDP nutritionists develop and implement nutrition education, provide consultation and training to CHDP providers, and coordinate follow-up and referrals to related programs.

The MCH and CMS Branches have begun work on the third biannual California Childhood Obesity Conference for January 9 -12, 2005 in San Diego. The conference theme is, "Launching a Movement: Linking Our Efforts to Make a Difference." A website has been established for information: <http://www.cce.csus.edu/cts/co/index.htm>.

SHC promotes healthy food choices and physical activity in schools through the endorsement of nutritional assessment tools, including the CDC's School Health Index. The AFLP, ASPPP, and the oral health programs are promoting healthy food choices and physical activity. The BIH program and the CPSP target the prevention of low birthweight babies and promote breastfeeding in an effort to reduce the risk of developing obesity.

The BIH Program promotes proper nutrition by encouraging healthy eating through discussions on how to cut the fat and lower the calories in the menu. It features classes on "making ends meet on a limited budget." This incorporates meal planning, grocery shopping, stretching supplies, etc., and working collaboratively with Nutritionists on the promotion of healthy eating and living.

A major initiative of DHS is the formation of a department-wide Nutrition and Physical Activity Action Team to address the role of DHS in confronting the obesity epidemic through the development of short, intermediate, and long term strategies for action to increase healthy eating and physical activity for all of California across all ages. These strategies are being coordinated within DHS and externally with other agencies. The MCH and CMS Branches have representative participants on this Action Team.

c. Plan for the Coming Year

The MCH and CMS Branches will continue to actively participate in coalitions and committees promoting nutrition and activity. The Nutrition and Physical Activity Action Team will be instrumental in helping to develop a Governor's Summit on the obesity epidemic to be held in December 2004. This team will develop an initiative to prioritize strategies that increase healthy eating and physical activity for all of California. MCH and CMS programs will continue

to promote healthy eating and activity and other obesity prevention measures. MCH, CMS, and WIC Branches will hold the third biannual California Childhood Obesity Conference in January 2005.

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

a. Last Year's Accomplishments

SPM 3, the rate of deaths to children caused by drowning in swimming pools, was stable for 1999-2001, between 2.0 and 2.2 per 100,000. In 2002 it was down to 1.7 (a total of 38 deaths), and the annual objective of 2.1 was achieved. (Caution should be applied in comparing mortality-related measures for 1999 and subsequent years to prior years' rates because of the uncertainty regarding the comparability of data resulting from the shift in codes used through 1998 to the ICD10 codes used in 1999 and subsequent years).

The Swimming Pool Safety Act, enacted in 1996, sets forth comprehensive statewide swimming pool safety guidelines. It requires that new residential pools be designed with safety features, such as a fence or safety cover, to help prevent young children from getting to a pool or spa when momentarily out of sight of their caregivers.

CIPPP serves as a resource center on child and adolescent injury prevention and provides technical assistance in the development, implementation and evaluation of injury prevention programs. CIPPP works with the MCH Branch to organize the annual childhood injury prevention conference. CIPPP also produces Safety Literature updates with weekly references of current injury prevention articles.

The MCH Branch funds local childhood injury prevention programs in five counties (Alameda, Kern, Humboldt, San Mateo, and Sonoma). In 2002, CIPPP, in collaboration with the MCH Branch, started a bi-monthly injury prevention teleconference with injury prevention professionals in the five counties; the regular teleconferencing enables statewide networking, joint planning, and skill development. This group then expanded to include other interested MCAH programs and other injury prevention stakeholders in 2003. In addition, an injury prevention list serve was started with the five funded programs and expanded to include a total of 23 MCAH jurisdictions. The list serve will be used to give updates, alert programs of funding sources, and share information.

Working with CIPPP and local coalitions, MCH has increased public awareness of the hazards of unprotected swimming pools and has undertaken education efforts regarding legislation that requires fencing around swimming pools.

b. Current Activities

The MCH Branch funds local childhood injury prevention programs (in five counties in three-year cycles. The funding cycle for the current counties (Alameda, Kern, Humboldt, San Mateo, and Sonoma) ended June 30, 2004. Beginning July 1, 2004, the jurisdictions of Plumas, Siskiyou, Sacramento, Stanislaus, and Ventura will receive funding for three years.

The MCH Branch holds regular meetings with the EPIC Branch to coordinate activities and collaborate to address joint areas of interest.

Local injury prevention efforts continue to address pool safety interventions. Modoc County

has an injury prevention program and dedicated injury prevention staff who address a wide variety of injury prevention concerns with a focus on children 1- 10 years of age. Lassen County promotes injury prevention through their home visitation activities and is in the process of compiling and analyzing injury prevention data. Humboldt County has obtained funding and hired a coordinator to plan and implement a CIPP. The Program includes several childhood safety projects, including the initiation, in FY 2003-04, of a life jacket loaner program at one ocean and two river locations. Childhood injury data are collected and analyzed.

To raise funds to support child injury and abuse prevention programs, the State sells personalized auto license plates, called "Kid's Plates". Kids Plates feature a heart, hand, star, or plus sign. The proceeds fund child injury and abuse prevention programs. The Kid's Plates Program provides a wide range of technical assistance to help foster effective regional and local injury prevention efforts and funds grants for training and equipment. Between 1998 and 2003, over 200 grants were awarded to community-based organizations, local health departments, and other organizations. CIPPP is the Kid's Plate program administrator for the EPIC Branch.

c. Plan for the Coming Year

The 18th Annual Childhood Injury Prevention Conference will be held September 27-29, 2004, in San Francisco to provide the latest information on practices and research in injury prevention and to provide in-depth training in specific areas. The MCH Branch, in collaboration with the CIPPP, is planning an orientation teleconference and in-person meeting for the five newly funded programs, to be held in conjunction with the September conference. CIPPP will be working with the local jurisdictions to provide technical assistance on data analysis, program planning, and evaluation.

DHS will continue to support programs and projects which work to prevent childhood injury. DHS will continue to support CIPPP in its efforts to provide data and technical assistance in the development, implementation, and evaluation of injury prevention programs and assists in creating linkages between agencies, researchers, and advocates.

State Performance Measure 4: *The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by homicide.*

a. Last Year's Accomplishments

The adolescent homicide rate fell steadily between 1994 and 1999, from 34.4 to 11.9 deaths per 100,000. Since 2000, it has hovered between 13.4 and 13.7. The 2002 rate was 13.7; the annual objective of 13.5 was not achieved. (Caution should be applied in comparing 1999 mortality-related measures to rates prior to that year because of the uncertainty regarding the comparability of data resulting from the shift in ICD9 codes used through 1998 to the ICD10 codes used in 1999 and subsequent years).

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. 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.

DHS conducts ongoing injury surveillance to look at broad statewide patterns and gathers data to better understand the risk factors and circumstances that can lead to specific types of injury. The EPIC Branch has an online injury prevention database that generates individualized

county level tables (by age, race, location, etc.). Local MCAH jurisdictions have utilized this resource to assist with program planning. Two surveillance projects of special interest by EPIC include a statewide child abuse and neglect fatality monitoring system and the Firearm Injury Surveillance Program. These projects provide data on incidence for program planning purposes and to inform policy makers of possible changes in regulations or direction of injury control programs.

The "Safe from the Start" Project, in the California Attorney General's Office, targets children age 18 and younger, with an emphasis on children age 5 and younger, who have been exposed to family, school and/or community violence.

The School Safety and Violence Prevention Act (Carl Washington Act) provides schools with funding for efforts related to school safety and violence prevention based on enrollment in 8-12 grades (\$35/student/year). This Act stemmed from the concern raised after the Columbine event 5 years ago. It is an \$82 million initiative based in CDE.

The School Law Enforcement Partnership, through CDE and the Attorney General's Crime and Violence Prevention Center, encourages schools and law enforcement agencies to develop interagency partnerships and activities that improve school attendance, encourage good citizenship, and promote safe schools.

b. Current Activities

The "Safe from the Start" Project, projects funded by the School Safety and Violence Prevention Act, and School Law Enforcement Partnership, described above, are ongoing.

Assets-based development of opportunities for youth complement the problem- focused responses to such risks as adolescent access to firearms and substance abuse. The MCH Branch has been a part of the California Coalition for Youth Development, a network of organizations throughout the state working to promote youth development in our programs.

The MCH Branch is working with NAHIC and AHC to develop the capacity for increased coordination between primary care, mental health, and schools.

Alameda County is focusing their injury prevention efforts on the adolescent population, in particular teen relationship violence. They are partnering with local organizations on this effort.

Marin County has an annual Peer Summit to promote peer health education at middle and high schools and an annual Parent University Program to educate and empower parents to more effectively communicate with teens on health issues. The Marin County MCH staff maintain collaborative partnerships with community agencies to address the unique needs of the teenage population. Partnerships include: the Huckleberry Youth Program, Healthy Teens Marin, Teen Tuesday, Marin Community Clinic, Juvenile Hall Health Education Program, Novato Teen Health Program, community faith-based organizations, and local law enforcement agencies.

Modoc County's Teen Health Coalition, which focuses on Tobacco Education and outreach and has been in existence for eight years, is expanding to encompass all teen health issues.

Sierra County has a mentoring program that connects young people with role models and gives them alternatives to alcohol and drug use and assists them in making wise decisions and choices.

c. Plan for the Coming Year

The MCH Branch plans to work with the EPIC Branch to assist in their grant application to develop a strategic plan for childhood and youth violence prevention.

The MCH Branch will continue to look for opportunities to promote youth development and to partner in youth violence prevention efforts both statewide and locally.

State Performance Measure 5: The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries.

a. Last Year's Accomplishments

The rate of motor vehicle deaths among 15-19 year olds declined significantly between 1990 and 1998, falling from 27.3 to 17.2 per 100,000. It fell further in 1999 and 2000, to 13.9 and 13.3, respectively, then jumped up to 18.0 in 2001 and to 20.7 in 2002. The annual objective of 16.0 for 2002 was not met. (Caution should be applied in comparing 1999 mortality-related measures to rates prior to that year because of the uncertainty regarding the comparability of data resulting from the shift from the ICD9 codes used through 1998 to the ICD10 codes used in 1999).

Motor vehicle injuries are the leading cause of death in California's teen population. The change from 13.3 in 2000 to 20.7 in 2002 represents an alarming increase of 56 percent in just two years, despite California's strong motor vehicle laws, including graduated licensing, zero tolerance for alcohol for youth less than 21 years, and primary seat belt law. Male death rates are higher than female death rates but both have been increasing since 2000.

The use of alcohol by young drivers is especially dangerous. In 2002, 29 percent of young drivers killed in motor vehicle crashes had been drinking.[35] Over the course of the last decade, the California Highway Patrol has increased enforcement of DUI laws and has undertaken extensive education and public awareness programs. These include: "Sober Graduation," a program that targets high school seniors; the "Designated Driver Program;" "Red Ribbon Week," an annual event to increase the public's awareness of the problems associated with using illicit drugs; and the "El Protector" program which was established in response to the disproportionate amount of fatal accidents and DUI arrests involving Hispanic youth.

CIPPP provides technical assistance on injury prevention activities at the state and local levels. This assistance includes support in data analysis and program development. CIPPP has been a valuable resource in the development of the injury-related sections of the adolescent health plan and in providing input and guidance on injury prevention in early childhood to local First Five commissions.

To raise funds to support child injury and abuse prevention programs, the State sells personalized auto license plates, called "Kid's Plates". Kids Plates feature a heart, hand, star, or plus sign. The proceeds fund child injury and abuse prevention programs. The Kid's Plates Program provides a wide range of technical assistance to help foster effective regional and local injury prevention efforts and funds grants for training and equipment. Between 1998 and 2003, over 200 grants were awarded to community-based organizations, local health departments, and other organizations. CIPPP is the Kid's Plate program administrator for the EPIC Branch.

b. Current Activities

The CIPPP continues to provide data and technical assistance in the development,

implementation and evaluation of injury prevention programs and create linkages between agencies, researchers, and advocates. CIPPP provides information for local MCAH Directors on the availability and use of California-specific data sources for injury prevention. The information is posted on the CIPPP website with links to the actual data sources. Money from the sale of Kid's Plates continues to support child injury prevention programs.

The MCH Branch is working with CIPPP and the Office of Traffic Safety to organize the annual childhood injury prevention conference, which brings together a wide array of organizations, agencies, and individuals working in or concerned with injury prevention.

The MCH Branch continues to fund selected counties for local injury control programs. Many counties are also participating in local SAFE KIDS Coalitions, child passenger safety seat checks and distribution, and bicycle helmet distribution and education. State law now requires that persons under 18 years of age wear a helmet while operating a non-motorized scooter or skateboard, in-line or roller skates or riding as a passenger on a non-motorized scooter or skateboard. Counties are also using the Child Death Review data to identify trends and to raise awareness for systems changes.

Lassen County promotes injury prevention through their home visitation activities and is in the process of compiling and analyzing injury prevention data.

Shasta County is involved in programs to increase the use of seat belts and decrease the number of teens driving under the influence. They are collecting and analyzing data related to motor vehicle occupant-related deaths and injury among children and adolescents.

Humboldt County convenes the regional Childhood Injury Prevention Coalition and is involved in multiple activities involving child passenger safety. Childhood injury data are collected and analyzed.

c. Plan for the Coming Year

The MCH Branch will seek resources to investigate the reasons for the notable increase in the last two years in the rate of teen motor vehicle deaths. The Branch applied for American Automobile Association (AAA) Foundation funding but was unsuccessful in its application and is seeking other possible funding sources for this project. The Branch is also exploring the option of collaborating on this project with other organizations in the newly formed Statewide Coalition on Traffic Safety. The MCH Branch also plans to work on the Child Death Review Council's Vehicle Occupant Safety Subcommittee; planning is currently taking place to form this committee during 2004.

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

a. Last Year's Accomplishments

Between 1998 and 2002 the incidence of neural tube defects has fluctuated between 5.4 and 9.1. After a high of 9.1 in 1999, the rate declined to 5.4 in 2001, then went back up to 7.7 in 2002. The annual objective of 6.5 for 2002 was not achieved. This incidence data, which is provided by the California Birth Defects Monitoring Program (CBDMP), is based on a sample from eight counties in the Central Valley.

Birth defects are the leading cause of infant mortality and greatly contribute to childhood morbidity and disability in California. Medical research has shown that maternal intake of folic

acid, prior to and in the early months of pregnancy, helps prevent neural tube defects, including spina bifida and anencephaly. Increasing the use of folic acid among preconception and pregnant women is an important element of California's efforts to improve infant health status and reduce disparities across racial and ethnic groups.

Respondents to the California Women's Health Survey (CWHs) have been asked various questions related to folic acid since 1997. Awareness of folic acid grew in every survey year between 1997 and 2000, from 55.4 percent in 1997 to 65.5 percent in 2000. Folic acid awareness increased for all race/ethnic groups over this time period. The trend was most notable among Hispanic women (from 26.2 percent to 39.6 percent) and African American women (from 45.4 percent to 60.2 percent). Nevertheless, there continues to be a gap in folic acid awareness, with 75.4 percent of Whites reporting awareness, compared to 60.2 percent of African Americans and 39.6 percent of Hispanic women (2000).

According to the CWHs, the proportion of respondents reporting taking a supplement containing folic acid remained steady at 55 percent from 1999 to 2001, but decreased to 50 percent in 2002. Overall, 90 percent of pregnant women and 57 percent of those trying to get pregnant reported taking folic acid in 2002. Non-White women were much less likely to be taking this supplement than White women, both when pregnant (84 percent for Non-Whites vs. 98 percent of Whites) and when trying to get pregnant (47 percent vs. 71 percent).

In 2002 the MCH Branch produced and distributed a new folic acid pamphlet and poster entitled "Folic Acid: Every Woman, Every Day". Both are available in Spanish and English. The material was sent to all MCH programs, distributed through the WIC Branch and the GDB, and posted on the MCH website. In 2001 the revised "Steps To Take: Guidelines for Comprehensive Perinatal Services Program" included a new prenatal handout entitled "Get the Folic Acid You Need." The MCH Branch has included folic acid guidelines in the Nutrition and Physical Activity Guidelines for Adolescents and in the revised Guidelines for Care for the CDAPP. In the 2002 Guidelines for Care, the CDAPP updated its folic acid recommendation to 600 micrograms of folic acid during pregnancy.

b. Current Activities

The reduction of the rate of neural tube defects through improved folate consumption is an important element of efforts to improve infant health status and reduce disparities across racial and ethnic groups. The MCH Branch continues to collaborate with and provide technical assistance regarding folate use to local MCH programs, such as BIH, AFLP, and CPSP; the March of Dimes; other programs in DHS, such as WIC, GDB, and the Nutrition Network; and other local agencies. The MCH Branch has a representative on the National Council of Folic Acid and the California Folic Acid Council. This person also serves as a liaison to all MCH Branch programs and other DHS programs.

DHS GDB promotes folic acid use by: 1) providing information about folic acid in the booklet "Your Future Together," which is distributed by marriage license clerks to all couples applying for a marriage license, 2) sending folic acid information to women who have had a baby with a neural tube defect, and 3) assisting health care providers, other professionals and the public with selection, utilization and development of accurate and appropriate educational materials on genetic screening, genetic disorders and services through the GeneHELP Resource Center.

DHS is partnering with the March of Dimes in promoting folic acid intake by women of reproductive age. The MCH Branch and March of Dimes are working to acquire Vitamin Price Fixing settlement funds for a folic acid media campaign and folic acid education for providers.

MCH Branch staff authored "Women's Use of Folic Acid Supplements and Knowledge of Its

Importance for Prevention of Birth Defects in California," a Data Point for the CWHS. CWHS Data Points can be found on the Office of Women's Health web page at <http://www.dhs.ca.gov/director/owh/PDF/womens%20health%20survey/99-00%20data%20points/16%20folic%20acid.pdf>. MCH staff are also contributing a chapter entitled "Folic Acid Awareness and Intake among California Women Aged 18-44: Findings from the California Women's Health Survey, 1997-2003" to an upcoming report on the CWHS.

c. Plan for the Coming Year

MCH programs will continue their efforts to promote folate use among women of reproductive age. The Branch will continue to be actively involved with the California Folic Acid Council.

Plans are underway to conduct a National Folic Acid Awareness week in January 2005. As the MCH Branch is represented on the National Council on Folic Acid, California has a direct link to the national planning for this event. One activity will be to link the counties to a national folic acid teleconference during that week. Another will be to share materials and links to information on folic acid with all MCH programs and contacts.

State Performance Measure 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.*

a. Last Year's Accomplishments

SPM 7 was developed in response to the identified need to facilitate case management and coordination of care through a statewide automated system. The percent of CCS children entered in CMS Net was 36.3 percent for FY 2000-01 and 41.6 percent for FY 2001-02. For FY 2002-03, the percent was 50.5, with 54 counties using CMS Net. This surpassed the objective of 45 percent. The four counties of LA, Orange, Sacramento, and San Mateo, with 49.5 percent of the active CCS cases, were not using CMS Net. San Diego and Alameda Counties converted to CMS Net in 2003. In addition to the work involved with bringing counties onto the CMS Net system, E47 development has continued over the past year.

b. Current Activities

San Mateo County has recently converted to CMS Net. Currently state staff are working simultaneously with Orange and LA Counties to bring them onto CMS Net. These two counties will be individually brought onto the system. Orange and LA Counties have 48.5 percent of the CCS active caseload. The goal to have all counties on CMS Net by August 2004 is not attainable due to the E47 implementation workload. E47 was implemented as scheduled on July 1, 2004. Help desk support for all counties on CMS Net continues.

c. Plan for the Coming Year

There will be continuing progress to convert all 58 counties to the CMS Net system. Work will continue on conversion activities for Orange and LA Counties with a goal of bringing these two counties onto the system later this year. Conversion activities include trainings, site visits, and implementation and post implementation work. Conversion activities with Sacramento County will be initiated later with a goal of bringing this last county onto the system in 2005. There will be ongoing work after July 1, 2004 on E47 implementation activities. Ongoing help desk support for all counties on CMS Net as well as those joining the system will continue and expand to address E 47 post implementation.

State Performance Measure 8: The percent of women 18 years or older reporting intimate partner physical abuse in the past 12 months.

a. Last Year's Accomplishments

SPM 8, the percent of women 18 years or older reporting intimate partner physical abuse in the past 12 months, declined from 7.5 percent in 1999 to 5.0 in 2003. The annual objective of 5.5 percent for 2003 was achieved. These data are from the CWHS. In addition to monitoring prevalence, survey data are also used to better understand the characteristics of and risk factors associated with partner abuse among California women.

To combat the serious health threat of DV, BWSP was established by legislative action in 1994 to provide comprehensive shelter-based services for battered women and their children. The MCH Branch was designated as the administering entity for this program. BWSP provides a spectrum of enabling services to women threatened by DV. DV agencies provide shelter-based services, DV prevention projects, and projects to increase access to shelter services for unserved/underserved populations. 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 the MCH Branch.

In recent years, DV shelter providers have encountered significant reductions in private donations and grant funding. With the input of the Domestic Violence Advisory Council, the BWSP made the decision to reduce the technical assistance and training contracts from ten to one. The remainder of the funding was redirected to direct service grantees. Funding for prevention/prevention planning and unserved/underserved grants were continued.

b. Current Activities

The MCH Branch currently funds: 1) ninety-seven shelter-based grantees to provide direct services to battered women and their children, 2) thirty-two DV prevention/prevention planning projects, and 3) fifteen unserved/underserved projects to establish partnerships with community-based organizations who have knowledge and expertise in working with identified unserved/underserved populations and to develop culturally sensitive services that will increase access to shelter-based services for these priority populations.

In June 2004 the MCH Branch convened a statewide meeting for its BWSP grantees in conjunction with a meeting with the program's Domestic Violence Advisory Council. Both meetings were a collaborative effort that involved grantee participation in planning and execution. Grantees served as facilitators and presenters on various topics such as cultural and complex client issues.

Program staff are currently in the process of redesigning the program's website, SafeNetwork, in order to provide DV information and resources for the public and BWSP grantees. MCH continues to participate in the CWHS to determine prevalence of DV statewide. Additionally, MCH uses data from the CWHS to determine the help-seeking behaviors of battered women.

c. Plan for the Coming Year

MCH administration has authorized a new policy and process by which grantees may receive advance payment of up to 75 percent of their grant at the beginning of the fiscal year. Concurrently, administration staff will implement an automated invoicing process for fiscal payment of the grant award. A new request for application (RFA) will be released no later than August 2004. The new RFA includes a new core service standard on cultural competence as a

funding criteria.

The MCH Branch is working with BWSP contractors to implement automated program progress reports to facilitate a more efficient mechanism for program monitoring.

The MCH Branch is currently working with the California Women's Mental Health Policy Council to involve the DV community in the council's efforts to promote trauma sensitive services and services to address the mental health and substance abuse needs of battered women. MCH is also working with the council to develop a curriculum for cross training DV advocates, mental health workers, and substance abuse counselors on sensitive services for battered women with co-occurring disorders (substance abuse and mental health). MCH is planning to conduct regional trainings for BWSP grantees on cultural competence and DV as a public health issue.

State Performance Measure 9: *The percent of youth aged 12-17 years who report smoking cigarettes in the past 30 days.*

a. Last Year's Accomplishments

The prevalence of cigarette smoking among youth 12-17 years of age in California decreased from about 11 percent in 1994 to 4.6 percent in 2002, as measured by the California Youth Tobacco Survey (CYTS). Youth smoking prevalence was fairly constant from 1994 to 1998 (ranging from 10.7 to 12.1 percent), but declined from 1999 to 2002. The annual objective of 5.9 for 2002 was achieved and surpassed. (The CYTS is a telephone survey, which tends to result in lower smoking prevalence rates than the rates from a classroom-administered survey.)

Among the four largest racial/ethnic groups, non-Hispanic White youth had the highest smoking prevalence, at 8.7 percent. They were followed closely by Hispanic youth at 8.0 percent. African American and Asian youth had the lowest smoking prevalence, at 5.7 and 4.9 percent, respectively. Data by race/ethnicity are for 1999. [36]

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.

These declines in youth smoking in California are largely attributable to the 50-cent per pack tax increase on cigarettes that took effect in 1999 and the long-term, combined effect on community norms around tobacco that resulted from the State's comprehensive tobacco control program. The program has included a statewide media campaign, a cessation help line (with tailored counseling for teens and pregnant women), approximately 100 local programs across the State based in local health departments and community based organizations, and the energetic efforts of four ethnic networks. These efforts have succeeded in reducing California's overall cigarette consumption from 1988 to 2002 at twice the rate of the rest of the nation; played an instrumental part in making virtually all indoor workplaces, including restaurants and bars, smoke free; and made tobacco in general less accessible, less acceptable, and less desirable among both adults and youth.

b. Current Activities

The California Tobacco Control Section of DHS has a variety of county, community, regional, and statewide smoking cessation projects. Each of the 61 health jurisdictions in California is

responsible for coordinating information, referral, outreach and education activities within their jurisdiction. Each jurisdiction involves a community coalition to engage in grass roots community mobilization activities that promote social norm changes and educate the public about health issues related to tobacco use and tobacco industry strategies that promote tobacco use.

Eleven regional community linkage projects encompass multiple local health jurisdictions. They coordinate media and advocacy campaigns that cross traditional political and geographic boundaries; provide technical assistance and training to local jurisdictions and community-based projects to support their policy and program activities; and administer a mini-grant program, awarding grants up to \$5,000.

Four statewide ethnic network projects address California's African American, American Indian, Asian/Pacific Islander and Hispanic populations. Through their statewide advisory committees and membership, they conduct culturally specific educational and advocacy campaigns, address tobacco cessation through creating system-level changes, administer a mini-grant program and provide technical support to the State, local jurisdictions, regions, and community-based organizations on how to effectively reach and work with California's multicultural population.

The California Smokers' Helpline provides intensive tobacco cessation counseling, via the telephone, for those who are ready to quit, in English, Spanish, Korean, Mandarin, Cantonese, Vietnamese and for the hearing impaired. Tailored counseling services are provided for teens, as well as for adults, pregnant women and chew tobacco users. The Helpline provides self-help materials and a referral list to other tobacco cessation programs. The services provided by the Helpline are free of charge.

Lake and Modoc Counties provide examples of some of the teen-focused smoking cessation activities undertaken by local MCH jurisdictions. Lake County currently offers education to all pregnant and parenting teens about the effects of alcohol, tobacco, and other drugs, and partners with community agencies to collect data on drug and alcohol use in the MCH population. Modoc County's Teen Health Coalition, which has been active for eight years, focuses on tobacco cessation education and outreach, and is currently expanding to encompass other teen health issues.

Local efforts are currently underway to ban smoking at several Southern California beaches. Beaches in Los Angeles, Santa Monica, San Clemente and Solana have already enacted bans. Smoking bans are currently being considered for beaches in Malibu and Newport.

c. Plan for the Coming Year

Future plans include increased focus of tobacco control efforts on countering tobacco industry marketing efforts, especially on tobacco advertising and promotions at the point of sale, where tobacco industry efforts have greatly intensified in recent years. DHS also plans to maintain smoke-free indoor air policies and their enforcement, and to continue the enforcement of laws against sales to minors, support the prohibition of smoking in busy outdoor public gathering places, and encourage voluntary smoke-free home policies.

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

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.				
1. CHDP outreach efforts for children & families to access preventive health exams continue.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Local CHDP staff participate on the Head Start Advisory Board.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. CHDP works with school districts on enforcing the state statute that school entrants receive a comprehensive health assessment.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Local CHDP programs work with providers on implementing the CHDP HAGs and recruit providers where there are shortages.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The CMS Branch and Local CHDP programs are facilitating the CHDP Gateway.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

2) The percent of low-income children who are above the 95th percentile of weight-for-length (less than 2 years) or BMI-for-age (2-12 years), or overweight.				
1. Five CHDP local programs are funded by the CA Nutrition Network for 2004 for CHDP Nutrition Special Projects.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Data collection from CHDP nutrition assessments for PedNSS continues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. State and local CHDP nutritionists develop and implement nutrition education and provide consultation and training to CHDP providers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The MCH and CMS Branches plan the biannual CA Childhood Obesity Conference.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. The CMS and MCH Branches participate in coalitions and committees on nutrition and physical activity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. MCH and CMS programs promote healthy eating and physical activity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. The MCH and CMS Branches assist with program planning, implementation and evaluation in the CDC funded COPI.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. MCH and CMS actively participate on PANCC.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. The MCH and CMS Branches participate on the DHS Nutrition and Physical Activity Action Team which is addressing the obesity epidemic in CA.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. SHC endorses nutritional assessment tools including the CDC's School Health Index.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

3) The rate of deaths per 100,000 children aged 1 through 4				
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years caused by drowning in swimming pools.				
1. The MCH Branch funds five local CIPPs in three-year cycles.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Local injury prevention efforts address pool safety interventions; examples include life jacket loaner programs, injury prevention during home visits, and compilation and analysis of local injury prevention data.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The CIPPP at SDSU provides data and technical assistance to local injury prevention programs and assists in creating linkages between agencies, researchers, and advocates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. To raise funds to support child injury and abuse prevention programs, including child drowning prevention efforts, the State sells special car license plates, called Kid's Plates.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The MCH Branch holds regular meetings with the EPIC Branch to coordinate activities and collaborate to address joint areas of interest.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by homicide.				
1. The Safe from the Start Project, in the California Office of the Attorney General, targets children age 18 and younger, with an emphasis on children age 5 and younger, who have been exposed to family, school and/or community violence.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The School Law Enforcement Partnership encourages schools and law enforcement agencies to develop interagency partnerships and activities that improve school attendance, encourage good citizenship, and promote safe schools.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. In an effort to complement problem-focused responses on firearms and substance abuse with assets-based development of opportunities for youth, the MCH Branch participates on the California Coalition for Youth Development.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The MCH Branch is working with NAHIC and the AHC to develop the capacity for increased coordination between primary care, mental health, and schools.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Marin County has an annual Peer Summit to promote peer health education at middle and high schools and an annual Parent University Program to educate and empower parents to more effectively communicate with teens.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Sierra County has a mentoring program that connects young people with role models and gives them alternatives to alcohol and drug use and assists them in making wise decisions and choices.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries.				
1. The CIPPP provides technical assistance on injury prevention activities at the state and local levels and has helped develop the injury-related sections of the adolescent health plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. The MCH Branch works with CIPPP and the Office of Traffic Safety to organize the annual childhood injury prevention conference, which brings together a wide array of organizations, agencies, and individuals working in injury prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Some local health jurisdictions participate in programs promoting bicycle helmet distribution and education, promoting the use of seat belts, and discouraging teens from driving under the influence.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Some local health jurisdictions are using the Child Death Review data to identify trends and to raise awareness about deaths due to motor vehicle injuries.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. The California Highway Patrol undertakes extensive education and public awareness programs, including programs aimed at high-risk groups such as high school students and Hispanic youth.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. To raise funds to support child injury and abuse prevention programs, including motor vehicle occupant protection and pedestrian safety, the State sells special car license plates, called Kid's Plates.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System.				
1. The MCH Branch produces and distributes pamphlets, posters, and other educational materials, in Spanish and English, which promote folic acid use among women of reproductive age.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The MCH Branch collaborates with and provides technical assistance regarding folate use to local MCH programs, such as AFLP, BIH, and CPSP; other programs in DHS, such as WIC, GDB, and the Nutrition Network; the March of Dimes; and other programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. The MCH Branch and March of Dimes are working to acquire Vitamin Price Fixing settlement funds for a folic acid media campaign and folic acid education for providers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The MCH Branch has a representative on the National Council of Folic Acid and the California Folic Acid Council.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

5. The GeneHELP Resource Center (GDB) assists health care providers and the public with selection, utilization and development of accurate and appropriate educational materials on genetic screening, genetic disorders and services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. DHS provides information about folic acid in the booklet ?Your Future Together?, which is distributed by marriage license clerks to all couples applying for a marriage license.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
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.				
1. There is continuing progress to convert all 58 counties to the CMS Net system with current work on conversion of LA, Orange, and Sacramento Counties.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Conversion activities are ongoing and include trainings, site visits, and implementation and post implementation work.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. E47 post implementation work continues.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. There is ongoing help desk support for all counties on CMS Net and this will be expanding with the implementation of E47.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The percent of women 18 years or older reporting intimate partner physical abuse in the past 12 months.				
1. The MCH BWSP currently funds 97 shelter-based grantees to provide direct services to battered women and their children.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The MCH Branch currently funds 32 domestic violence prevention/prevention planning projects.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. MCH funds 15 community-based organizations, with expertise in working with identified unserved/underserved populations, to develop culturally sensitive services that will increase access to shelter-based services for these priority populations.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
STATE PERFORMANCE MEASURE		Pyramid Level of Service			
		DHC	ES	PBS	IB
9) The percent of youth aged 12-17 years who report smoking cigarettes in the past 30 days.					
1. The California Smokers Helpline, a project of the California Tobacco Control Program, provides tailored counseling services for teens, as well as for adults, pregnant women and chew tobacco users.		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The California Smokers Helpline provides intensive tobacco cessation counseling for those who are ready to quit, via the telephone, in English, Spanish, Korean, Mandarin, Cantonese, Vietnamese and for the hearing impaired.		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Four statewide ethnic network projects, addressing the African American, American Indian, Asian Pacific Islander and Hispanic populations, conduct culturally specific educational and advocacy campaigns.		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Local health departments and community-based organizations undertake activities such as educating pregnant and parenting teens about the effects of tobacco use and educating the public about tobacco industry strategies that promote tobacco use.		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The California Tobacco Control Program includes eleven regional community linkage projects that coordinate media and advocacy campaigns and provide technical assistance and training to local jurisdictions and community-based projects.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Local efforts are currently underway to ban smoking at several Southern California beaches.		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

E. OTHER PROGRAM ACTIVITIES

Telephone Hotlines

Local MCAH jurisdictions have phone number/hotlines that citizens can call to obtain information regarding prenatal care services and programs. There are also statewide toll free telephone hotlines run by the State, including AIM and Family PACT.

//2005/ In FY 2002-2003, an estimated 38,000 calls were received for the MCH toll-free information hotline. This compares to 35,000 calls in FY 2001-2002 and about 45,000 calls each in FY 1999-2000 and FY 2000-2001. The reasons for the decrease in FY 2001-2002 are not known. //2005//

Bioterrorism

DHS has established a Bioterrorism (BT) team that is part of a multidisciplinary initiative to strengthen public health infrastructure to detect, identify, investigate, and control illnesses due to biological or chemical terrorist attacks. The lead agency for the team is the DHS Emergency Preparedness Office. The team focuses on enhancing state and local health surveillance and epidemiologic response capacity for diseases due to biological or chemical agents. If a suspected bioterrorism event occurs, the BT team will provide epidemiologic assistance and coordination to local health departments. DHS has prepared and distributed a guide for hospitals called "California Hospital Bioterrorism Response Planning Guide." This Guide includes treatment recommendations for pregnant women (for example, the smallpox vaccine is contraindicated for pregnant women), infants, and children, as well as for non-pregnant adults, in case of exposure to the agents most likely to be used in a terrorist event.

//2005/ The MCH Branch has a representative on the BT Training and Education Workgroup. Pregnant women and children would be two of the most vulnerable populations in the event of an act of bioterrorism. MCH staff will help assure that front-line perinatal and family practice providers are kept informed on bioterrorism issues. MCH programs inform providers of BT-related issues; an example of this is a recent article in the CPSP newsletter about smallpox and pregnancy. //2005//

//2005/ The CMS Branch has received \$300,000/year in funding as part of the Department's HRSA BT Grant for pediatric provider education; funding is for four years beginning October 1, 2003. The proposal addressed providing a training curriculum for pediatric primary care providers in order to build a unique pediatric infrastructure for: recognition and treatment of rare diseases with bioterrorism potential; immediate and delayed manifestations of radiation illness; assessment and management of mass trauma and burn casualties; distinguishing between the medical and psychiatric manifestations of bioterrorism; recognition, assessment and response to the psychological and behavioral manifestations of terrorism-generated fear; and recognition and treatment of acute and long-term psychosocial responses. //2005//

//2005/ There will be an emphasis on mental health because much mental health assessment and counseling is delivered by pediatric primary care providers and the staff will work in collaboration with DHS staff from one of the CDC Focus Areas. The CMS Branch is in the process of completing a needs assessment to identify, from the practicing providers' perspective, the areas to which targeted information can be developed.//2005//

March of Dimes

The MCH and CMS Branches collaborate with the March of Dimes on perinatal health issues. March of Dimes works to improve the health of infants by promoting the prevention of birth defects and infant mortality. One of the methods for accomplishing this mission is to provide community awareness and education in order to decrease the disparities in infant mortality among ethnic groups.

The March of Dimes launched a five-year Prematurity Campaign in January 2003. The goal of this \$75 million campaign is to invest in research, education and community programs in order to identify the causes of prematurity and develop strategies to improve birth outcomes. The five aims of the Prematurity Campaign are to: 1) raise public awareness of the problems of prematurity; 2) educate pregnant women about the signs of preterm labor; 3) assist practitioners with tools to identify women at risk of preterm birth and for risk reduction; 4) invest in research into the causes of preterm birth; and 5) increase women's and children's access to health insurance.

Another major March of Dimes campaign currently underway is the Alcohol and Pregnancy Campaign, which aims to increase knowledge and awareness about the consequences of substance use during pregnancy. Alcohol and drug use during pregnancy continue to be a major cause of negative birth

outcomes. In San Bernardino County, nearly 15 percent of women have used alcohol and/or drugs during their pregnancy. Nationally 70-80 percent of children in the foster care system have been directly and significantly impacted by substance and/or alcohol use by parents and guardians. The March of Dimes poster campaign was developed to address the high rate of alcohol and drug use during pregnancy. Posters were developed in collaboration with community members via 12 focus group sessions. Distribution of the posters targeted zip code areas within San Bernardino County that have the poorest birth outcomes. Pre-intervention survey results revealed that community education is needed to increase awareness regarding the repercussions of perinatal drug use.

Nurse Family Partnerships

/2005/ Local MCAH jurisdictions develop unique programs to meet local needs as defined by their respective community needs assessments and action plans. Nine counties in California (Fresno, Kern, Los Angeles, Orange, Riverside, San Diego, Santa Clara, San Luis Obispo and Sacramento) utilize Nurse Family Partnerships to follow high risk first time pregnant women, mothers and families. This is the David Olds home visiting model that has been researched in several areas in the United States. //2005//

/2005/ Fresno and several other counties have incorporated the work of Dr. Ira Chasnoff of the Children's Research Triangle in dealing with fetal alcohol issues and perinatal substance abuse issues. Most of these interventions include a public health nurse home visiting component built into the local program. //2005//

F. TECHNICAL ASSISTANCE

/2005/

Diverse populations/immigrants

California's diverse population creates challenges for effectively promoting the health of mothers, infants, and children. In 2000, 26 percent of California's population was foreign-born, and it is estimated that in 2002 alone California added almost 50,000 legal immigrant children (age 0-17) to its population. In 2003, 43 percent of delivering mothers were born outside of the U.S.

California's Title V programs strive to provide these populations with culturally-appropriate services and in many areas are highly successful. Technical assistance and guidance on the health risks of particular immigrant populations would help direct training so that additional local programs work proactively to address these issues. For instance, health risks for some Asian subpopulations are not recognized because subpopulations at higher risk are grouped for statistical reporting with subpopulations at lower risk. Training in the development of culturally-appropriate healthcare delivery systems as well as public health interventions and materials is also requested. This training (going beyond translation of existing materials) would help ensure that services and messages were effective and well-received by each group.

Adolescent health

California also provides exemplary services to adolescents and meets their needs with age-appropriate programs and services, as well as conducting research and evaluation appropriately for this population. There are several areas relating to the health of adolescents for which DHS requests technical assistance. First is a request for assistance for the System Capacity Tool for Adolescent Health, including recommendations for future activities. MCH Branch applied for a Technical Assistance Grant for this project in the recent past, but the

grant application was unsuccessful.

Second, MCH Branch requests assistance for adolescent mental health and violence, including suicide and homicide prevention. Assistance with best practices, particularly those that can be implemented at little or no cost, would be helpful in order to integrate enhanced approaches to prevent adolescent violence into existing MCH Branch programs to augment skills at the local level and make these programs more responsive to these important needs.

Third, MCH Branch requests assistance in helping to understand the antecedent factors in California's increase in the teen motor vehicle death rate. Although California has many tough traffic safety laws in place (e.g., graduated driver licensing, zero tolerance, primary seat belt law), the rate of death by motor vehicle accidents has been increasing in recent years and the reasons for this increase are as yet unknown. MCH Branch is working with others in California on traffic safety issues, but assistance on understanding the cause of teen motor vehicle deaths would inform efforts to reverse this trend.

Finally, MCH Branch requests assistance in identifying valid population measures of youth development for surveys. Recommendations for measures that have been standardized across states and piloted and validated for adolescent populations would ensure that population estimates are based on age-appropriate measures, scientifically sound, and comparable to other estimates.

Methodological training in epidemiology and program evaluation

The MCH Branch Epidemiology and Evaluation Section (MCH-EPI) has an excellent staff of researchers and analysts for epidemiological analyses and evaluation of Title V programs. However MCH-EPI requests training for recent hires and junior research staff on several aspects of the methodology of epidemiological analyses of maternal and child health and program evaluation. These issues include epidemiological methods, analyses of the cost-effectiveness or budget neutrality of programs, and the analysis of trend data. While it would be desirable to obtain this training directly through seminars and workshops offered at CDC, HRSA, and other Federal agencies, policies designed to address budget constraints in California prohibit out-of-state travel.

A workshop on epidemiology (e.g., risk ratios, sensitivity, specificity, validation) and appropriate statistical analyses commonly used in maternal and child health would be valuable. Applied examples, including examples of analyses commonly used by comparable state and federal entities, would demonstrate concepts and inform possible areas for enhanced analysis and program development. Many MCH Branch programs are local; data collected at the state level may be useful for smaller geographies, so an overview of small-area and geographic analysis would also enhance current and suggest future analyses.

Technical assistance on how to conduct cost-effectiveness or cost-benefit analyses for Title V programs would also be beneficial for staff. During the current era of budget shortfalls in California, there has been greater scrutiny by decision-makers as to the cost-effectiveness and fiscal neutrality of MCH Branch and other programs. Technical assistance on the steps involved in analyses, parameters to consider, accepted methodologies, and effective presentation of results would supplement MCH Branch staff's ability to provide this critical information to program managers and administration officials.

Technical assistance in methods to analyze trend data and effective presentation of results would also enhance MCH Branch's expertise. The ability to conduct these analyses would assist in identifying factors that lead to increases or decreases in key performance measures and other rates, as well as how to recognize the significance of changes in indicators across years. The capacity to conduct these analyses would enhance reporting for National and State

Performance Measures and aid in setting goals for these measures, as well as evaluating the performance of Title V programs.

//2005//

V. BUDGET NARRATIVE

A. EXPENDITURES

//2005/ The budget and expenditures for FFY 2005 are presented in Forms 2, 3, 4, and 5. //2005//

B. BUDGET

Since the enactment of OBRA 89, California has maintained the availability of Title V funds under both the maintenance of effort and the match requirements. The California Title V agency will continue to do so in the coming year.

The proposed allocation of Title V funds for California for FFY2001 was \$43,010,496. Preventive and primary services for pregnant women, mothers, and infants were 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 were proposed at \$2,213,024 (5.15 percent).

The proposed allocation of Title V funds for California for FY2002 was \$42,994,205. Preventive and primary services for pregnant women, mothers, and infants were designated to receive \$13,279,689 (30.89 percent of the total), preventive and primary services for children to receive \$14,284,664 (33.22 percent), and CSHCN to receive \$13,216,828 (30.74 percent).

The proposed allocation of Title V funds for California for FY2003 was \$44,289,287. Preventive and primary services for pregnant women, mothers, and infants were designated to receive \$13,920,846 (31.43 percent of the total), preventive and primary services for children to receive \$14,525,388(32.80 percent), and CSHCN to receive \$13,420,028 (30.30 percent).

The proposed allocation of Title V funds for California for FY2004 was \$44,341,423. Preventive and primary services for pregnant women, mothers, and infants were designated to receive \$13,192,755 (29.75 percent of the total), preventive and primary services for children to receive \$14,897,624 (33.59 percent), and CSHCN to receive \$13,820,050 (31.16 percent).

//2005/ The proposed allocation of Title V funds for California for FY2005 is \$48,441,502. Preventive and primary services for pregnant women, mothers, and infants are designated to receive \$10,785,667(22.27 percent of the total), preventive and primary services for children to receive \$15,457,674 (31.91 percent), and CSHCN to receive \$19,767,167 (40.81 percent). //2005//

State Match/Overmatch:

At the time the Title V Annual Report and Grant Application for FFY 2001 was written, California was to receive \$43,010,496 in Federal Title V Block Grant funds for FFY 2001. The required match was \$32,257,872. California's FFY 2001 expenditure plan for MCH programs included \$664,726,146 in State funds. Consequently, the state-funded expenditures for preventive and primary health care services for the Title V populations exceeded the required 4:3 matching ratio.

At the time the Title V Annual Report and Grant Application for FFY 2002 was written, California was to receive \$42,994,205 in Federal Title V Block Grant funds for FFY 2002. The required match was \$32,245,654. California's FFY 2002 expenditure plan for MCH programs included \$772,185,068 in State funds. Consequently, the state-funded expenditures for preventive and primary health care services for the Title V populations exceeded the required 4:3 matching ratio.

At the time the Title V Annual Report and Grant Application for FFY 2003 was written, California was to receive \$44,289,287 in Federal Title V Block Grant funds for FFY 2003. The required match was \$33,216,965. California's FFY 2003 expenditure plan for MCH programs included \$777,395,553 in State funds. Consequently, the state-funded expenditures for preventive and primary health care

services for the Title V populations exceeded the required 4:3 matching ratio.

At the time the Title V Annual Report and Grant Application for FFY 2004 was written, California was to receive \$44,341,423 in Federal Title V Block Grant funds for FFY 2004. The required match was \$33,256,067. California's FFY 2004 expenditure plan for MCH programs included \$849,821,442 in State funds. Consequently, the state-funded expenditures for preventive and primary health care services for the Title V populations exceeded the required 4:3 matching ratio.

//2005/ California will receive \$48,441,502 in Federal Title V Block Grant funds for FFY 2005. The required match is \$36,331,127. California's FFY 2005 expenditure plan for MCH programs includes \$980,327,697 in State funds. Consequently, the state-funded expenditures for preventive and primary health care services for the Title V populations exceed the required 4:3 matching ratio.//2005//

Administrative Costs Limits:

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 in any year. Projections for California's percentage of Title V funds to be expended on administrative costs were 5.15 percent for FFY 2001 and FFY 2002, 5.47 percent for FFY 2003, and 5.48 percent for FFY 2004.

//2005/ In FFY 2005, 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 2005, California will expend only 5.02 percent of Title V funds on administrative costs.//2005//

Definition of Administrative Costs:

In this Application, administrative costs are defined as the portion of the Title V dollars used to support staff in the MCH and CMS Branch Operations Sections. Funds supporting State program and data staff (but not administrative staff) in the MCH and CMS Branches are considered to be program rather than administrative costs.

Administrative costs include staff and operating costs associated with the administrative support of specific MCH Branch and CMS Branch programs. These support functions include, but are not limited to, contract management, accounting, budgeting, personnel, audits and appeals, maintenance of central contract files, and clerical support for these functions.

"30-30" Minimum Funding Requirement:

At least 30 percent of the MCH Title V Block Grant funds will be used for children's preventive and primary care services delivered within a system which promotes family-centered, community-based, coordinated care. At least 30 percent of the Title V Block Grant funds will be used to provide services to CSHCN delivered in a manner which promotes family-centered, community-based, coordinated care.

/ In some cases, the DHS uses estimates to assess expenditures for both individuals served and the types of services provided. These estimates are based on the target population and program activities authorized in statute, excluding the State budget, and specified in the scope of work for each contractor. Requiring contractors to bill according to actual amounts spent on each type of individual served and by service provided is not possible within current administrative and fiscal policies. Changing State contractual policies would result in undue financial and administrative hardship to local governments and non-profit community-based organizations. This added burden without increased funding would result in many of them not being able to continue to provide needed services

to women and children in the state.

Maintenance of State Effort:

DHS 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 base year FFY 1989 was \$87,158,750. The State's General Fund contribution was projected in the Title V report/application for the respective years to be \$664,726,146 for FFY 2001, \$772,185,068 for FFY 2002, \$777,395,553 for FFY 2003, and \$849,821,442 for FFY 2004.

//2005/ The State's General Fund contribution for FFY 2005 is \$980,327,697 which is \$893,168,947 greater than the State's General Fund contribution of \$87,158,750 in base year FFY 1989.//2005//

Additional Program Budget Information:

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 infants and 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.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.