



CACSHCNNEWS

Children's Regional Integrated Service System (CRISS) Summary of the State Budget Fiscal Year 2010-2011

By: Laurie A. Soman

Overview

On October 8 the Legislature passed the budget for the current fiscal year, 2010-2011; on the following day the Governor vetoed \$963 million and the budget was finalized after the longest delay in state history. The budget addresses the state's \$17.9 billion deficit via the following steps:

Table with 2 columns: Budget item and Amount. Items include Budget cuts (\$7.5 billion), Anticipated federal funds (\$5.3 billion), Additional revenue (\$2.5 billion), Fund shifts (\$2.8 billion), Alternative funding (\$0.5 billion), and Workload adjustments (\$0.2 billion).

Table with 2 columns: Budget item and Amount. Items include Total solutions (\$18.3 billion) and Final reserve (\$0.3 billion).

The budget does not include any new taxes or fees. The budget impact on affect child health and human services is described below.

Medi-Cal Program

Medi-Cal Cuts

In the January draft budget and the May Revise, the Governor had proposed reductions in Medi-Cal through "cost containment measures" that included increased cost sharing (co-payments on physician, clinic, dental, pharmacy and emergency room visits, and \$100 per day co-payments and \$200 maximum for hospital stays) and utilization controls (annual caps on medical supplies and durable medical equipment). Provider rates would have been decreased by the amount of the co-pays and hospitals required to provide services regardless of whether

See BUDGET on Page 2.

In this Issue:

- Page 2: Special Features
Page 4: Articles and Reports
Page 6: Resources



CACSHCNNEWS is produced by a consortium whose members work toward the common goal of improving systems of care for children with special health care needs in California:



- Los Angeles Partnership for Special Needs Children (LAPSNC)
Family Voices of California (FVCA)
Children's Regional Integrated Service System (CRISS) Project
USC University Center for Excellence in Developmental Disabilities (UCEDD) at Childrens Hospital Los Angeles

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Next Issue Date: February/March, 2011

Special Features

National Health Care Reform: Important Provisions for Children and Youth Took Effect September, 2010

By: Laurie A. Soman

On March 23, 2010 President Obama signed historic national health care reform legislation (HR 3590, the Patient Protection and Affordable Care Act) that will have a profound effect on health care delivery in California. Most provisions in the reform package will take effect in 2014, but some very important provisions for children and youth are required to begin implementation within six months of the date of enactment—as of September 23, 2010. These child-friendly provisions, now in effect, will:

- ban health insurers from denying coverage to children with pre-existing conditions or from excluding their health conditions from coverage;
- prohibit insurance companies from rescinding the coverage policies of consumers who become ill (except in case of demonstrated fraud);
- eliminate lifetime coverage limits in plans;
- allow young adults to remain under their parents' health plans until age 26 if they are otherwise uninsured; and
- require all new group and individual plans to provide recommended preventive services (such as well-child visits and immunizations) without co-pays.

Implementation of these provisions will have tremendous positive impact on children with special health care needs and their families. The elimination of lifetime caps on coverage and the elimination of restrictions due to pre-existing conditions for children can assist children to secure and maintain private insurance, and the provision to permit young adults to age 26 to buy into their parents' coverage offers options for youth with special needs as they transition out of child-focused health programs.

See the following new websites for more information on health care reform and options for access to insurance coverage:

www.healthcare.gov: New federal website that guides consumers through their insurance coverage options and explains their rights under health care reform law; also see the Spanish-language version at www.cuidadodesalud.gov.

A comprehensive review of health care reform law and its specific provisions with a clear and understandable timeline for implementation can be found at: <http://www.commonwealthfund.org/Health-Reform/Health->

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Previous issues available at
<http://www.cshcn-ca.org/index.php?pageid=29>



California Children with Special Health Care Needs

BUDGET (Continued from Page 1)

the co-payment is made. The cost-sharing proposals would have applied to children, but children with full-scope Medi-Cal would have been exempt from any service limitations. **The Legislature's October 8th Budget Agreement rejected these proposed cuts and the Governor did not reinstate them.** Other Medi-Cal changes affecting children include freezing hospital Medi-Cal contract rates at the current level (reduction of \$84.5 million) and a requirement that the Department of Health Care Services develop and implement diagnosis-related groups (DRGs) for hospital reimbursement.

The Budget Agreement also reduces state support for county operating costs for the Medi-Cal program by \$32.8 million. These operating costs include employee salaries, health coverage, rent, and utilities. The Budget Agreement also continues the \$60.1 million cut to state funding for county operating costs that the Governor imposed in 2009-10 using his line-item veto authority.

Federal Section 1115 Medi-Cal Waiver

The Budget Agreement included approval of the Governor's proposals for the federal 1115 waiver, including a new requirement that all seniors and people with disabilities enroll in managed care plans, if they reside in counties with these plans. **The proposal for mandatory managed care enrollment of people with disabilities does apply to children; there are approximately 75,000 children statewide in disability-related Medi-Cal aid codes (primarily those on SSI) who are not already enrolled in managed care plans. Many of these children are believed to be CCS-eligible, as well.** The deadline for full enrollment of all Medi-Cal recipients in these aid codes has been delayed till June 1, 2011. The state anticipates \$187 million in savings from mandatory managed care enrollment.

CCS Program

The Budget Agreement includes language adopted by the Budget Conference Committee that directs the Department of Health Care Services to seek foundation support for a study of the CCS program. The study will include a stakeholder group and will address such issues as a systems analysis of the core business processes and practices of the program, including authorizations and claims payment; provider paneling; medical eligibility determination processes; quality management and oversight; and identification of best practices and efficiencies.

In addition, the Department of Health Care Services is continuing to develop its final Request for Proposals/ Application for potential CCS pilot projects under the 1115 waiver. It is anticipated that the final RFA/RFP will be rel-

See **BUDGET** on Page 3.

Special Features

BUDGET (Continued from Page 2)

eased on December 1st.

Healthy Families Program

The Governor had proposed cuts to Healthy Families that included a reduction in income eligibility, increases in premiums and co-pays, and elimination of the vision benefit. (An earlier proposal to eliminate the program entirely was withdrawn in the May Revise.) The eligibility reduction and increases in premiums and co-payment, as well as any proposal to eliminate the program, were prevented by the Maintenance of Effort provision in the federal health care reform law, and rejected by the Legislature. **The Legislature's October 8th Budget Agreement rejected all of these proposed cuts and the Governor did not reinstate them.**

Department of Mental Health

In the May Revise the Governor proposed to suspend the AB 3632 mandate and eliminate \$52 million in General Fund expenditures. AB 3632 mandates counties to provide mental health services to children who need them in order to succeed in school. **The Budget Agreement rejected this proposal, but the Governor used his veto power to suspend the mandate by eliminating the funding.** Under federal law, it appears that responsibility to provide mental health services to special education services (i.e. for children with IEPs) will fall on schools but it is not yet known how this will be implemented and what the impact will be on children who need these services.

Department of Developmental Services

The Governor had proposed maintaining the current 3% reduction in Regional Center operations and provider payments and further reducing these reductions to 4.25%. **The Budget Agreement included maintenance of the 3% reduction and the Governor used his veto power to further reduce funding by \$25 million to implement the additional 1.25% cut. It appears that the total 4.25% reductions will be retroactive to July 1, the start of the new budget.**

In-Home Supportive Services

The Governor had proposed cutting \$637 million in IHSS with the reductions developed with stakeholder consultation. (This proposal replaced the Governor's original budget actions of 2009 to eliminate IHSS services for anyone with a Functional Index Score below 4.0 and to reduce state participation in wages of IHSS workers to the state minimum wage. The 2009 changes were halted by recent court decisions and remain on hold while the state appeals.) **The Budget Agreement rejected that pro-**

Continued in the Next Column.

posal and instead sought \$300 million in spending cuts. These cuts will be achieved through implementation of a provider fee to draw down \$190 million in federal match; \$75 million in savings as a result of reduced caseload; and \$35 million in savings as a result of an across-the-board reduction of 3.6% in service hours for IHSS recipients.

CalWORKs

The Governor had proposed to eliminate the CalWORKs program entirely, effective October 1, 2010, with a reduction of \$1.6 billion in state General Funds. This proposal would have eliminated benefits for 500,000 to 600,000 families (including about 1.1 million children) who receive assistance from the program and resulted in a loss of lose \$3.5 billion in federal TANF matching funding in 2010-11, growing to \$3.8 billion in 2011-12. **The Legislature's October 8th Budget Agreement rejected these proposed cuts and the Governor did not reinstate them.**

Conclusion

Many observers feel that the new Budget Agreement is built on very optimistic and unrealistic assumptions (\$5.3 billion in new federal dollars, for example). As a result, observers expect that the new Administration will have another large deficit to address.

Update: California's Section 1115 Waiver

On Tues., Nov. 2, 2010 the federal government approved California's Section 1115 Waiver. California will use the waiver to phase in Medi-Cal coverage for more people; shift individuals into managed care; increase funding to safety net hospitals that better coordinate care and meet new quality standards; help slow the rate of growth in health care costs in the Medi-Cal program; and serve as a model healthcare delivery system. \$3.3 billion has been allocated for investments in CA's public hospital safety net; \$2.9 billion for additional coverage for low-income individuals; and \$3.9 billion for uncompensated care costs. The waiver increases and expands health coverage to as many as 500,000 low-income uninsured residents, including adults up to 133% of the federal poverty level. Residents will be enrolled in a medical home and receive a core set of services including inpatient and outpatient services, prescription drugs, mental health, and other medically necessary services. The waiver will eventually offer coverage to adults with incomes between 134% and 200% of the federal poverty level. In addition, it expands the Safety Net Care Pool to provide additional resources to support safety net hospitals' uncompensated care costs and other critical state programs. Further, it improves care coordination for vulnerable populations by authorizing mandatory enroll-

See **1115 WAIVER** on Page 4.

Articles and Reports

Article: Authors Report Finding From Pilot School-Based Health Care Transition Education Intervention (MCH Alert, 10/15/2010)

This intervention "builds on federally mandated educational transition planning by integrating health care transition into school-based transition practice," state the authors of an article published in the *Journal of Pediatric Psychology* online (ahead of print) on October 5, 2010. The 2005-2006 National Survey of Children with Special Health Care Needs reports that only 41 percent of adolescents with special health care needs ages 12-17 in the United States receive the services they need for transition to adult health care, work, and independence. A study funded by the American Academy of Pediatrics concluded that the public education system may provide an effective alternative -- or complementary -- venue to the health care system in reaching and educating adolescents and young adults about health care transition. The article describes the development and components of a pilot school-based health care transition education program implemented in 2005 in a large urban county in central Florida. The authors present data on program acceptability (report of relevance and satisfaction) and feasibility (ease of implementation, integration, and expansion), and provide recommendations for future execution of the program, research, and practice.

Partners in the pilot intervention were the local school district and the University of South Florida College of Medicine. A seven-member interdisciplinary advisory committee comprising professionals in special education, social work, and health care guided the development of a health care transition curriculum. The eight-unit module consisted of approximately 40 hours of instruction and was piloted in five geographically and demographically diverse high schools over 8 weeks as part of a required science, health, or life-management course (varied by school and class). Classroom instruction provided 137 adolescents and young adults (ages 14-22) in 13 special education classes (grades 9-12) with health-related information and skills. Topics included the importance of self-advocacy; rights and responsibilities at age 18; finding and communicating with adult providers, completing medical forms; understanding health insurance; reading prescription labels, managing medication needs; safety, bullying, and abuse; and constructing a health journal and medical summary to keep and use after completing the class. Three focus groups were conducted following completion of the curriculum: two student focus groups (N=15) and an educator focus group (N=7). Study results were summarized around three major themes: perceived relevance of the curriculum, readability, and degree of interest and completeness.

The authors found that:

- All teachers and students said the curriculum was highly

See **TRANSITION EDUCATION** on Page 5.

1115 WAIVER (Continued from Page 3)

ment of seniors and persons with disabilities into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes and testing up to four health care delivery models for providing organized systems of care to children with special health care needs who are eligible for the CCS program (enhanced primary care case management, provider-based accountable care organization, specialty health plan, Medi-Cal managed care health plan). Finally it provides for implementation of a series of improvements to public hospital delivery systems to strengthen their infrastructure, prepare for implementation of health care reform and test strategies to slow the rate of growth of health care costs.

Adapted from Department of Health Care Services, California Bridge to Reform, A Section 1115 Waiver Fact Sheet, November, 2010.



Article: Assesses Underinsurance Among U.S. Children

(MCH Alert, 9/10/2010)

"As discussions about the contours of health care reform evolve, it may be worthwhile to consider not only the number of uninsured children in the United States but also the adequacy of coverage for those with current insurance," write the authors of an article published in the August 26, 2010, issue of *The New England Journal of Medicine*. Policy discussions on children's health insurance have focused largely on reducing the number of uninsured children. Considerably less attention has been devoted to the problem of underinsurance, or insurance that does not sufficiently meet the child's needs. Recently, the American Academy of Pediatrics (AAP) issued a policy statement highlighting the importance of this issue. The major problems cited were cost-sharing requirements that are too high, benefit limitations, and inadequate coverage of needed services. The study described in this article incorporated the multiple dimensions of insurance inadequacy cited by AAP to address the extent of underinsurance among continuously insured children, the sociodemographic and health factors associated with underinsurance and each of its components, and the association between underinsurance and measures of access and quality.

On the basis of data from the 2007 National Survey of Children's Health (a nationally representative study of 91,642 children), the authors estimated underinsurance among U.S. children. Data on insurance adequacy were based on parents' or guardians' judgments of whether their children's insurance covered needed services and providers and reasonably covered costs. Data on adequacy were combined with data on continuity of insurance coverage to classify children as never insured during the

See **UNDERINSURANCE** on Page 6.

Articles and Reports

Article: Journal Supplement Highlights Progress and Challenges of the Early Hearing Detection and Intervention System

(MCH Alert, 8/13/2010)

The supplement to the August 2010 issue of Pediatrics focuses on improving the system of care for infants and children with hearing loss. The first article reports the work and recommendations for action of national experts on transforming the system of care. The second article reports the types of barriers to system performance, including lack of service-system capacity, lack of provider knowledge, family challenges in obtaining services, and inaccessible data systems. Other topics include Medicaid reimbursement of hearing services for infants and young children, ensuring financial access to hearing aids for infants and young children, teleintervention for infants and young children who are deaf or hard of hearing, and improving follow-up to newborn hearing screening.

The supplement is available at: http://pediatrics.aappublications.org/content/vol126/Supplement_1.

Report: Looks at Program Practices and Challenges Faced by Children with Down Syndrome and Their Families

(MCH Alert, 10/15/2010)

Children with Down Syndrome: Families Are More Likely to Receive Resources at Time of Diagnosis Than in Early Childhood reports on the effectiveness of current health care and family support programs for families of children with Down syndrome. The report, produced by the Government Accountability Office, is based on an analysis of fee-for-service claims data and Medicaid claims data, interviews with specialists and advocacy groups, and an analysis of data from the 2005-2006 National Survey of Children with Special Health Care Needs on barriers to accessing needed services. The authors examine (1) what is known about the extent to which children with Down syndrome receive medical care during early childhood, (2) what resources families of children with Down syndrome receive through their health professionals, and (3) what barriers families face to using these resources.

The report and highlights are available at: <http://www.gao.gov/products/GAO-11-57>.

President Obama Signs Rosa's Law

(Tatra Center Reference Points, 10/6/2010)

Rosa's Law will change references in federal law from "mental retardation" to "intellectual disability", and from a "mentally retarded individual" to an "individual with an intellectual disability".

More information can be found at: <http://www.acf.hhs.gov/programs/pcpid/>.

TRANSITION EDUCATION (Continued from Page 4)

relevant and important for students.

- Both students and teachers said the reading level was too high for some students.
- While all participants said the content of the material was interesting to students, degree of interest varied by topic.
- Other than the challenges associated with difficult vocabulary and time limitations, teachers had few problems implementing the curriculum.

Readers: Individuals or groups interested in replicating this intervention may access program materials at:

http://www.health.usf.edu/medicine/pediatrics/ad_med/resources.htm.

Hess JS, Straub DM. 2010. Brief report: Preliminary findings from a pilot health care transition education intervention for adolescents and young adults with special health care needs. Journal of Pediatric Psychology [published online ahead of print on October 5, 2010].

Abstract available at: <http://jpepsy.oxfordjournals.org/cgi/content/abstract/jsq091v1?ct=ct>.

Report: Improving Physical Education and Athletic Opportunities

(Tatra Center Reference Points, 8/6/2010)

According to a new report from the GAO, "Students with Disabilities: More Information and Guidance Could Improve Opportunities in Physical Education and Athletics", available data show that students with disabilities generally are participating in physical education classes to a similar extent as students without disabilities and that some also are involved in school sports. The GAO also found that many districts and schools are interested in improving how they provide physical education and athletic opportunities to these students. The US Department of Education plans to identify useful information on this subject and share such information by posting it on its Web site, <http://www.ed.gov>.

Find the complete report at: <http://www.gao.gov/cgi-bin/getrpt?GAO-10-519>.

Article: Children's Hospitals do not Acutely Respond to High Occupancy

Agency for Healthcare Research and Quality (AHRQ) Weekly Digest Bulletin (8/15/2010)

Abstract is available at: <http://www.ncbi.nlm.nih.gov/pubmed/20403931>.

Fieldston ES, Hall M, Sills MR, et al. Children's hospitals do not acutely respond to high occupancy. Pediatrics 2010 May;125(5):974-81. (Supported in part by grant 5 R03 HS16418; uses 2006 Healthcare Cost and Utilization Project [HCUP] Kids Inpatient Database [KID] data, citing AHRQ's HCUP KID Overview Web page.)

Resources

UNDERINSURANCE (Continued from Page 6)

past year, sometimes insured during the past year, continuously insured but inadequately covered (i.e., underinsured), and continuously insured and adequately covered. The authors examined the association between this classification and five overall indicators of health care access and quality: delayed or forgone care, difficulty obtaining needed care from specialists, receipt of preventive care, receipt of developmental screening at a preventive visit (for children up to age 6), and care in a medical home.

The authors found that:

- An estimated 19.3 percent (14.1 million) of all U.S. children (and 22.7 percent of children with continuous insurance coverage) were underinsured in 2007, exceeding the number of children without any insurance at all during the year (3.4 million) and the number who had insurance during only part of the year (7.6 million).
- Older children, children in fair or poor health, and children with special health care needs were more likely to be underinsured.
- Hispanic and black children were more likely to be underinsured than non-Hispanic white children, and children in the Midwest were more likely to be underinsured than children in the Northeast.
- Compared with continuously and adequately insured children, underinsured children were significantly more likely to be without a medical home, to have delayed or foregone care, and to have difficulty obtaining needed specialist care.

The authors conclude that "this study shows that underinsured children have problems with access to health care that are similar to those of uninsured children and that underinsurance among children is actually more prevalent than lack of insurance."

Kogan MD, Newacheck PW, Blumberg SJ, et al. 2010. Underinsurance among children in the United States. *The New England Journal of Medicine* 363(9):841-851. Full text available at <http://www.nejm.org/doi/full/10.1056/NEJMsa0909994>.

Survey of State Disability Policy 2010

(Tatra Center Reference Points, 9/10/2010)

This survey, from the Council of State Governments, looks at disability policies in 31 states in areas including housing, employment, health and independent living. The report details the many challenges and issues facing federal and state governments as they develop policies in these areas.

For more information go to <http://knowledgecenter.csg.org/drupal/content/survey-state-disability-policy-2010>

Health Outcomes and IEPs

(Tatra Center Reference Points, 8/6/2010)

"Embedding Health Outcomes in the Individualized Education Program" is a video recording of a 40 minute teleconference that provides information and specific examples of health related goals for an IEP.

This recording is available from the Wisconsin Department of Public Instruction web site: <http://dpimedia.wi.gov/main/Viewer/?peid=f44dfa70439241dd85e99cce0cb70e26>.

Measuring Medical Homes: Tools to Evaluate the Pediatric Patient- and Family-Centered Medical Home

(Medical Home Update from the National Center for Medical Home Implementation, 10/15/2010)

The purpose of the Measuring Medical Homes monograph is to present various tools available and in use to identify, recognize, and evaluate a practice as a pediatric medical home. Because no one tool is recognized as the de facto tool to assess pediatric practices, a review of the relative merits of existing tools will help inform purchasers, payers, providers, and patients in evaluating pediatric practices. Many of the multistakeholder and single-payer medical home demonstration projects focus on adult populations and adult outcomes. An understanding of tools to assess pediatric practices may assist such pilots in incorporating and evaluating pediatric practices in both practice transformation and payment reform.

The monograph is available at: <http://www.medicalhomeinfo.org/downloads/pdfs/MonographFINAL3.29.10.pdf>.

The development of this monograph was funded by the American Academy of Pediatrics National Center for Medical Home Implementation through a cooperative agreement (U43MC09134) with the HHS/HRSA/MCHB.

AAP Policy Statement—Principles of Health Care Financing

(National Center for Medical Home Implementation Medical Homes@Work e-newsletter, November 2010)

Published in the October 2010 Issue of *Pediatrics*, this policy statement discusses how access to care depends on the design and implementation of payment systems that ensure the economic viability of the medical home, as well as other factors including the support and growth of the professional pediatric workforce, and the promotion of the adoption of health information technology. Health insurance plans must be affordable and have cost-sharing policies that protect patients and families from financial strain and are without risk of loss of benefits because of plan design, current illness, or preexisting condition.

The policy statement is available at: <http://pediatrics.aappublications.org/cgi/content/abstract/peds.2010-2182v1>.

Resources

AHRQ'S Health Care Innovations Exchange Features Guide to Coordinating Care

(MCH Alert, 10/15/2010)

Connecting Those at Risk to Care: A Guide to Building a Community "HUB" to Promote a System of Collaboration, Accountability, and Improved Outcomes describes current challenges in serving at-risk populations, the implications of these challenges, and a step-by-step process for developing the infrastructure within a local community to improve the quality, efficiency, and coordination of services. The guide was designed by the Agency for Healthcare Research and Quality to inform and guide public and private efforts to identify and connect individuals within a community to appropriate health care and social services. Contents include background information on addressing problems through an infrastructure known as a Pathways Community HUB. The following topics are addressed: planning the HUB, creating tools and resources for the HUB, and launching the HUB. Descriptions of initiatives and links to related tools and resources are included.

The guide is available as a resource in AHRQ's Health Care Innovations Exchange at: <http://www.innovations.ahrq.gov/resources/HUBManual/CommunityHUBManual.pdf>.

Readers: A related AHRQ Health Care Innovations Web Event was held on Thursday, September 16, 2010. The audio file, panel slides, and transcript are available at <http://www.innovations.ahrq.gov/resources/resources.aspx>.



New Resource on Sexuality and Youth/Adults with Disabilities

(Tatra Center Reference Points, 9/22/2010)

What does it mean to affirm and support sexuality as a part of the lives of youth and adults with disabilities? That's the focus of the new publication Impact: Feature Issue on Sexuality and People with Intellectual, Developmental and Other Disabilities published by the Institute on Community Integration, University of Minnesota. Its articles cover topics ranging from sexuality education in the home and school, to personal stories of dating and marriage, to legal and ethical issues for staff and agencies providing services for people with disabilities.

The new Impact issue on sexuality is available only at: <http://ici.umn.edu/products/impact/232>. In addition, a free print copy can be requested by calling (612) 624-4512 or emailing icjpub@umn.edu.

Brief Highlights Potential for Young People to Access Comprehensive Benefits as Key Aspect of New Law

(MCH Alert, 9/10/2010)

The Patient Protection and Affordable Care Act of 2010: How Does it Help Adolescents and Young Adults? reviews major provisions of the health care reform legislation enacted this year that could either enhance or limit adolescents' and young adults' access to health care services. The issue brief sets forth an analysis of the Patient Protection and Affordable Care Act similar to that presented in an earlier fact sheet, including questions that remain to be answered during implementation at state and federal levels. Both the fact sheet and the issue brief were published by the Center for Adolescent Health and the Law and the National Adolescent Health Information and Innovation Center at the University of California, San Francisco, with support from the Health Resources and Services Administration's Maternal and Child Health Bureau. The brief begins with a general timeline of implementation requirements of particular significance for adolescents and young adults, followed by more detailed explanations. Topics include expanding health insurance coverage, improving access to comprehensive benefits, improving training and compensation of providers, increasing emphasis on prevention and wellness, increasing access for vulnerable adolescents and young adults, and implications (actions and challenges). References on statutes, regulations, Society for Adolescent Health and Medicine Principles, and additional resources are included.

The issue brief is available at: http://nahic.ucsf.edu/downloads/HCR_Issue_Brief_Aug2010_Final_Aug31.pdf.

Resource Center Launches Portal to Provide Data About Medical Homes

(MCH Alert, 8/13/2010)

The Data Resource Center for Child and Adolescent Health recently retooled its Web site to help state and family leaders access data on how children and adolescents in each state experience receiving care within medical homes. The Medical Home State Data Pages are a project of the Child and Adolescent Health Measurement Initiative at the Oregon Health and Science University and were produced with support from the Health Resources and Services Administration's Maternal and Child Health Bureau. The portal allows users to see a state's medical home performance profile for all children and adolescents or for those with special health care needs. Visitors can also compare across all states or view state ranking maps. Additional tools for searching for more medical home data and learning about medical homes are provided.

Resources on medical home measurement in states and practices, policy and data in action, and medical home measurement for families are also included. The portal is available at: <http://www.medicalhomedata.org/content/Default.aspx>.