CACSHCNEWS

e-Newsletter with a Focus on Children with Special Health Care Needs in California

Volume 1, Issue 3

January 2007

Statewide Perinatal & Neonatal Quality Improvement Efforts

- California Perinatal Quality Care Collaborative (CPQCC)
- Neonatal Quality Improvement Initiative

California Perinatal Quality Care Collaborative (CPQCC)

The Children's Medical Services (CMS) Branch collaborates with numerous agencies and organizations. The California Perinatal Quality Care Collaborative (CPQCC) is one example of how collaborative efforts can result in improved neonatal and perinatal care statewide.

CPQCC, first proposed by the California Association of Neonatologists, was organized in 1998, and is a cooperative effort of public and private obstetric and neonatal providers; CMS; Maternal, Child and Adolescent Health (MCAH); Regional Perinatal Programs; Center for Health Statistics; Office of Statewide Health Planning and Development; Northern CA Perinatal Dispatch Center; insurers; Vermont Oxford Network; public health professionals; and business groups.

CPQCC has been working to develop an effective perinatal and neonatal quality improvement infrastructure at state, regional, and hospital levels. The Collaborative aims to improve the health of pregnant women, infants and children by collecting high quality information on perinatal outcomes and resource utilization, which will then allow for performance improvement and benchmarking processes in perinatal care and neonatal intensive care units (NICUs) throughout California. A CPQCC Executive Committee with all the Collaborative partners represented, including CMS, meets regularly to discuss, review, prioritize and plan the direction in which the Collaborative moves. Such dialogue assures continued success within all project components.

Health care providers and academic researchers benefit from CPQCC's Data Center's demographically and biologically rich database, which is beginning to offer real time data management and 3-year comparative data. Sound data is critical for generating new hypotheses to be tested in the field, and for developing new analytical approaches to understand-

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CA**CSHCN**EWS 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:

- California Children's Services Medical Branch
- 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

If you...

- would like to contribute news items, please submit via email: **ngarro@ucla.edu**
- have any questions about this newsletter, please contact Kathryn Smith, MN, RN: **kasmith@chla.usc.edu**

To receive CA**CSHCN**EWS, please send an email message to **ycasillas@chla.usc.edu** with "*CACSHCNEWS*" in the subject line.

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ing health risks and public health in general.

CMS requires all CCS approved NICUs to join CPQCC as member hospitals and to submit annual morbidity and mortality data through participation in CPQCC. Total CPQCC membership includes over 120 hospitals (over 90% of these are CCS approved) and accounts for most of the newborns requiring critical care in California. The collaborative efforts of CMS and CPQCC for data collection and analysis are proving successful and have enhanced the ability of CMS to assess the quality of care in CCS approved NICUs. Participating hospitals receive an annual online report with comparative analysis on perinatal and neonatal data. This feedback is vital for NICUs to select quality improvement projects to correct weaknesses, and to ascertain their strengths for sharing effective practices with other NICUs that might be weak in the same area.

The Perinatal Quality Improvement Panel (PQIP), a subcommittee of CPQCC which includes CMS representation, 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, follow-up and webcasts. Toolkits released to date include Antenatal Corticosteroid Therapy, Improving Initial Lung Function: Surfactant and Other Means, Nosocomial Infection Prevention, Postnatal Steroid Administration, Early Onset Group B Streptococcus Prevention, Nutritional Support of the Very Low Birth Weight Infant: Part I and Part II, Severe Hyperbilirubinemia Prevention, Perinatal HIV Prevention, and Delivery Room Management for the Very Low Birth Weight Infant.

The MCAH Branch recently developed the Maternal Quality Collaborative (MQC), a joint effort with the CPQCC and UCLA's Maternal Quality Indicators group. MQI will direct statewide maternal quality improvement activities utilizing the methodology developed by the CPQCC.

No other state in the country has anything similar to CPQCC, making this collaborative a vanguard for the nation. For more information on CPQCC, go to www.cpqcc.org.

Neonatal Quality Improvement Initiative

Children's Medical Services (CMS) Branch and California Children's Hospital Association (CCHA) are jointly sponsoring a statewide Neonatal Quality Improvement Initiative (NQI), which includes an experienced multidisciplinary project team, to improve neonatal care by working toward eliminating catheter related blood stream infections in NICUs. The NQI hospital and NICU participants are neonatologists, nurses, and administrators from the eight CCS approved California children's hospitals and the six CCHA associate members which are the California Children's Services (CCS) approved University of California medical centers and Sutter Memorial Medical Center (Sacramento). The Initiative is also partnering closely with the California Perinatal Quality Care Collaborative (CPQCC) for assistance with data outcome measures and to build upon their significant efforts in the area of neonatal nosocomial infections.

The approach of the NQI to improving quality at the point of care is the Institute for Healthcare Improvement (IHI) Breakthrough Series (BTS) model. In the BTS model, clinicians, administrators and other experts identify best practices and potential change strategies. A group of clinicians is then convened with the goal of testing these change strategies, learning from one another, and implementing the best demonstrated practices. Similarly, the NQI is delineating evidence-based processes of care to reduce neonatal nosocomial infections with the goal of eliminating catheter related blood stream infections; participants are receiving training and technical assistance to implement the agreed-on change package; and lessons learned are shared among participants via learning sessions with regular conference calls and focused site visits.

Outcomes, as well as observational process data, will be tracked from baseline through the course of the 9-month initiative. A major focus of the evaluation will be a detailed analysis of the processes each site uses to implement and maintain evidence-based best practices. The most efficient and effective practices will be shared with all sites. This information can then be used to improve processes and outcomes in other CCS approved NICUs throughout the state (114 total), benefiting all hospitalized infants, regardless of payor source.

The NICU participants are focusing on improving practices relative to baseline, as opposed to comparing practices across participating sites. Each site's nosocomial infection rate (catheter related blood stream infections) will be compared to itself over time. Results from individual sites will remain confidential and any reporting of data will be done in aggregate form, to demonstrate overall improvement. After the end of the 9-month initiative, aggregated outcomes will be distributed to a variety of stakeholders, including the state legislature, large commercial payers, and the public.

Despite Confusion, Newborns of Immigrant Mothers Remain Eligible for Medi-Cal

As reported in an earlier CACSHCNEWS (see July 2006 issue), the recently passed federal Deficit Reduction Act (DRA) requires documentation of citizenship status for all initial Medicaid applicants and current Medicaid enrollees being recertified for the program. The DRA made no changes in eligibility for emergency Medi-Cal or pregnancy-related Medi-Cal-- that is, both emergency and pregnancy-related Medi-Cal are still available to people regardless of their documentation status and are not affected by the new DRA documentation requirements. In addition, infants born in the United States, regardless of their parents' documentation status, are citizens and may receive full-scope Medicaid.

Several recent news reports have suggested that the federal government has changed its policy concerning infants born in the United States to undocumented women who received pregnancy-related Medicaid. The reports are a result of the preamble to the DRA's interim regulations in which the federal Centers for Medicare and Medicaid Services (CMS) stated its opinion that these citizen babies require proof of citizenship beyond knowledge of their birth in US hospitals. CMS stated its belief that these infants are not eligible for the automatic or "deemed" Medicaid eligibility available to newborn citizens whose mothers are receiving Medicaid at the time of their birth. As a result of this language in the non-binding preamble, several states implemented requirements for provision of birth certificates or other documentation for newborns born in the US to undocumented mothers.

The California Immigrant Policy Center (formerly the California Immigrant Welfare Collaborative) and the National Immigration Law Center have issued a brief ("Access to Medicaid for Newborns of Immigrant Mothers", November 2006) clarifying that, despite the preamble language, these infants remain eligible for Medicaid regardless of the immigration status of their mothers. Furthermore, the groups emphasize that there has been no change in law requiring these citizen babies to further document their status, and that they remain eligible for automatic or "deemed" Medicaid if their mothers have given birth while receiving Medicaid. California Medi-Cal officials have announced that there has been no change in state policy governing Medi-Cal eligibility for these infants, and that they should be enrolled in Medi-Cal without delay. The full text of the brief is available at www.caimmigrant.org.

Los Angeles County EDSI Learning Collaborative

The Early Developmental Screening and Intervention (EDSI) Initiative is an ambitious five-year project to enhance the systems of care in Los Angeles County that support early identification and promotion of young children's development. The five-year EDSI project will include work at the policy level and efforts to improve systems through action-oriented collaborative improvement programs. The first EDSI Learning Collaborative will take place over 12 months beginning in 2007.

Background: Improving the delivery of developmentally oriented services can improve early childhood parenting experiences and the timely identification of developmental problems. Yet current health systems are not providing services effectively to promote optimal physical, cognitive, social, and emotional development. Clinicians and other professionals working with young children and families face time and resource constraints. Time pressures and ever-increasing guidelines for counseling parents on a range of topics can make it difficult for clinicians to address parent priorities. They are often frustrated in their efforts to connect parents with needed supports because resources in communities are limited and frequently target only children who meet specific diagnostic criteria. Such eligibility constraints often limit the resources available to promote the earliest intervention before problems become severe. Given the increasing knowledge around early identification and intervention, and the opportunities that communities have to optimize children's learning and development, many professionals report a need for more training and greater supports to make their early identification efforts more effective.

EDSI intends to improve early identification and reduce current disparities through a population-based approach to improve developmental services that is family-centered, culturally appropriate, empirically-based, and seeks to address all parent concerns. By establishing clear roles and responsibilities

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and improving communication, we believe primary care clinicians, early care and education professionals and other personnel working with young children and families, can make better use of observations and interactions with families to assure that parents are well informed and receive the supports they need.

EDSI Learning Collaborative 2007: Beginning in the spring of 2007, 30 primary care practices and 10 Early Care and Education sites from the Metro and Westside areas of Los Angeles will participate in a Learning Collaborative designed to enhance care for children up to five years of age. The pediatric and family medicine practices will test the most recent recommendations for providing excellent developmental services, including guidelines for developmental screening from the American Academy of Pediatrics issued in 2006. Teams will participate in three Learning Sessions, each followed by an action period where they will have the opportunity to try out changes in their setting, measure their own progress with support from collaborative staff, and share results and insights with other participants and local and national faculty. Participating practices will make changes in three broad areas including eliciting and addressing parents' informational needs and promoting positive interactions between parent and child, identifying children at risk, and linking families to community resources. While the EDSI project is built upon the Healthy Development Collaborative recently conducted in Vermont and North Carolina, it adds an innovative approach of building partnerships with local early care and education providers and other community resources. The EDSI Learning Collaborative will also identify policy priorities that may ultimately influence the way developmental screening and services are provided in Los Angeles County.

The EDSI Learning Collaborative brings together local and national experts from a variety of fields led by faculty co-chairs Dr. Marian Earls and Richard Cohen, Ph.D. Dr. Earls is medical director of Guilford Child Health, a clinic serving low-income families in North Carolina, and served as clinical director for The Commonwealth Fund's *Assuring Better Child Development* (*ABCD*) Project, which sought to assist states in improving the delivery of early child development services for low-income children and their families, and for which her clinic is a pilot site. She also chaired the Healthy Development collaborative in Vermont and North Carolina that piloted many of the changes that are a part of the EDSI Learning Collaborative. Dr. Cohen is the Executive Director of the Westside Children's Center in Los Angeles. Westside Children's Center provides subsidized childcare as well as foster care, adoption and family preservation services. Dr Cohen served as Director of Head Start in Pasadena/Glendale and as Director of the Pacific Oaks Research Center.

EDSI is a strategic partnership including First 5 LA and team members from the Center for Health Care Quality at Cincinnati Children's Hospital, the Center for Healthier Children, Families and Communities at UCLA, Childrens Hospital Los Angeles, Cedar-Sinai Medical Center, Cal State LA, Public Health Enterprises Women, Infants and Children (PHFE-WIC), and the BioMed WIC program.

For more information about the collaborative and the application process, contact:

Thomas Rice
EDSI Project Manager
Phone: 310-794-0907
E-mail: **edsi@ucla.edu**

Announcements

New Website for the California Medical Home Project & Los Angeles Medical Home Project

Effectively immediately, the California/ Los Angeles Medical Home websites can be found at http://mchneighborhood.ichp.ufl.edu/medicalhomela/. Please **DELETE** www.medicalhomela. org from any favorites lists, etc.

KASA Youth Advisory Council Update

The Kids As Self Advocates (KASA) Youth Advisory Council met for the first time on November 20, 2006 for an all day meeting at Support for Families in San Francisco. Ten of the thirteen members were able to attend. Much of the meeting was spent getting to know each other and setting up ground rules for the group. Members also learned about the federal MCHB grant, "Implementing Systems of Care for CSHCN," of which the formation and work of the council is a component.

FVCA is still recruiting new members who are between the ages of 14-24 and have California Children's Services (CCS) eligible conditions. Members must be available for quarterly all-day meetings in the Bay Area and for monthly one hour-long phone conference calls. A $50.00 stipend is provided for all meetings and transportation is reimbursed for quarterly meetings. Interested youth should contact Judith Lesner (Youth Facilitator) via email or phone: **MAVENno1@aol.com /** (510) 459-6940.

Reports Available from Legislative Analyst's Office (LOA), California's Nonpartisan Fiscal and Policy Advisor

- **California Spending Plan 2006-07: The Budget Act and Related Legislation**

The state spending plan for 2006-07 includes total budget expenditures of $128.4 billion, sharply increasing funding for education, providing targeted increases in several other program areas, and prepaying nearly $3 billion in budgetary debt. The expanded commitments included in this spending plan are in striking contrast to the four previous years, when policymakers were faced with closing major budget shortfalls. Despite much stronger-than-expected revenues, 2006-07 expenditures exceed revenues, with the difference being covered by the drawdown of carryover reserves available from 2005-06. Based on out-year estimates of revenues and expenditures, it is estimated that this imbalance will continue in 2007-08 and 2008-09 absent corrective action, with annual operating shortfalls in the range of $4.5 billion and $5 billion projected for this period.

Available in the following formats:

HTML: http://www.lao.ca.gov/2006/spend_plan/spending_plan_06-07.html

Adobe Acrobat: http://www.lao.ca.gov/2006/spend_plan/spending_plan_06-07.pdf

- ***Cal Facts*: California's Economy and Budget in Perspective**

With a state as big, as populous, and as complex as California, it would be impossible to quickly summarize how its economy or state budget works. The purpose of *Cal Facts* is more modest. By providing various "snapshot" pieces of information, the goal is to provide the reader with a broad overview of public finance and program trends in the state. *Cal Facts* consists of a series of charts and tables which address questions frequently asked of LOA.

Available in the following formats:

HTML: http://www.lao.ca.gov/2006/cal_facts/ 2006_calfacts_toc.htm

Adobe Acrobat: http://www.lao.ca.gov/2006/cal_facts/2006_calfacts_pdf_toc.htm

Calendar of Events

January 2007

17 **Legal Updates You Need to Know Before Your Child's Next IEP — Los Angeles** (http://www.lanterman.org/training/Flyers/BureauofJewish_EducationofGreaterLA_20062007_brochure.pdf)

20 **Handle with care: Managing the Childhood Cancer Survivor in Your Practice — Los Angeles** (http://www.childrenshospitalla.org/body.cfm?id=1225)

22–26 **21st Annual San Diego International Conference on Child and Family Maltreatment — San Diego** (http://www.chadwickcenter.org/conference.htm)

23 **4th annual Dorothy J. Waffarn Memorial Lecture - What We Can Learn from the Northwest Indians' Totems and Masks — Irvine** (for information, contact Josephine McIntyre: **jmcintyr@uci**)

23–26 **California Childhood Obesity Conference – Anaheim** (http://www.labestbabies.org/listserv/attachments/CO%202007%20postcard.pdf)

26–27 **Reflective Supervision and Consultation: Creating the Capacity for Authenticity and Connection — San Leandro** (http://first5solano.org/home/first5s/home/first5s/MyMedia/Training%204.pdf)

29 **Reflective Supervision & Consultation: Creating the Capacity for Authenticity & Connection — Los Angeles** (http://www.uscucedd.org/Portals/0/docs/Registration%20Form%201-29-07%20v8.pdf)

31–Feb 2 **Putting the Pieces Together for Children and Families: The National Conference on Substance Abuse, Child Welfare and the Courts — Anaheim** (http://www.cffutures.org/conference_information/conference_info.shtml)

February 2007

5–6 **A New Day 2007 - Exploring Inclusive Alternatives to Traditional Strategies for Living and Working — San Diego** (http://www.anewdaycalifornia.net/2007_conference.html)

7–10 **California School Nurses Organization 57th Annual Conference: School Nurses Transform Challenges into Opportunities — Santa Clara** (http://www.csno.org/docs/2007ConfBrochure.pdf)

14 **Finding the Calm in the Storm: Strategies for Helping Families with Chronically Ill Children — Los Angeles** (http://www.lanterman.org/training/Flyers/BureauofJewishEducationofGreaterLA_20062007_brochure.pdf)

15 **Coordinating Services for Children with Special Health Care Needs in the Community — Los Angeles** (http://uscucedd.org/Portals/0/docs/Coordinating%20CSHCN%20Feb%2015%202007.pdf)

20 **Wrightslaw Special Education and Advocacy Conference — San Diego** (http://www.wrightslaw.com/speak/07.02.ca.htm)

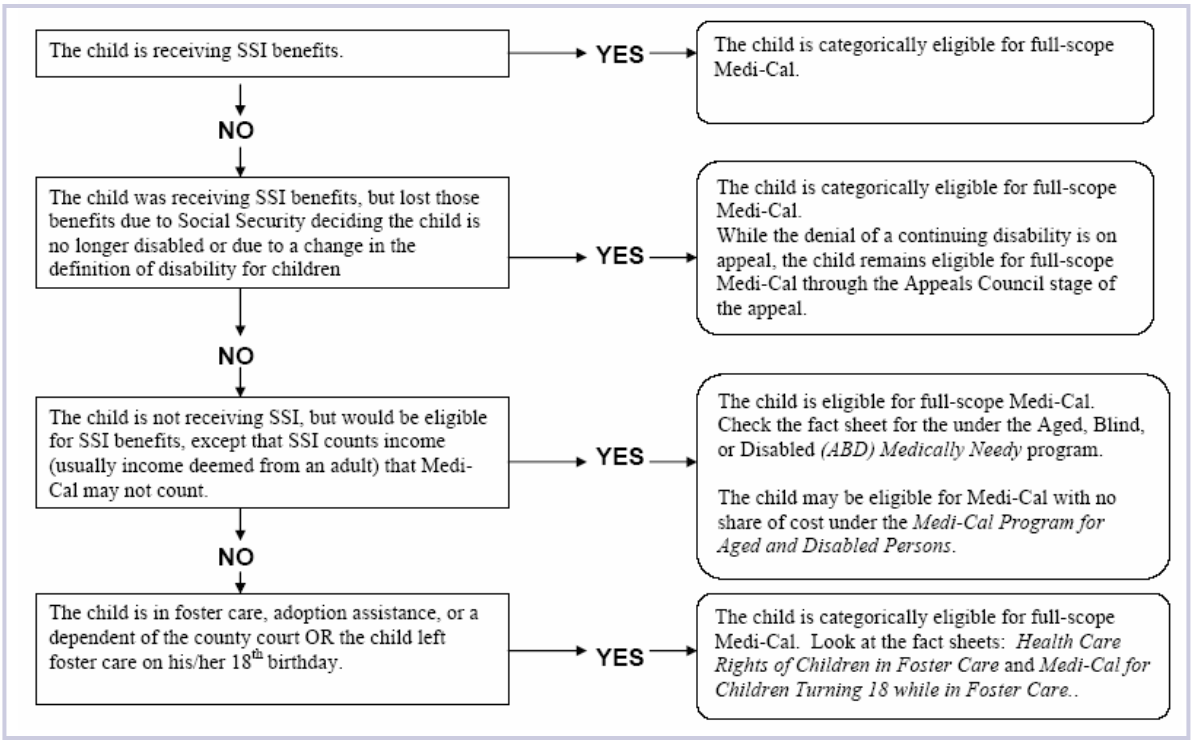
26–28 **Special Education Early Childhood Administrators Project (SEECAP) Lessons for Leadership Symposium — San Jose** (http://www.sdcoe.net/student/eeps/seecap/?loc=symposium)

Medi-Cal Waiver Programs for Children with Special Needs

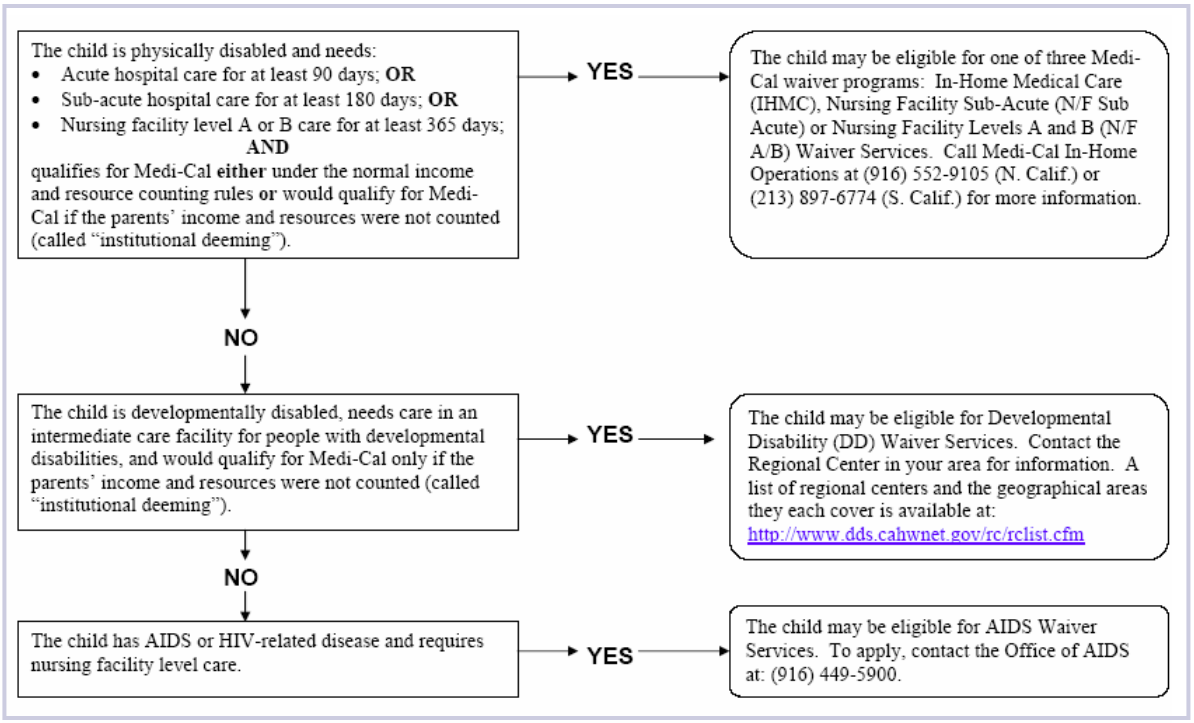
Families across the state have been reporting difficulty in accessing information about Medi-Cal "waiver programs" for which their child may be eligible. They have also reported difficulty determining which program to apply for and how to apply. The flowcharts below are adapted from the *Medi-Cal Flowchart B*, part of a larger flowchart that was developed by the National Health Law Program (NHLP) to provide information about Medi-Cal programs for children with special health care needs. To access the full document, go to www.healthconsumer.org/cs041Medi-CalFlowChart.pdf.

CHART B
(A child with a disability or special needs)

Children with special needs are eligible for the same types of Medi-Cal as children without special needs, including EPSDT services. However, children with special needs may be eligible for the programs in this panel or for the waiver services on the next panel of this chart as well.



The waiver programs on this panel are available for children who would otherwise need some type of nursing or institutional care. Eligible children can receive certain Medi-Cal services in order to be able to live at home or in the community.



– Adapted from *Medi-Cal Flowchart B (National Health Law Program,* August 2005)

Update on Report of Federal Medicaid Advisory Commission

In November, the federal Medicaid Advisory Commission released its recommendations for inclusion in the final Commission report. The Commission was established by the US Department of Health and Human Services in 2005 under the terms of the Fiscal Year 2006 budget agreement, and is charged with identifying reforms necessary to stabilize and strengthen Medicaid. Its 13 voting and 15 non-voting members represent health policy leaders from both political parties, state health department officials, public policy organizations, individuals with disabilities, and others with special expertise. The following is a summary of the report's recommendations, with commentary from *Families USA:*

- **Encourage long-term care planning by providing tax incentives for individuals and employers for the purchase of long-term care insurance.**
  Families USA: This recommendation does nothing to make long-term care insurance more affordable or better regulated for low-income individuals, who truly need Medicaid for long-term care when they are elderly.
- **Give states new "flexibility" to separate eligibility criteria for long-term and acute care services, and let states determine benefits for individuals based on lifestyle and personal behaviors.**
  Families USA: This recommendation would make it easier for states to cut benefits for Medicaid beneficiaries.
- **Allow states to "simplify" eligibility categories provided it is cost-neutral to the federal government.**
  Families USA: This is intended to allow states to cover populations that have not traditionally been covered by Medicaid, like adult men with incomes below 100 percent of the federal poverty level. This recommendation actually limits the states' ability to expand Medicaid to new populations because the federal government cannot spend more money than it does now.
- **Give tax credits to the uninsured to purchase health insurance (so as not to default into Medicaid).**
  Families USA: Low-income individuals who might actually qualify for Medicaid are unlikely to be able to use these tax credits and purchase affordable coverage.
- **Create new options that would make it easier for states to put dual eligibles (i.e. people eligible for both Medicare and Medicaid, also known as Medi-Medis) into managed care**.
  Families USA: Dual eligibles are some of the sickest and most impoverished individuals in Medicaid. Strong consumer protections are essential if dual eligibles are to be enrolled in managed care systems, but the Commission rejected an amendment that would have done just that.
- **Eliminate the existing institutional bias in Medicaid.**
  Families USA: This favorable recommendation would make it easier to allow individuals to receive care in the home, rather than in a nursing home.

Families USA notes it is likely that these recommendations will go nowhere in the new Congress: "*While the White House may use these recommendations as the basis for its budget proposals, it is safe to say that there is little appetite on the Hill for adopting these recommendations*." Regardless of the anticipated Congressional response to the Commission report, the Bush Administration remains committed to reducing federal Medicaid costs. Advocacy organizations will continue to monitor and report on any proposals to reform the program.

Policy Brief Examines Implications of Medicaid Reform Initiatives

Defined Contribution Plans and Limited Benefit Arrangements: Implications for Medicaid Beneficiaries explores the implications of state Medicaid reforms that limit benefits, coverage, and payments for medically necessary health care. The 22-page policy brief, produced by the George Washington University School of Public Health and Health Services with support from America's Health Insurance Plans, presents a background and overview and identifies a series of considerations that come into play when states approach the issue of benefit redesign.

Topics include Medicaid's important safety net

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(Continued – Medicaid Policy Brief)

role, Medicaid's evolution as a purchaser of health benefit plans, the economic and health status of Medicaid beneficiaries, and potential benefit gaps and the loss of coverage for critical health care needs. The importance of attracting and maintaining a strong and competitive health plan market for Medicaid beneficiaries, the importance of comprehensive benefits in attracting and maintaining a strong provider network, and the importance of purchasing arrangements that advance cross-plan accountability for efficiency and patient safety and quality are also discussed. The policy brief is available at http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/Rosenbaum_AHIP_FNL_091306.pdf. (MCH Alert, 9/22/06)

Report Discusses Progress Toward Achieving Maternal and Infant Health People 2010 Objectives

"The 19 states included in this report have made progress in achieving certain maternal and child health HP [Healthy People] 2010 objectives. However, increased efforts are needed for states to achieve all eight HP 2010 objectives examined in this report," state the authors of a report published in the October 6, 2006 issue of MMWR Surveillance Summaries. Healthy People 2010 (HP 2010) serves as the national comprehensive guide for disease prevention and health promotion. The report provides a snapshot of state progress toward achieving HP 2010 objectives with a focus on perinatal indicators associated with the following eight objectives: (1) pregnancy intention, (2) multivitamin use, (3) physical abuse, (4) cigarette smoking during pregnancy, (5) cigarette smoking cessation, (6) drinking alcohol during pregnancy, (7) breastfeeding initiation, and (8) infant sleep position.

Data for the analysis were drawn from the Pregnancy Risk Assessment Monitoring System (PRAMS), an ongoing, state- and population-based surveillance designed to monitor selected self-reported maternal behaviors and experiences that occur before, during, and after pregnancy among women who deliver live-born infants. Results from 19 states that collected data during 2000-2003 and

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Calendar of Events (continued)

March 2007

1–4 **Autism Biennial Congress, 2007 Autism Through the Lifespan — Vancouver, B.C.** (http://www.autismvancouver2007.com/)

6 **Implementation of Final IDEA Regulations for Part B and Part C*: Making it Work at the Local Level (SEECAP) — Anaheim** (http://www.sdcoe.net/student/eeps/seecap/?loc=calendar)

7 **A Skill-Builder on Social Marketing (SEECAP) — Anaheim** (http://www.sdcoe.net/student/eeps/seecap/?loc=calendar)

8–10 **Developmental Disabilities: An Update for Health Professionals — San Francisco** (https://www.cme.ucsf.edu/cme/CourseDetail.aspx?coursenumber=MOC07001)

14 **Non-Drug Approaches to Behavior and Learning Problems in Children — Los Angeles** (http://www.lanterman.org/training/Flyers/BureauofJewish_EducationofGreaterLA_20062007_brochure.pdf)

22–24 **13th Infant Development Association Conference - Common Threads in Early Intervention: Innovations and Realities — San Jose** (http://www.idaofcal.org/conference.html)

22–26 **21st Annual San Diego International Conference on Child and Family Maltreatment — San Diego** (http://chadwickcenter.org/conference.htm)

23–24 **The Safe and Effective Use of Psychiatric Medication in Children and Adolescents: A Mini-Fellowship for Primary Care Clinicians — Carlsbad** (http://www.kidsmentalhealth.org/PPP.html)

26–28 **37th Annual National Council Conference — Las Vegas, NV** (http://www.nccbh.org/conferenceataglance.pdf)

April 2007

18 **Autism and the Family — Los Angeles** (http://www.lanterman.org/training/Flyers/BureauofJewish_EducationofGreaterLA_20062007_brochure.pdf)

19–22 **Healthy Kitchens, Healthy Lives: Caring for Our Patients and Ourselves — St. Helena** (http://www.healthykitchens.org/healthy-kitchens.pdf)

May 2007

2 **Keeping Depression a Secret is Dangerous - With Proper Treatment, Recovery Can Lead to a Healthy, Fulfilling Life — Los Angeles** (http://www.lanterman.org/training/Flyers/BureauofJewish_EducationofGreaterLA_20062007_brochure.pdf)

3–4 **Institute for Healthcare Advancement's Sixth Annual Health Literacy Conference: Health Literacy and Chronic Illness Management — Anaheim** (http://www.iha4health.org/)

30–Jun 1 **Building on Family Strengths - Effective Services for ALL: Strategies to Promote Mental Health and Thriving for Underserved Children and Families — Portland, OR** (http://www.rtc.pdx.edu/)

(Continued — 2010 Objectives Progress Report)

achieved weighted response rates of greater than or equal to 70% in 1 year were included in the analysis.

The authors found that:

- Preconception period -- No state achieved the HP 2010 objectives for intended pregnancy, multivitamin use during the month before pregnancy, and physical abuse during the 12 months before pregnancy.
- Prenatal period -- No state achieved the objective for abstinence from smoking during pregnancy. However, all states achieved the objective for smoking cessation during pregnancy, and more than three-fourths achieved or exceeded the objective for abstinence from alcohol during pregnancy.
- Postpartum period -- Nearly half of the states achieved the objective for breastfeeding, and slightly more than one-third achieved the objective for infant sleep position.

"More progress has been made in the health indicators related to maternal behaviors during pregnancy...and after pregnancy...than for those related to behaviors before pregnancy," state the authors. They conclude that "continued use of PRAMS data to monitor these maternal behaviors is important for implementing, evaluating, and setting priorities for future initiatives at the state level." (MCH Alert, 10/13/06)

Suellentrop K, Morrow B, Williams L, et al. 2006. Monitoring progress toward achieving maternal and infant Healthy People 2010 objectives --19 states, Pregnancy Risk Assessment Monitoring System (PRAMS), 2000-2003. MMWR Surveillance Summaries 55(SS09):1-11. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5509a1.htm?s_cid=ss5509a1_e.

The Health Status of Young Adults in the United States

The health issues of young adulthood have received relatively little attention compared with those of adolescence, although the critical issues in young adulthood parallel those of adolescence. Young adults, however, often fare worse than adolescents on health indicators, with many measures of negative outcomes, including rates of injury, homicide, and substance use, peaking during the young adult years. This article synthesizes national data to present a health profile of young adults and can be found at http://www.jahonline.org/article/PIIS1054139X06001431/fulltext. (TATRA Center, 10/23/06)

Child Health USA 2005 Released

Child Health USA 2005 is a compilation of secondary data for more than 50 health and health care indicators. The 2005 report, the 16th in an annual series of reports from the Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB), provides both graphical and textual summaries of data and addresses long-term trends where applicable. Data are presented for the target populations of Title V funding, including infants, children, adolescents, children with special health care needs, and women of childbearing age. The report addresses population characteristics, health status, and health services financing and utilization. Progress toward meeting the goals of MCHB's strategic plan is also discussed. The report is intended to provide public health professionals and other individuals in the private and public sectors with a snapshot of measures of children's health in the United States. The report is available at http://mchb.hrsa.gov/mchirc/chusa_05/index.htm. (MCH Alert, 10/27/06)

Report Presents Well-Child Care Change Ideas

A High-Performing System for Well-Child Care: A Vision for the Future articulates changes needed to realize a high-performance system for the delivery of well-child care. The report, published by the Commonwealth Fund, is based on a review of the current literature to assess key findings in well-child care research and important trends affecting the future of well-child care. The report also draws on the ideas of leaders in child health care, including pediatric health professionals and family advocates.

Information about the study methodology and trends affecting preventive and developmental services are presented, followed by a template for ideal well-child care and recommendations to the field from the perspectives of families, the microsystem, the health care organization, and the broader environment. The report is intended to serve as a template for implementing changes in clinical practice and as a guide for further policy and research efforts. The report is available at http://www.cmwf.org/usr_doc/Bergman_high-performsyswell-childcare_959.pdf. (MCH Alert, 11/3/06)

Joint Policy Statement Released on the Provision of Patient– and Family– Centered Care in the Emergency Department

Patient- and Family-Centered Care and the Role of the Emergency Physician Providing Care to a Child in the Emergency Department addresses the particular challenges in, and opportunities for, providing patient- and family-centered care (PFCC) in the emergency department (ED) setting. The joint policy statement of the American Academy of Pediatrics (AAP) and the American College of Emergency Physicians (ACEP) defines PFCC as an approach to health care that recognizes the role of the family in providing medical care; encourages collaboration between the patient, the family, and the health professional; and honors individuals' and families' strengths, cultures, traditions, and expertise. Select topics include (1) overcrowding and acuity in the ED, resulting in delay or disruption of care and challenging the ability of ED staff to provide respectful and sensitive care; (2) the lack of a previous relationship between the patient, the family, and the health professional, making it difficult to create an effective partnership;(3) the many cultural and societal variations among families, making it difficult to identify a child's legal guardian; and (4) situations unique to the ED, requiring thoughtful advanced planning. AAP and ACEP recommendations are included. The policy statement is available at http://aappolicy.aappublications.org/cgi/reprint/pediatrics;118/5/2242. (MCH Alert, 11/10/06)

Article Looks at Primary Care in Seven Countries

"Results from the seven-country survey depict a time of extensive global experimentation in primary care redesign," state the authors of an article published as a Health Affairs Web Exclusive on November 2, 2006. Even in the United States, with its highly specialized physician work force, primary care physicians account for the majority of visits for common conditions and are the physician individuals named when asked if they have a regular source of care. This article discusses the 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians, which interviewed physicians in seven countries: Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States. The survey focused on information technology (IT) and clinical record systems, care coordination, use of teams, participation in quality incentives, and financial incentives.

The survey consisted of interviews with representative samples of primary care physicians in seven countries using a common questionnaire. The authors found that:

(Continued next page)

Resources

Parent Information Sheet Series: *What Parents of Children with Developmental Disabilities Need to Know About Safety*

This 5-part parent information sheet series provides essential information on identification, reporting, and prevention of abuse and neglect. The series, developed through an ADD *Project of National Significance*, is a companion to *Keeping Our Children Safe: A Booklet for Caregivers and Providers of Children with Developmental* (2000). Available in English and Spanish, each 2-page sheet presents information in easy-to-digest pieces to enhance accessibility for low literacy readers. Titles include:

- *What is Child Abuse?*
- *How Do I Know if My Child Has Been Abused?*
- *What Should I Do if I Think That My Child Has Been Abused?*
- *What Can I Teach My Child To Help Keep Him Safe?*
- *How Can I Keep My Child Safe?*

To download the information sheets and the provider booklet, go to http://child.uscucedd.org/Products_Resources/EducationalMaterialsCurricula/tabid/573/Default.aspx.

Free Accredited CME Seminars in Developmental Disabilities Available Online from Exceptional Parent

EP Global Communications, announces the launch of a new, real-time online service that delivers ongoing CME accredited seminars to physicians. For more information and to access online events, go to www.eparent.com/epliveonline/default.cfm.

Knowledge Path: Child and Adolescent Health Insurance and Access to Care

The new edition of *Knowledge Path: Child and Adolescent Health Insurance and Access to Care* is an electronic guide to a selection of recent, high-quality resources about child and adolescent health insurance and access to care with an emphasis on Medicaid and the State Children's Health Insurance Program. The knowledge path, produced by the MCH Library, includes a section on child and adolescent health coverage campaigns. A separate section lists resources for families. The knowledge path is intended for use by health professionals, program administrators, policymakers, educators, researchers, and families who are interested in obtaining timely information on this topic. The knowledge path is available at http://www.mchlibrary.info/KnowledgePaths/kp_insurance.html. (MCH Alert, 10/6/06)

(Continued — Primary Care)

- Primary care physicians in Australia, the Netherlands, New Zealand, and the United Kingdom have the most widespread and multifunctional systems; Canada and U.S. physicians lag well behind. German rates tend to be in the mid-range.
- More than one-third of physicians in all countries except Germany said that their clients sometimes or often experience coordination problems (e.g., care was not well coordinated across multiple sites or providers, medical records were not available at the time of a scheduled visit, tests or procedures had to be repeated because findings were unavailable).
- A high proportion of physicians in all countries except Germany said that they are less than well prepared to care for clients with multiple conditions. Concerns are particularly acute in Canada.
- Physicians in Australia, Germany, and the Netherlands are most likely to offer early morning office hours and some hours beyond the typical work day. In the other four countries, fewer than half of the physicians reported early morning, evening, or weekend office hours. One-third or more of U.S., New Zealand, and U.K. physicians reported no office hours during these times.
- All seven countries have initiatives to engage physicians in collaborative efforts to learn and innovate, benchmark clinical performance, set targets for improvement, and provide incentives to improve care and manage chronic conditions.
- In each country, the question of how to pay for care and to reward and support improved performance has been central to policy discussions.

The authors conclude that "as the United States confronts how to redesign incentives to improve access, quality, and efficiency amid a more fragmented payer system, it has an opportunity to learn from the diverse approaches in countries that are implementing system-wide initiatives." The authors continue, "cohesive, broad-based policy changes in the United States could lead to improved absolute and relative performance." (MCH Alert, 11/22/06)

Schoen S, Osborn R, Huynh PT, et al. 2007. On the front lines of care: Primary care doctors' office systems, experiences, and views in seven countries. Health Affairs 25(6):w555-w571. Available at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.25.w555.

Resources (continued)

Manual Outlines Coordinated, Statewide System of Early Detection and Intervention for Children

How to Develop a Statewide System to Link Families with Community Resources: A Manual Based on Help Me Grow offers guidance for exploring, creating, or enhancing a statewide single-point-of-access system to connect children with community resources. Available in its entirety on the Commonwealth Fund Web site, it is based on Connecticut's Help Me Grow initiative, a program that assists families and providers in identifying developmental concerns, finding appropriate resources, and helping families connect with programs and services. Topics include recruitment, retention, and recognition of partners; call centers; community-based liaisons; data collection; evaluation; and continuous quality improvement. The manual is available at http://www.cmwf.org/General/General_show.htm?doc_id=381829. (MCH Alert, 10/20/06)

High School Health Care Transition *Curriculum*

What's Health Got to Do with Transition? was published in 2005 by the Florida Developmental Disabilities Council. The curriculum and a related teacher's guide are available for download from the University of South Florida's web site at http://usfpeds.hsc.usf.edu/adolescent/. (TATRA Center, 10/23/06)

Fact Sheets on Federal Programs for Transitioning Youth with Serious Mental Health Conditions

Myriad federal programs can address the wide range of needs of youth with serious mental health conditions who are transitioning into adulthood. The Bazelon Center has prepared fact sheets about 57 programs, run by 20 or more different agencies in nine departments of the federal government. For more information go to http://www.bazelon.org/publications/movingon. (TATRA Center, 9/21/06)

Fact Sheet on Parental Roles in Active Lifestyles for Youth with Disabiliities

A new fact sheet, *Parental Roles in Facilitating and Supporting an Active Lifestyle for a Child with a Disability*, from the National Center on Physical Activity and Disabilities can be found at http://www.ncpad.org/wellness/fact_sheet.php?sheet=450&view=all&print=yes.

Authors Examine Effects of Medicaid Policies on Mental Health Service Use Among Children in the Child Welfare System

"Our data suggests that access to mental health services already falls below need in this nationally representative sample of children in child welfare environments," state the authors of an article published in the December 2006 issue of Children and Youth Services Review. The article presents findings from an analysis of the effects of Medicaid managed care policies on access to ambulatory and inpatient mental health services among children in child welfare environments in the United States.

Data for the analysis were collected from principal caregiver and child-welfare-worker interviews conducted as part of the National Survey of Child and Adolescent Well-Being (NSCAW), a study of children coming into contact with child welfare agencies nationwide. Policy data were drawn from the Caring for Children in Child Welfare study, a telephone-administered key informant interview of NSCAW contact persons in each county. The analysis examined the relationship between policy variables and use of ambulatory and inpatient mental health services, controlling for child-level characteristics and county-level health resources.

The authors found that:

- There was no significant relationship between managed care and access to ambulatory mental health services.
- Children living in counties that carved out behavioral health services had significantly lower inpatient mental health service use than children in counties that did not deploy behavioral health carve-outs, controlling for child-level sociodemographic, insurance, and need variables.

"Adoption of health care delivery structures that further decrease service utilization may have adverse consequences for the mental health of children in the child welfare environments," state the authors. They conclude that "integrative approaches are crucial in ensuring that children in the child welfare system obtain the care they require for their mental health needs." (MCH Alert, 12/1/06)

Raghavan R, Leibowitz AA, Andersen RM, et al. 2006. Effects of Medicaid managed care policies on mental health service use among a national probability sample of children in the child welfare system. Children and Youth Services Review 28 (12):1482-1496.

New Chartbook Highlights Findings on the Health and Well-Being of Infants, Children, and Adolescents Residing in Rural Areas

The *Health and Well-Being of Children in Rural Areas: A Portrait of the Nation 2005* presents national- and state-level data on the health status, health care use, and risk factors experienced by infants, children, and adolescents (from birth to age 17) who reside in rural areas in the United States. The chartbook draws from an analysis of parent reports from the National Survey of Children's Health, which is supported by the Maternal and Child Health Bureau (MCHB). Measures included oral, physical, and mental health; health care utilization and insurance status; and social well-being. Aspects of the environment (family structure, poverty level, parental health and habits, and community surroundings) were also assessed. The chartbook contains information about infants', children's, and adolescents' health and health care by location and by major demographic characteristics (age, sex, race and ethnicity, and family income). The technical appendix of the chartbook provides information about the survey sample and methodology. The report is available at http://www.mchb.hrsa.gov/ruralhealth/pdf/01rh.pdf. More detailed analyses of the survey results are available from the Data Resource Center on Child and Adolescent Health Web site at http://www.nschdata.org. (MCH Alert, 12/8/06)

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