



CACSHCNEWS

February is National Children's Dental Health Month (NCDHM)

Each February, the American Dental Association sponsors NCDHM to raise awareness about the importance of oral health. The 2008 campaign features two posters, one for use with children and the other for use with adolescents. Additional campaign materials include activity sheets for children and a program planning kit and presentation materials for use by health professionals, teachers, parents, and others interested in promoting oral health. For more information, go to <http://www.ada.org/prof/events/featured/ncdhm.asp>.



To learn about other activities related to NCDHM, visit the National Maternal and Child Oral Health Resource Center website at <http://www.mchoralhealth.org/default.html>.

Oral Health Knowledge Path Updated

Knowledge Path: Oral Health and Pregnant Women, Infants, Children, and Adolescents has been updated for 2008. This knowledge path about oral health and pregnant women, infants, children, and adolescents has been compiled by the National Maternal and Child Oral Health Resource Center (OHRC) and the Maternal and Child Health Library at Georgetown University. It offers a selection of current, high-quality resources that analyze data, describe effective programs, and report on policy and research aimed at improving access to oral health care and quality of oral health for pregnant women, infants, children and adolescents. Separate sections identify resources on specific aspects of oral health including child care and Head Start (HS), dental sealants, early childhood caries (ECC), fluoride varnish, K-12 education, pregnancy, and school-based care. A separate section lists oral health resources for consumers. This knowledge path is aimed at health professionals, program administrators, educators, policymakers, and consumers, and it will be updated annually. To access the knowledge path, go to <http://www.mchoralhealth.org/KNWPathOralHealth.html>.

CACSHCNEWS 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:

- ◆ Department of Health Care Services, Children's Medical Services 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 CACSHCNEWS, please send an email message to ycasillas@chla.usc.edu with "CACSHCNEWS" in the subject line.

Next Issue Date:
April 2007

Framework Combines Advances in Science and Program-Evaluation Research to Inform Early Childhood Policy Designs

A *Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children* combines scientific knowledge about early childhood and early brain development with findings from four decades of program evaluation research into a unified framework to guide policy decisions on behalf of young children and their families. The report, published by the Harvard University Center on the Developing Child, builds on a process of systematic analysis that began with the publication in 2000 of a landmark report by the National Academy of Sciences titled *From Neurons to Neighborhoods: The Science of Early Childhood Development*, followed by the ongoing work of the National Scientific Council on the Developing Child and the National Forum on Early Childhood Program Evaluation, both of which are based at the Center on the Developing Child at Harvard University.



The authors describe the process by which brain architecture is formed in very young children and integrate this scientific knowledge with the identification of factors from the program-evaluation literature that appear to offer the best course toward positive outcomes for children. Factors identified include the following: strengthening the family environment, serving children in out-of-home environments, combining support for vulnerable families with direct services for children, family economics and maternal employment, and the vulnerability of the young brain. An executive summary, references, and selected background readings are included. The report is available at http://www.developingchild.harvard.edu/content/downloads/Policy_Framework.pdf. (MCH Alert, 10/12/2007)



Announcements



New California CSHCN Informational Website!

California Children with Special Health Care Needs Informational Website launches in March, 2008. Please be sure to bookmark www.cshcn-ca.org. If you have any questions please contact info@cshcn-ca.org.

Camp Coelho: Epilepsy Foundation of Northern California

The Epilepsy Foundation of Northern California is excited to sponsor the 3rd annual Camp Coelho to be held June 15-20, 2008. Camp Coelho is a 5-night, 6-day adventure for children ages 9-15 with a primary diagnosis of epilepsy, held in the Yosemite Valley. The camp is staffed by doctors, nurses, Epilepsy Foundation staff, and volunteers. Activities include horseback riding, arts and crafts, swimming, archery, and a ropes course.



Camp Coelho gives children the opportunity to learn more about their epilepsy and to promote self-confidence and independence in a safe environment.

For more information please contact Stephanie Eistetter at stephaniee@epilepsynorcal.org or go to <http://www.epilepsyfoundation.org/local/norcal/Camp-for-Kids.cfm>.

Hospice and Palliative Medicine Sub-Board

Registration for the American Board of Pediatrics (ABP) pediatric hospice and palliative medicine sub-board certification exam opens 2/4/08 and the test will be administered on 10/29/08. It will only be offered bi-annually, so it is imperative that folks intending to get in through the grandfathering mechanism (which includes being ABHPM certified currently) take the test this year, 2010 or 2012. Thereafter, a 12 month ACGME accredited fellowship training will be a requirement for eligibility. The details can be found at: <http://www.aahpm.org/certification/abms.html#individual>.

Article Addresses the Roles and Responsibilities of Primary Care Health Professionals in Supporting Newborn Screening

"[Primary care pediatricians] have a proactive role to play in supporting the performance of the newborn screening system and ensuring the successful completion of their responsibilities to the program," state the authors of a clinical report published in the January 2008 issue of *Pediatrics*. Advances in newborn screening technology, coupled with recent advances in the diagnosis and treatment of rare but serious congenital conditions that affect newborn infants, provide opportunities for positively affecting the lives of children and their families. These opportunities, however, also pose new challenges to primary care pediatricians (PCPs). The report addresses the steps that individual PCPs and practices must take to effectively support the newborn screening system. The authors also discuss other health professionals' and agencies' roles in supporting the system and identify ways these entities can improve newborn screening, thereby helping to improve health outcomes for newborns.

Two algorithms for addressing the specific roles of a PCP within the newborn screening system are provided. Information about the roles of PCPs and subspecialists in implementing the algorithms is also included. The authors follow with recommendations for how PCPs can more effectively address their roles and responsibilities within the newborn screening system. Topics include preparing the practice and collaboration with other health professionals, hospitals and other birthing facilities, pediatric medical subspecialists, state systems, state newborn screening advisory committees, national partnerships, and national medical specialty organizations.

Authors' conclusions:

- PCPs require immediate access to clinical and diagnostic information and guidance.
- PCPs must develop office policies and procedures to ensure that newborn screening is conducted and that results are transmitted to them in a timely fashion.
- PCPs must develop strategies to use should systems fail.
- The system is challenged by error, lack of education or information on the part of families and health professionals, systemic challenges such as the national shortage of pediatric medical subspecialists, barriers inherent in state licensing, lack of universal health care coverage,



Announcements (continued)

FVCA Kids As Self Advocates

Family Voices of California *Kids As Self Advocates* (KASA) is committed to working with Children's Medical Services to enhance the way that transition services are delivered to youth to provide a more comprehensive, effective and efficient system, and 15 months ago created a Youth Advisory Council. This group is now composed of 10 young people ages 14-24. We are now looking for two new members who reflect the diversity (geographic, ethnic, age and gender) of youth in California and have Children's Medical Services eligible conditions.



The mission of FVCA KASA is to improve transition from youth to adult medical services. In order to create a system that works for you, we need your voice!

All day meetings are held the second Saturday of every other month (February, April, June, August, etc.) in San Francisco. In alternate months, we hold meetings by phone conference call at 7pm on the last Sunday of the month. All travel expenses of participants for meetings and a stipend of \$50.00 per meeting are provided.

If you are interested in joining other young people to have your voice heard, and you can commit to regular attendance at our meetings, please contact Judith Lesner at (510) 459-6940 or at maveno1@aol.com.

We are a dynamic group of young people committed to having our voices heard. Youth living outside the San Francisco Bay Area are especially encouraged to apply for membership.

and limited funding.

- State and federal entities, hospitals, prehospital health professionals, pediatricians, and pediatric medical subspecialists should act collaboratively to address the challenges or reduce their effects on the newborn screening system.

(MCH Alert, 1/11/2008)

Newborn Screening Authoring Committee. 2007. Newborn screening expands: Recommendations for pediatricians and medical homes -- Implications for the system. Pediatrics 121(1):192-218. Abstract available at <http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;121/1/192>.

Report Shows Under-Detection of Early Developmental Delays

A new literature review has been conducted to determine the effectiveness of current efforts by primary care providers to detect developmental delays in young children. Sadly, this report shows that there seems to be a considerable under-detection of these delays, and makes several recommendations for improving screening and surveillance throughout communities. The entire report is available at http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=605625. (*Champions eNewsletter*, 1/8/2008)



Family Medical History in Pediatric Primary Care Practice and Public Health

A supplement to the September issue of *Pediatrics* summarizes a workgroup meeting to discuss extending the scope of the Centers for Disease Control and Prevention's Family History Public Health Initiative to include children and their families. The supplement contains articles that summarize the proceedings and explore four topics that emerged as leading issues from the meeting: optimizing use of family history in primary care; linking obstetric and pediatric clinicians through preconception health care; assessing potential campaigns to prevent chronic disease, starting with family history assessment in childhood; and, using birth defect family histories for prevention efforts. http://www.cdc.gov/ncbddd/bd/family_history.htm (*AMCHP Pulse for Partners*, 9/28/2007)

Calendar of Events

March 2008

- 7-8 **2008 Respect-ABILITY Conference** — Los Angeles (<http://www.respectabilitycoalition.org>)
- 13 **Special Start Training Program: Providing Developmentally Supportive Care to NICU Graduates** — Ukiah (<http://www.mills.edu/specialstart/calendar.html>)
- 13-14 **UC Davis Annual Pediatric Conference** — Napa (<http://www.ucdmc.ucdavis.edu/cme/conferences/>)
- 13-14 **Center for Prevention and Early Intervention Early Starts Institutes: Facilitating Relationships, Communication and Behavior** — Foster City (<http://www.wested.org/cs/cpei/print/docs/211>)
- 16-19 **NACHRI & N.A.C.H. 2008 Creating Connections Conference** — Miami, FL (http://www.childrenshospitals.net/AM/Template.cfm?Section=Creating_Connections)
- 26-29 **Pediatric Emergency Medicine 2008: Advances and Controversies for the Clinician** — Lake Buena Vista, Florida (<http://www.pedseducation.org/dalibrary/disneycard2008.pdf?Pid=2902&Wid=1>)
- 28-29 **Lucile Packard Children's Hospital Pediatric Otolaryngology Update 2008** — Palo Alto (<http://www.lpch.org/CMECourses/cmePediatricOtolaryngologyUpdate2008.html>)



April 2008

- 2-4 **Kids Included Together: 4th Annual National Conference on Inclusion** — San Diego (<http://kitconference.org/index.php>)
- 3-5 **CA Association for the Education of Young Children 2008 Annual Conference and Expo** — Long Beach (<http://caeyc.org/main/page/conference>)
- 3-6 **AAP CA Chapter 2, 19th Annual Las Vegas Postgraduate Pediatric Meeting - "Advances in Pediatrics"** — Las Vegas (<http://www.aapca2.org/futureevents.htm>)
- 10-12 **2008 National Conference in Child Health Psychology** — Miami Beach, FL (<http://www.psy.miami.edu/department/announcements.html>)
- 13-14 **2008 Federal Hemophilia Treatment Centers/Region IX Annual Conference** — La Jolla (www.hemophiliaregion9.org)
- 14 **Emergency Preparedness and Disaster Planning for Children with Special Health Care Needs** — Los Angeles (for information, contact Yolanda Casillas, ycasillas@chla.usc.edu/323-361-1187)
- 14-16 **ACEP Advanced Pediatric Emergency Medicine Assembly** — San Diego (<http://meetings.acep.org/meetings/peds>)

Article Looks at Pediatricians' Involvement in and Perspectives on Community Child Health

"Pediatricians' training, perspectives, and involvement in community child health activities vary by age," write the authors of an article published in the November 2007 issue of *Pediatrics*. Many pediatric residency programs now provide didactic and experiential training in community pediatrics; however, it is unclear whether pediatricians who were trained more recently have more skills or more favorable perspectives than more established pediatricians. The objective of the study described in this article was to examine whether pediatricians' training, perspectives, and involvement in community activities vary by age.

Study participants took part in the 2004 American Academy of Pediatrics periodic survey, which includes topics important to pediatricians. The 2004 survey asked respondents about their participation in child-health-promotion activities. For analytical purposes, four age groups were constructed: ages 34 and younger, 35-39, 40-50, and 51 and older.

Authors' findings:

- Participation in community child health tended to be least frequent in the youngest age group (37.9% for ages 34 and younger, 44.4% for ages 35-39, 46.2% for ages 40-50, and 48.3% for ages 51 and older).
- The majority of respondents indicated that their community involvement is only on a volunteer basis, with the youngest age group being the most likely to volunteer (86.8% for ages 34 or younger, 79.7% for ages 35-39, 85.1% for ages 40-50, and 71.1% for ages 51 and older).
- A greater percentage of younger pediatricians reported that their current level of participation is too little, whereas more than half of pediatricians in the oldest age category believed that their involvement is "just right."
- Younger vs. older pediatricians were more likely to sense moderate or great responsibility for improving the health of children in their community (83.6%, 77.2%, 76.7%, and 70.2%, respectively).
- A higher percentage of younger vs. older pediatricians expected to increase their community involvement in the next 5 years (81.3%, 73.5%, 60.7%, and 47.1%, respectively).

The authors conclude that "prospective longitudinal studies . . . are needed to address whether

(Continued next page)

Calendar of Events (continued)

May 2008

- 5-8 **2008 CA WIC Association Annual Conference — San Diego** (http://www.calwic.org/spring_conference.aspx)
- 7-9 **2008 California Mental Health Advocates for Children and Youth Conference: Promoting Wellbeing Through Partnerships — Pacific Grove** (<http://www.cmhacy.org/conf-conference-overview.html>)
- 12 **Care Notebook Training — Los Angeles** (for information, contact Yolanda Casillas, ycasillas@chla.usc.edu/323-361-1187)
- 19-22 **2008 National Conference, Prevent Child Abuse America, Connecting the Dots: Turning Knowledge into Action — Milwaukee, WI** (<http://www.preventchildabuse.org/events/conference/index.shtml>)
- 24-26 **AAP CA Chapter 1, Pediatric Best Practices, Annual Spring Post Graduate Course — Monterey** (<http://www.aap-ca.org/meetings.html>)



June 2008

- 4-5 **Center for Prevention and Early Intervention Early Starts Institutes: Cognition and Early Learning — Anaheim** (<http://www.wested.org/cs/cpei/print/docs/211>)
- 17-18 **California Head Start Association Summer Health Institute — Riverside** (<http://www.caheadstart.org/conference.html>)



July 2008

- 8 **Autism Spectrum Disorder and Employment** (sponsored by CRP-RCEP) —webcast (<http://www.crp-rcep.org/training/webcastDetails.cfm/115>)
- 16-18 **UIC MCH Leadership Program, A Retreat to Advance Maternal and Child Health Scholarship and Practice — Chicago** (http://www.uic.edu/sph/mch/mch_leadership_conference.htm)
- 16-20 **Georgetown University Training Institutes 2008: Developing Local Systems of Care for Children and Adolescents with Mental Health Needs and their Families — Nashville, TN** (http://gucchd.georgetown.edu/programs/ta_center/TrainingInstitutes/)

greater exposure to community training during residency and expectations for greater involvement translate into enhanced involvement once pediatricians are established in their careers." (MCH Alert, 11/16/2007)

Minkovitz CS, O'Connor KG, Grason H, et al. 2007. Pediatricians' perspectives regarding community child health: Training, involvement, and expectations according to age. *Pediatrics* 120(5):1035-1043. Abstract available at <http://www.aap.org/research/abstracts/05abstract13.htm>.



Article Assesses Quality of Ambulatory Care Delivered to Children in the U.S.

"On the basis of medical record documentation, deficits in the delivery of indicated care to children (for which the overall adherence rate was 46.5%) are similar in magnitude to those previously reported for adults (for which the overall adherence rate was 54.9%)," write the authors of an article published in the October 11, 2007, issue of *The New England Journal of Medicine*. Problems with the quality and safety of health care in the United States have been widely documented, but this evidence comes mainly from studies focused on adults and the elderly. In the study described in this article, the authors sought to answer five questions:

1. How good is the quality of care for children overall?
2. Does quality of care vary according to type of care (care for acute or chronic medical problems or preventive care)?
3. Does quality vary across the continuum of care functions (screening, diagnosis, treatment, and follow-up)?
4. Does quality vary according to mode of care

(history taking, physical examination, laboratory testing or radiology, medication, immunization, encounter, education, or counseling)?

5. Does quality vary according to type of clinical area?

The authors collaborated with the Community Tracking Study (CTS), conducted by the Center for Studying Health System Change. The CTS recruited households in 12 metropolitan areas from across the country. The communities were randomly selected to represent metropolitan areas with a population of more than 200,000. Researchers telephoned participating households that had a child enrolled in the CTS and interviewed the adult in the household who was most familiar with the child's medical history to obtain medical information and consent to request copies of the child's medical records from all health professionals seen during the 2-year period before the date of interview. A total of 1,553 children were included in the analysis.

Authors' findings:

- On average, children received 46.5% of the indicated care for acute medical problems, 53.4% of the indicated care for chronic medical conditions, and 40.7% of the indicated preventive care.
- Adherence rates for the continuum of care functions ranged from 37.8% of the indicated screening processes to 65.9% of indicated treatment processes.
- In the group of 11 clinical areas for which data for at least 50 children were included in the composite-score calculation, the rates of documented adherence ranged from 92.0% for indicated care for upper respiratory tract infection, to 34.5% for indicated preventive care for adolescents.

The authors conclude that "expansion of access to care through insurance coverage, which is the focus of national health care policy related to children, will not, by itself, eliminate the deficits in the quality of care." (MCH Alert, 10/19/2007)

Mangione-Smith R, DeCristofaro AH, Setodji CM, et al. 2007. The quality of ambulatory care delivered to children in the United States. *The New England Journal of Medicine* 375(15):1515-1523. Abstract available at <http://content.nejm.org/cgi/content/full/357/15/1515>.

CACSHCNEWS

Previous issues available at
[http://uscucedd.org/CACSHCNEWS/
tabid/665/Default.aspx](http://uscucedd.org/CACSHCNEWS/tabid/665/Default.aspx)

House Rebuffed
Again on Override of
SCHIP Funding Expansion Veto

CaCShcNews readers will remember that our last Policy Corner discussed the October 2007 failure of the U.S. House of Representatives to override President Bush's veto of bipartisan legislation to expand the State Children's Health Insurance Program (SCHIP, in California called the Healthy Families Program) as part of the program's reauthorization process. In response, Congress passed a continuing resolution to fund the program at its current level and marshaled support for another run at the veto.

This January the House failed again to override the President's second veto. The bill (HR 3963) would have expanded SCHIP by \$35 billion over five years to \$60 billion, with the expansion financed by an increase in tobacco taxes, including a 61-cent hike of the cigarette tax to \$1.00 per pack. Supporters said the money would be enough for SCHIP to cover 10 million children, about 4 million more than it covers now. The failed override does not endanger the existing program or current enrollees, as the law the President signed last year keeps SCHIP running through the end of March 2009 with enough funds to maintain coverage at current enrollment levels.



It is unclear how this funding will affect new applicants to the program. MRMIB, the California State Board that oversees the Healthy Families Program, has said that our state program needs \$1.23 billion in federal funds in Federal Fiscal Year 2008 to support the existing caseload and projected new enrollees-- \$440 million more in federal funds than the feds provided in FFY 2007. Emergency regulations were approved by MRMIB in November that would permit the Board to disenroll children from the program and start a waiting list for new applicants, if the Board decides that fiscal prudence requires it. The regulations appear to be on hold, with the program continuing to enroll as usual, at least for now. (See the related story on proposed state budget cuts, including cuts to Healthy Families.) Meanwhile, Congressional Democrats, sensing a powerful political issue in a presidential election year, may mount further veto override attempts before November.



Federal & State Updates

State Health Care Reform Dead – Or Is It?

As everyone knows by now, AB X1 1 – the joint legislative vehicle embodying state health care reform – was defeated in the Senate Health Committee on January 28th. The bill would have created a complex new system marrying the Governor's original health care reform proposal, released last January, with the Assembly and Senate legislative vehicles for reform. The bill's defeat made national news, as the California proposal, which was adapted from the Massachusetts state plan, was being watched as a possible template for other states and the nation. The reasons for the bill's death are as complex as the proposal itself, ranging from concerns that it went too far to disappointment that it didn't go far enough. (For example, the Senate Health Committee chair, Senator Sheila Kuehl, has her own health care reform bill, SB 840, which would create a state-sponsored single payer system with universal coverage, and voted against AB X1 1.) The proposal's financing may have been the final nail in the coffin, after the nonpartisan Legislative Analyst's Office released a report suggesting that the plan's financial foundations were unstable. The Governor and Assembly Speaker Nunez issued statements reiterating their interest in continuing to pursue reform, while Senate President Perata said that the bill was overshadowed by the state's \$14.5 billion budget deficit and the Administration's proposed cuts in health care. There is talk of perhaps splitting the reform bill into sections or pursuing expansion of children's coverage separate from adults over the coming year. CaCShcNews will carry updates on this issue as events unfold.



Proposed State Budget Addresses Big Deficit with Big Cuts to Health

As noted above, the State Department of Finance is projecting a budget deficit of \$14.5 billion over the two-year period including this state fiscal year (7/1/06 – 6/30/07) and next fiscal year (7/1/08 – 6/30/09). (Note the just-released Legislative Analyst's Office review of the budget puts the projected deficit at \$16 billion over the two-year budget period.) On January 10th the Governor released a proposed budget that would meet this deficit by enacting 10% cuts in many departments, including Health Care Services, Mental Health, and Social Services. Many of the cuts are proposed to take effect this year while other cuts would be enacted as of July 1st, the start of the new fiscal year. Complicating

(Continued next page)

the picture is the Governor's proclamation of a fiscal emergency under Proposition 58. Prop 58, passed in 2004, allows a governor to call the Legislature into special session to deal with "substantial revenue decline or expenditure increase" via legislation to address the emergency. If the Legislature fails to pass and send to the Governor legislation to address the emergency by the 45th day after the proclamation, the Legislature may not act on any other bill-- i.e. the Legislature ceases to function until it acts on the fiscal emergency bill. The fiscal emergency was declared January 10th, on release of the proposed budget, putting the end of the 45 day period at about February 24th.

Proposed Cuts in Current Fiscal Year

The Governor proposed a total reduction of \$181.1 million for health and human services in the current fiscal year, i.e. between March 1 and June 30. Some of the cuts proposed to take effect this fiscal year (additional cuts are proposed in other health-related programs not listed below):

Health Care Services:

- 10% cut in provider reimbursement for Medi-Cal/CCS/GHPP physicians and those hospitals without Medi-Cal contracts
- Elimination of nine adult Medi-Cal benefits (e.g. dental, psychology, optometry)

Mental Health:

- Rate cuts to mental health managed care plans
- Rate cuts to EPSDT/mental health providers

Social Services:

- Cuts in CALWorks (cuts in and eventual elimination of child grants if parent doesn't comply with work requirements)
- Suspension of state SSI/SSP COLAs
- Reduced rates for foster care homes and adoption assistance

The Senate and Assembly already have reviewed and taken action on some of the cuts proposed for implementation in the current fiscal year, and the health-related cut approved so far is the 10% cut in provider reimbursement for Medi-Cal, CCS, and Genetically Handicapped Persons Program services, including physicians and non-contract hospital services. Under the Legislature's action, the cuts will not take effect until July 1st, the start of the new fiscal year.

Proposed Budget for Fiscal Year 2008-2009

The proposed budget for next year is predicated on passage of the Governor's budget cuts in the current year, many of which have not been approved by the Legislature. The proposed budget would extend cuts from this year and make additional cuts, for a total reduction of \$2.7 billion in State General Funds for health

and human services.

The cuts have been billed by the Administration as equally distributed, 10% across-the-board reductions, but, according to the Senate Budget Committee, cuts to health and human services represent 29% of all overall reductions in the next budget year. Here are some of the proposed reductions (additional cuts are proposed in other health-related programs not listed below):

Health Care Services:

- Continued 10% cut in provider rates (Medi-Cal/CCS/GHPP/CHDP physicians and non-contract hospital service)
- Elimination of 12-month continuous Medi-Cal eligibility for children and reinstatement of quarterly Medi-Cal recertifications for children and adults
- Continued elimination of adult Medi-Cal benefits (e.g. dental, psychology, optometry)
- Cuts in Medi-Cal payments to counties, including 10% cut in administrative base that supports county costs for Medi-Cal eligibility and administrative funding for CCS and CHDP
- Cuts of 10% and payments to CCS county programs for administrative funding for non-Medi-Cal patients and MTU.

Healthy Families:

- Reduced rates to Healthy Families plans by 5%
- Increased premiums for families with incomes over 150% of Federal Poverty Level (premiums for families at 150 – 200% of FPL would increase from \$9 per child per month to \$16 per child per month; premiums for families at 200 – 250% of FPL increase from \$15 per child per month to \$19 per child per month)
- Increased co-pays for non-preventive services for families with incomes over 150% of FPL from \$5 per visit to \$7.50
- Cap on annual dental benefit at \$1000 (would affect approx. 5% of enrollees)

Mental Health:

- Continued rate cuts to mental health managed care plans
- Continued rate cuts to EPSDT/mental health providers and require prior authorization for day treatment for more than 6 months

Social Services:

- Continued cuts in CALWorks (cuts in and eventual elimination of child grants if parent doesn't comply with work requirements)
- Reduced Child Welfare Services allocations to counties

(Continued next page)

- Continued reduced rates for foster care homes and adoption
- Suspension of state SSI/SSP COLAs
- Reduced hours of non-medical services through IHSS

Regional Centers:

- Extension of existing Regional Center vendor rate freezes (set to sunset 6/08)
- Expansion of existing family costs for day care, respite care, and camps



Impact of Proposed Cuts

The impact of these cuts on children and families will be profound. Just to cite a few examples:

- The provider reimbursement cuts will further threaten the currently fragile network of health care providers still serving children with special health care needs and may result in longer waits for service in mental health and pediatric specialty care.
- The loss of one-year continuous Medi-Cal eligibility for children and reinstatement of quarterly Medi-Cal recertifications will result in more children losing their coverage.
- Cuts to administrative funding for CCS and CHDP may mean lost staff, including those providing care coordination and other services for children.
- Higher Healthy Families premiums and co-pays may result in families dropping coverage or not using services as often as needed.
- Healthy Families plan rate reductions probably will

translate to health provider rate cuts.

- Cuts to counties for administering Medi-Cal — coupled with four times the work load with the new recertifications — may result in delays processing Medi-Cal applications.

And, of course, we must remember that in the health arena, cuts in State General Fund dollars translate into much larger cuts in overall spending as a result of the loss of federal matching funds: for every state dollar cut, California loses at least one federal dollar and sometimes more.

While the Governor has proposed only spending cuts to address the deficit, the nonpartisan Legislative Analyst's Office (LAO) — the state office charged with impartial fiscal and policy review — has called for a mixed approach that would result in a balanced (the LOA calls it "precariously" balanced) budget by 2009 via the following strategies:

- targeted reductions;
- reductions in or elimination of ineffective or non-essential programs;
- potential additional realignment of more programs to the local level; and
- increased revenue through reductions in or elimination of specific tax credits.

The LAO analysis of the state budget was released on February 20th and is available on their website. If you are concerned about the proposed budget, stay informed through websites such as the following:

- California Budget Project: www.cbp.org
- Support for Families legislative website: <http://www.supportforfamilies.org/legislative/current.html>
- 100% Campaign (Children Now/Children's Defense Fund/Children's Partnership): <http://www.100percentcampaign.org/>
- California Senate Budget Committee: http://www.senate.ca.gov/ftp/sen/committee/STANDING/BFR/_home1/PROFILE.HTM
- California Assembly Budget Committee:

Policy Corner

For more information on federal or state issues, contact Laurie Soman at 510-540-8293, LSoman6708@aol.com.



Addressing the Needs of Young Children in Child Welfare: Part C Early Intervention Services

The Part C referral provisions in the Child Abuse Prevention and Treatment Act (CAPTA) and the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) are designed to help children under age 3 involved in substantiated cases of abuse or neglect. The provisions connect child welfare staff to early intervention service providers who can assist in assessment, service delivery and permanency planning. This Children's Bureau bulletin looks at how states are implementing the new referral provisions and offers lessons learned. Available at <http://www.childwelfare.gov/pubs/partc/index.cfm> (CFK Weekly, 9/19/2007)



New Report on Federal Investment in Children

Urban Institute According to the Urban Institute report *Investing in Children*, the Federal investment in children is likely to decline markedly within the next decade. The share of the federal budget for programs that enhance kids' future productivity or income is forecast to drop from 1.6 percent of the gross domestic product in 2006 to 1.3 percent by 2017 under current policies. Available at <http://www.urban.org/publications/411539.html> (CFK Weekly, 9/19/2007)



Social Security Announces 2.3 Percent Benefit Increase for 2008

The Social Security Administration has announced that monthly Social Security and Supplemental Security Income benefits for more than 54 million Americans will increase 2.3 percent in 2008. The 2.3 percent Cost-of-Living Adjustment (COLA) will begin with benefits that nearly 50 million Social Security beneficiaries receive in January 2008. Increased payments to more than 7 million Supplemental Security Income beneficiaries began on December 31. Information about Medicare changes for 2008 can be found at www.cms.hhs.gov. The press release can be found at <http://www.socialsecurity.gov/pressoffice/pr/2008cola-pr.htm>. (TATRA Center Reference Points, 10/21/2007)

National Summit on Preconception Health and Health Care

The second National Summit on Preconception Health and Health Care, *Improving the Health of Women and Infants Before, Between, and Beyond Pregnancy*, was held on October 29-31, 2007 in Oakland, California. The event was hosted by the Preconception Council of California, March of Dimes California Chapter, California Department of Public Health - Maternal Child and Adolescent Health (MCAH) Program, Sutter Health, Kaiser Permanente, University of California Berkeley, Alameda County Healthy Start Program, and the Los Angeles Preconception Care Project in partnership with the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration, and the CDC Preconception Care Initiative Steering Committee. The purpose of the summit was to gather public health, clinical medicine, and community-based organization leaders and advocates from around the U.S. and the world to advance strategies for implementing the national recommendations for preconception health published by the CDC in April 2006.

A variety of opportunities exist for individuals who are interested in improving preconception health and health care. One such opportunity is joining the work of the Preconception Care Council of California, a statewide forum for planning and decision-making for the integration, development, and promotion of optimal health before pregnancy. The Council's mission is to "engage individuals, communities, and policymakers to optimize the health and well-being of women and their partners, leading to healthier infants and families." Council members have developed provider education tools, advocated for preconception-related bills in the legislature, and clarified the role of existing MCAH programs in preconception health promotion. To become involved in the work of this group, contact Kiko Malin at the March of Dimes at (415) 217-6373.

Additionally the CDC has formed three workgroups as part of its Preconception Health and Health Care Initiative: a clinical workgroup, a public health workgroup, and a consumer workgroup. For information about these workgroups please visit <http://www.cdc.gov/ncbddd/preconception/default.htm>.

For additional information about the summit and to view PowerPoint presentations and video recordings of all conference lectures, visit <http://cdc.confex.com/cdc/pcs2007/techprogram/MEETING.HTM>. (PACLAC Perinatal Care Matters, January 2008)

The Next Generation of Antipoverty Policies, Fall 2007 Journal Issue

Reducing poverty is by no means an impossible task, according to the latest issue of the Princeton/Brookings *Future of Children*. The authors say strategies should use a combination of work requirements and social welfare policies. They stress four short-term policies: supplementing the earnings of low-wage workers, strengthening work incentives for fathers, providing good child care and ensuring health care for children and families. They also propose four long-term aims: reducing non-marital births, increasing preschool, improving public education and providing support to chronically poor mothers. Available at http://www.futureofchildren.org/pubs-info2825/pubs-info_show.htm?doc_id=521579. (CFK Weekly, 9/26/2007)



NCCP: Too Many Kids in Low Income Families

The National Center for Children in Poverty's latest demographic data reveal that 39 percent of children in the United States live in low-income families – a level that remains unchanged from the previous year. Check out the updated fact sheets, state profiles and trend book. Available at http://nccp.org/publications/pub_787.html. (CFK Weekly, 9/26/2007)

Unnatural Causes: Is Inequality Making Us Sick? Documentary Film

Airing on PBS on March 27 and April 3, 10 and 17 at 10:00 p.m., this broadcast will launch the public impact campaign and foster media attention on the root causes of health inequities in our country--and what we can do to address them. Ultimately, the power of this series depends on how *you* can use the DVD and companion tools over the next year to advance your own health equity work through internal trainings, community forums, policy briefings and other events. The series will be released on DVD March 2008 along with a companion website — <http://www.unnaturalcauses.org>.

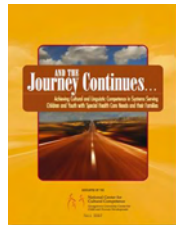


is a four-hour documentary series produced by California Newsreel with Vital Pictures, Inc. Presented for PBS broadcast by the National Minority Consortia of Public Television. Public Engagement Campaign in association with the Joint Center Health Policy Institute.

Cultural Competency & Patient Communication

Monograph Provides Insights on Implementing Cultural and Linguistic Competence in Organizations Addressing Maternal and Child Health

And the Journey Continues: Achieving Cultural and Linguistic Competence in Systems Serving Children and Youth with Special Health Care Needs and Their Families highlights experiences in infusing cultural and linguistic competence into the policies, structures, and practices of selected state programs. The monograph, developed by the National Center for Cultural Competence (NCCC) at Georgetown University with support from the Maternal and Child Health Bureau, presents stories collected from 23 Title V Children with Special Health Care Needs programs. Also included are key lessons that NCCC faculty, staff, and consultants have learned about providing program guidance, as well as an analysis of the various aspects of linguistic and cultural competence described in each state's story. A list of references and state and territorial contacts is included. The monograph is available at <http://www.gucchdgeorgetown.net/NCCC/journey>. (MCH Alert, 12/7/2007)



HRSA Unveils Free Online Literacy Training for Health Professionals

Unified Health Communication 101: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency is a free online learning experience designed to help health professionals improve their patient-communication skills, increase their awareness and knowledge of factors that affect their communication with patients, and implement patient-centered communication practices. The course, developed by the Health Resources and Services Administration, comprises five modules and is estimated to take a total of 5 hours to complete. The course may be completed at the user's own pace and may be taken for credit (CEU/CE, CHES, CME, and CNE) or not for credit. More information, including registration instructions, is available at <http://www.hrsa.gov/healthliteracy/training.htm>. (MCH Alert, 12/14/2007)

Analysis Examines Socioeconomic Disparities in U.S. Childhood Mortality

"The data presented here underscore the increasingly important role of area socioeconomic deprivation in producing health disparities in US childhood mortality," state the authors of an article published in the September 2007 issue of the *American Journal of Public Health*. Because childhood mortality rates are the lowest of all age-specific mortality rates and because national mortality statistics lack relevant socioeconomic information, socioeconomic disparities in childhood mortality are rarely documented, particularly in a temporal fashion. The article presents an analysis of changing socioeconomic inequalities in U.S. childhood mortality in the past three decades.

Socioeconomic data from the 1990 decennial census were linked with data from the National Vital Statistics System to obtain county- and cause-specific childhood death data for the period 1969 through 2000.

Each of 3,097 counties was assigned to one of five deprivation quintiles, ranging from the most socioeconomically deprived to the least socioeconomically deprived. Trends in childhood mortality by deprivation were computed annually and across different time periods, after adjusting for the effects of age, gender, and race and ethnicity.

Authors' findings:

- Compared with children in the least deprived socioeconomic quintile, the mortality rate for children in the most deprived socioeconomic quintile was 52% higher in 1969-1971, 65% higher in 1988-1990, and 86% higher in 1998-2000.
- In 1969-1971, children in the most deprived socioeconomic quintile had a 69% higher rate of unintentional injury mortality than did children in the least deprived socioeconomic quintile. The differential widened to 177% in 1998-2000.
- In 1998-2000, children in the most deprived socioeconomic quintile had a 159% higher homicide rate than did children in the least deprived socioeconomic quintile. The rate for the most deprived socioeconomic quintile was only 76% higher in 1969-1971.
- In 1969-1971, children in the most deprived socioeconomic quintile had a 13% higher birth defects mortality rate than did children in the least deprived socioeconomic quintile. The differential widened to 44% in 1998-2000.

"Narrowing the socioeconomic gap in child mortality may require designing strategies that are not only aimed at improving child health services but also aimed at mitigating the effects of inequalities in material and social living conditions," conclude the authors. (*MCH Alert*, 9/7/2007)

Singh GK, Kogan MD. 2007. Widening socioeconomic disparities in US childhood mortality. *American Journal of Public Health* 97(9):1658-1665. Abstract available at <http://www.ajph.org/cgi/content/abstract/97/9/1658>.



Policy Implications of Disparities in Access and Quality

The Robert Wood Johnson Foundation produced a synthesis of rigorous national studies that examine the prevalence and causes of disparities in access to and quality of health care, and the policy implications of these findings. The report finds that racial and ethnic disparities in access to and quality of care are pervasive, but not universal. The largest disparities in access are for Spanish-speaking Hispanics. Insurance coverage, income and other factors explain a portion of the disparities, but racial and ethnic gaps in access and quality remain after accounting for these conditions. After adjusting for other factors, disparities in recommended processes of care—the appropriate use of screening tests, medications and laboratory tests—tend to be small or nonexistent. Disparities are larger for intermediate outcomes, newer therapies and invasive outcomes, even after adjusting for other factors. http://www.rwjf.org/pr/synthesis/reports_and_briefs/issue12.html?c=EMC-CA142 (*AMCHP Pulse for Partners*, 9/28/2007)



Urban Health Comparisons

The *Big Cities Health Inventory 2007: The Health of Urban USA*, from the National Association of County and City Health Officials, provides city-to-city comparisons of leading measures of health in the 54 largest metropolitan areas in the U.S. Available at <http://www.naccho.org/topics/crosscutting/documents/BCHI07COLORFINAL.pdf> (*AMCHP Pulse for Partners*, 12/14/2007)



Practice-Based Care Coordination: A Medical Home Essential

This article in *Pediatrics* finds that children, youth and families benefit from the organization of critical information into written care summaries and action plans. If primary care pediatricians, family physicians and internists are to achieve optimal health care quality and improve existing health care delivery, care coordination will be an essential contributing process to their team approach. It includes several national health policy recommendations that identify care coordination as a cross-cutting intervention to fill the gap between what exists and what is needed in health care today. Available at <http://pediatrics.aappublications.org/cgi/content/abstract/120/3/e723?etoc>. (AMCHP Pulse for Partners, 9/28/2007)



Support for Medical Home to Be Focus of Upcoming Bill

The patient-centered medical home received another boost on Capitol Hill. Senate Assistant Majority Leader Richard Durbin, R-Ill., and Sen. Richard Burr, R-N.C. plan introduced a bipartisan bill in October 2007 that would give states money to establish patient-centered medical home demonstration projects for Medicaid and State Children's Health Insurance Programs (SCHIP). For the full news article, go to <http://www.aafp.org/online/en/home/publications/news/news-now/government-medicine/20070925medhomebill.html>. (Champions eNewsletter, 10/2/2007)

About the bill:

This bill is in the first step in the legislative process. Introduced bills go first to committees that deliberate, investigate, and revise them before they go to general debate. The majority of bills never make it out of committee. Keep in mind that sometimes the text of one bill is incorporated into another bill, and in those cases the original bill, as it would appear here, would seem to be abandoned. (GovTrack.us. S. 2376--110th Congress (2007): Medical Homes Act of 2007, *GovTrack.us (database of federal legislation)*, accessed Feb 16, 2008) To view the bill in full text, go to <http://www.govtrack.us/congress/bill.xpd?bill=s110-2376>.

Data Released from the National Survey of CSHCN



On November 28, 2007, the National Center for Health Statistics, State and Local Area Integrated Telephone Survey (SLAITS) released microdata from the 2005-2006 National Survey of CSHCN. The survey data can be used to develop updated estimates of the prevalence of special health care needs among children, both nationally and within each state. This survey also explored the extent to which children with special health care needs have medical homes, adequate health insurance, and access to needed services. Other topics include functional difficulties, care coordination, satisfaction with care, and transition services.

The data files are posted at:

ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/slait_s_cshcn_survey/2005_2006/Datasets/

Visit the SLAITS website at:

http://www.cdc.gov/nchs/slait_s.htm

Also visit the Data Resource Center for access to national and state data at:

<http://www.childhealthdata.org/content/Default.aspx> (Champions eNewsletter, 12/4/2007)

AHRQ Releases 4.0 Version of CAHPS™ Item Set for Children with Chronic Conditions

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Consortium has updated the *Item Set for Children With Chronic Conditions* so that it is consistent with the 4.0 version of the CAHPS Health Plan Survey. The revised item set has been integrated into the *Child Medicaid Questionnaire*, which is available in the *CAHPS Health Plan Survey and Reporting Kit*: <https://www.cahps.ahrq.gov/cahpskit/Healthplan/HPChooseQx2.asp>. A Spanish translation of these items will be available by early fall. For more information about this item set, go to https://www.cahps.ahrq.gov/CAHPSkit/files/102_Children_with_Chronic_Conditions_Set.htm. (AHRQ *Child and Adolescent Health Listserv*, Volume 9, Number 12 October 9, 2007)



For an overview of the CAHPS Program, go to https://www.cahps.ahrq.gov/content/cahpsOverview/Over_Program.asp?p=101&s=12.



Authors Examine Unmet Mental Health Needs Among Children with Special Health Care Needs

"Although perceived need for mental health treatment was greatest among CSHCN [children with special health care needs] with a chronic EBDP [emotional, behavioral, or developmental problem], mental health needs were also reported for 9 [percent] of [U.S.] children with chronic medical conditions that are not emotional or behavioral in nature," state the authors of an article published in the November-December 2007 issue of *Ambulatory Pediatrics*. The article describes rates of need among a national sample of CSHCN, distinguishing children with chronic EBDPs from children with primarily medical chronic conditions. The authors specifically examine whether race and ethnicity and language are associated with unmet need for the child and family members who have a mental health need attributed to the child's special health care needs. Additional possible factors associated with unmet need for children and family members are also explored.

Data for the study were drawn from the National Survey of Children with Special Health Care Needs, which included a sample of 38,866 CSHCN (ages 17 and younger) and provided information about functional limitations, impact of the condition on the family, sociodemographics, health insurance, and access to care. Dependent variables included parental report of (1) the child's need for mental health treatment or counseling, (2) family member need for treatment or counseling resulting from the child's special health care needs, (3) the child's unmet need for mental health services, and (4) family members' unmet need for mental health services. Covariates included health condition characteristics (type, impact, and stability of the child's condition), sociodemographics (gender, family income, maternal education), presence and type of health insurance, and medical home characteristics (having a usual source of care and a regular clinician). The analysis examined rates of need and unmet need for children and family members overall and by presence of an EBDP.

Authors' findings:

- Having a higher-impact condition and experiencing family burden were each associated with greater mental health need.
- Race and ethnicity were associated with need only among children with a chronic EBDP.
- In a multivariate analysis of unmet need, greater condition impact, lower household income, and lacking insurance were each associated with higher odds of unmet need for CSHCN both with and without a chronic EBDP.
- Unmet need was greatest for CSHCN who lack both a usual source of care and a personal doctor or nurse.

"Our study shows that unmet need for mental health treatment [or] counseling is greatest among CSHCN with



chronic emotional, behavioral and developmental problems but also affects children with primarily medical chronic conditions and family members of CSHCN," state the authors. They add that "underserved populations, as indicated by greater parental perception of unmet need, include African-American CSHCN and family members of Hispanic children with potential limited English profi-

Inkelas M, Raghavan R, Larson K, et al. 2007. Unmet mental health need and access to services for children with special health care needs and their families. Ambulatory Pediatrics 7(6):431-438. Abstract available at <http://www.ambulatorypediatrics.org/article/PIIS1530156707001438/abstract>.



Access to Specialty Care and Medical Services in Community Health Centers

This Commonwealth Fund-supported study reveals that community health center (CHC) patients – particularly those who are uninsured or covered by Medicaid – have difficulty obtaining off-site specialty services, including referrals to medical specialists and mental health and substance abuse treatment. In interviews with medical directors of federally qualified CHCs, the research team found that the most common barriers to care are providers' unwillingness to take Medicaid patients or those without insurance, the inability of patients to pay for services up front, and inadequate coverage for needed services. http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=564080&#doc564080. (AMCHP Pulse for Partners, 11/9/2007)



Commission Prepares Report for Legislative Action

This resource guide, *How Many Uninsured? A Resource Guide for Community Level Estimates*, provided by The Access Project (TAP), provides detailed analysis of different approaches to data collection. The mission of TAP is to strengthen community action, promote social change, and improve health, especially for those who are most vulnerable. For additional information and to download a copy of the report, go to: <http://www.accessproject.org/medicaid.html>. (Champions eNewsletter, 11/6/2007)

CRISS Holds Regional Workshop on Care Coordination

CRISS (Children's Regional Integrated Service System) presented a very successful regional workshop promoting local care coordination strategies last fall. The workshop, entitled *Implementing Innovative Care Coordination Strategies for Children with Special Health Care Needs*, brought together more than 90 participants from over fifteen counties in the Greater SF Bay Area. The workshop is part of a two-year effort to bring together representatives from county mental health, regional centers, and special education with the CRISS membership of family support organizations, CCS programs, and pediatric hospitals and organizations. Regional meetings of these multi-disciplinary groups convened by CRISS have focused on identifying feasible strategies to improve care coordination across multiple systems for children with special needs. The goal of the fall workshop was to introduce participants to successful models of care coordination for these children that have been implemented and are operating in our region.

Workshop keynote speakers Devon Dabbs and Sophia Schultz of the Children's Hospice and Palliative Care Coalition presented exciting information on the palliative care approach to care coordination as a possible model for other children with special health care needs. The workshop also included intensive breakout sessions showcasing three county-wide care coordination models for young children with special needs that have been implemented successfully. These models included an integrated system for behavioral and developmental care for children birth to five; medical home projects focused on pediatric practices and clinics serving children with special needs; and a multi-agency roundtable to ensure successful referrals and coordinate care for children with special needs. The in-depth breakouts provided practical information to assist attendees in organizing these models in their own communities. More information on the workshop, including materials from the keynote speakers and the breakout presentations, is available from Laurie Soman, CRISS Project Director, at LSoman6708@aol.com.



Medicaid HCBS Recipients Are Increasingly Likely To Live With Parent Or Other Relatives

A study by Charlie Lakin et al. published in the October issue of the journal, *Intellectual and Developmental Disabilities*, shows that the number of people with intellectual disability receiving Medicaid Home and Community Based Services (HCBS) while living with family members is an estimated 224,264 individuals as of June 30, 2006, 17 times higher than in June 1999. A notable policy trend that corresponds with this increased reliance of family-based living is the growth of Medicaid Supports Waiver programs. Although HCBS Supports Waivers limit total expenditures to amounts that are typically considerably less on average than is provided in the regular HCBS program, it also provides greater flexibility to the individuals and families enrolled. To review the study, go to http://www.aaid.org/Reading_Room/pdf/HCBSOct07IDD.pdf. (TATRA Center Reference Points, 11/22/2007)



Issue Brief Focuses on Use of Telemedicine in California to Meet Children's Health Care Needs

Meeting the Health Care Needs of California's Children: The Role of Telemedicine informs leaders and the public of how telemedicine, when applied appropriately, can address the health care needs of children in California, particularly children from families with low incomes who live in medically underserved areas. The issue brief is the third in the Digital Opportunity for Youth series produced by The Children's Partnership. Content includes (1) an overview of the benefits of telemedicine for children and families, health systems, and communities; (2) the challenges associated with the successful adoption of telemedicine; and (3) recommendations for ensuring that telemedicine reaches its full potential in meeting the health care needs of California's most vulnerable children. The use of telemedicine is specifically illustrated in the following areas: emergency and critical care, oral health, vision screening, mental health, children with special health care needs, home health care, telepharmacy, child abuse evaluations, educating families, supporting families, supporting rural health professionals, providing medical education, disease management, caring for children where they are located, and language translation. Information on the history of telemedicine and additional resources from the Children's Partnership are included. The issue brief is available at <http://www.childrenpartnership.org/AM/Template.cfm?Section=Home&Template=/CM/ContentDisplay.cfm&ContentID=11343>. (MCH Alert, 9/28/2007)



Study Provides Information on Inclusion of Assistive Technology in the Curricula of Health Professional Training Programs

"The use of AT (assistive technology)/AT services improves the quality of life for children with disabilities and increases their access to school and community activities but remains underutilized," state the authors of an article published in the winter 2007 issue of the Journal of Allied Health. AT and AT services that enable people with disabilities to participate in society are increasingly part of health professionals' practice. How well training programs for health professionals prepare participants to provide AT and AT services is unclear. The study described in this article examined the extent to which AT and AT services were included in the curriculum content of academic programs that provide training for professionals in the fields of occupational therapy (OT), physical therapy (PT), special education (SE), and speech-language pathology (SLP).

(Continued next page)

Resources

Three Resources for Providers Who Work with CYSHCN

Drawn from three recently published books based on the latest research on comprehensive care, Brooks Publishing provides resources (a comparison chart of pain assessment tools, a recommendation chart for providers to help parents optimize the system of care for their child, and a case study illustrating mother and son perspectives on the health care transitioning process) for enhancing the quality of care for CYSHCN. To download these resources, visit: <http://www.brookspublishing.com/newsletters/dd-article-0907.htm>. (TATRA Center Reference Points, 10/21/2007)

Resource for Families of CYSHCN Who Use HMO's

The Independent Living Resource Center San Francisco is providing copies of *California's HMO Guide* to help families make informed decisions about health care coverage for their families. It provides answers to common questions, information about your rights, and where to go to get more help. To receive a copy of the *Guide* contact the center at 415-543-6222. They can also assist families and youth with questions and help them navigate the system. To access a copy electronically, go to http://www.opa.ca.gov/english/about/consumer_information/HMO_Guide.aspx.

Strengthening the Community System of Care for CYSHCN

This workbook by Suzanne Bronheim, Ph.D. and Tom Tonniges, M.D. discusses the integration of the health care system that serves CYSHCN and their families with broader community systems. It can be accessed at http://gucchd.georgetown.edu/programs/ta_center/object_view.html?objectID=3919. (Champions eNewsletter, 10/16/2007)

New Fact Sheet on SCHIP Reauthorization History

The Kaiser Commission on Medicaid and the Uninsured published the fact sheet *State Children's Health Insurance Program (SCHIP): Reauthorization History* which provides an overview of the 2007 reauthorization debate. To access electronically, go to <http://www.kff.org/medicaid/upload/7743.pdf>.

As part of a major initiative on the use of AT and telehealth practices by allied health professionals and SE professionals, in fall 2004 an online survey was developed and sent via e-mail to program directors from all the accredited OT, PT, SE, and SLP professional training programs in the United States. The questionnaire consisted of 25 multiple-choice questions that solicited demographic information about the respondents and the programs and general information about the placement of AT and AT services content within the curriculum, as well as more specific course information. Respondents were also asked to identify the time devoted to nine specific AT and AT service topics related to children and adolescents.

Authors' findings:

- Of the 959 questionnaires that were sent, 153 were returned.
- Most of the SE programs granted bachelor's degrees; whereas most of the OT and SLP programs granted master's degrees. PT programs were about evenly divided between master's and clinical doctoral degrees.
- Nearly all the programs covered AT and AT services in their curricula, including all the OT programs, 94% of the PT programs, 96% of the SE programs, and 93% of the SLP programs.
- SLP programs reported spending the most time (more than 20 hours within the duration of the program) on AT content, while most PT and SE programs reported spending less than 20 hours. OT programs were about evenly divided between those spending 20 hours or less and those spending more than 20 hours. Of the programs that reported spending more than 20 hours, most spent 21-40 hours on AT and AT services content.
- Fifty percent of all the programs reported that only full-time faculty taught the courses that contained AT and AT services content. Other programs reported using both full-time and adjunct faculty to teach such courses.
- Coverage of pediatric-related AT topics varied by type of program.

The authors conclude that "to promote contemporary practice in the areas of AT/AT services, entry-level curricula should be designed to creatively expand and enhance instruction in this growing service area." (*MCH Alert*, 1/11/2008)

Brady RT, Long TM, Richards J, Vallin T. 2008. Assistive technology curriculum structure and content in professional preparation service provider training programs. *Journal of Allied Health* 36(4):183-192. Abstract available at <http://www.ingentaconnect.com/content/asahp/jah/2007/00000036/00000004/art00002>.

Resources (continued)

Investing in Maternal and Child Health: An Employer's Toolkit



The National Business Group on Health released *Investing in Maternal and Child Health: An Employer's Toolkit*. Developed by Business Group members and national experts in pediatrics and primary care, *Investing in Maternal and Child Health* provides concrete recommendations on employer sponsored health benefits and related programs for children, adolescents, and pregnant women. The toolkit presents strategies and tools to improve the health of children; adolescents; and women before, during, and after pregnancy. Toolkit highlights include:

- The business case for investing in maternal and child health.
- The Maternal and Child Health Plan Benefit Model, which outlines 34 evidence-informed health, pharmacy, vision, and dental benefits recommended by the Business Group.
- Actuarially-driven cost-impact assessments for each recommended benefit.
- Tools for developing a maternal and child health strategy, and evaluating the relationships between health outcomes and business performance.
- A benchmarking crosswalk that links Maternal and Child Health Plan Benefit Model recommendations to current HEDIS® measures.
- Guidance for employers on effective health communication, beneficiary education, and employee engagement.
- Education materials for beneficiaries about important maternal and child health topics.

To access the *Toolkit* electronically, go to www.businessgrouphealth.org/healthtopics/maternalchild/investing.

Voices from Home 2006 Now Available

This 65-page report provides information on activities of the Family Voices network of family and youth leaders in the states. Also included are highlights from the FV project, Kids as Self Advocates (KASA), data summaries, and charts of FV state initiatives and partners. Download from the Family Voices website (<http://www.familyvoices.org/pub/general/2006VoicesFromHomeFinal.pdf>) or order a hard copy through their catalog (<http://www.familyvoices.org/catalog.php>). (*Champions eNewsletter*, 11/6/2007)



Guide Lists Federal Resources for Youth Development

Published by America's Promise, a coalition of communities, organizations, businesses, and individuals supporting youth development programs, the *Guide to Federal Resources for Youth Development* provides information on federal funds available to support youth development programs. The guide lists more than 100 federal programs, including programs from the U.S. Department of Justice, which are cross-referenced to five core resources regarded as crucial to effective youth development. The *Guide* can be found at <http://www.americaspromise.org/uploadedFiles/AmericasPromise/Resources/Publications/Federal%20Funding%20Guide.pdf>. (TATRA Center, 10/8/2007)



New Study By World Health Organization Establishes Benchmark On Services And Resources Available For People With Intellectual Disabilities In 147 Countries

Atlas: Global Resources for Persons with Intellectual Disabilities from the World Health Organization is a benchmark study on the services and resources available for 95% of the world's population with intellectual disabilities in 147 countries. The study charts information in the following areas: terms and classification used to describe the disability; policy and legislation; financing and benefits; prevention efforts; health and social care services; human resources and training initiatives; research and information systems; and the role of NGOs and international organizations. *Atlas* is a solid first step towards understanding the world of intellectual disability. http://www.who.int/mental_health/evidence/atlas_id_2007.pdf. (AAIDD F.Y.I., 12/2007, Vol.7, No.12)

Resources (continued)

Family Friendly Checklist for Organizations

Family friendly is a term that applies to how and to what extent organizations involve, welcome, and value the participation of family members in every aspect of the organization. In an effort to increase awareness about family friendly organizations, the Ohio Family Support Council (FSCouncil) developed two editions of the *Family Friendly Check List*: one for families and one for staff in organizations. The check lists can help administrators determine if their organization has adopted family friendly practices and may give the staff of an organization ideas for improving family friendly approaches in specific areas. Administrators can also compare staff perceptions compared to family member responses. The check lists are available electronically: <http://olrs.ohio.gov/Other/checklistagency.pdf> (for agencies) / <http://olrs.ohio.gov/Other/checklistfamily.pdf> (for families). (TATRA Center, 12/18/2007)

DOE Releases Annual Report to Congress on Implementation of the IDEA

The U.S. Department of Education (DOE) has released the *27th Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act, 2005*. The Individuals with Disabilities Education Act (IDEA) requires that the Department of Education report annually on the progress made toward the provision of a free appropriate public education to all children with disabilities and the provision of early intervention services to infants and toddlers with disabilities. The report consists of two volumes. Volume 1 focuses on the children and students being served under IDEA. Topics covered include trends in numbers and percentages of infants, toddlers, preschool, and school-age children served; educational environments of preschool-age children; declassification of elementary school-age students; and characteristics of secondary students served for emotional disturbance. Volume 2 contains state-level data profiles. The report is available at <http://www.ed.gov/about/reports/annual/osep/2005/parts-b-c/index.html>. (CWD Working for Tomorrow Newsletter, November 2007, Vol. 7, Issue 10)