Performance and Outcome Data on the Implementation of Sexual and Reproductive Health Training and Education

Report to the Legislature

STATE OF CALIFORNIA

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Report to the Legislature

LEGISLATIVE MANDATE

Assembly Bill (AB) 172 Human Services (Committee on Budget, Chapter 696, Statutes of 2021) added subdivisions (j) and (k) to Section 16521.5 of the Welfare and Institutions Code requiring the California Department of Social Services (CDSS) to:

1. Compile and report annual performance and outcome data on the implementation of sexual and reproductive health training and education and the availability and use of sexual and reproductive health care services.

   A. Performance data shall include the total number and rate of all of the following:

      i. Social Workers and Probation Officers who have received the information described in subdivision (i) through a training program described in Section 16206.

      ii. Judges who have received the information described in subdivision (i) through a training program described in Section 304.7.

      iii. Group home administrators who have received the information described in subdivision (i) through a training described in subdivision (c) of Section 1522.41 of the Health and Safety Code.

   B. Outcome data shall include integrated data drawn from data maintained by CDSS, the State Department of Health Care Services (DHCS), and the State Department of Public Health (DPH). Outcome indicators used within each category may include, but are not limited to, measures found in the Core Set of Children's Health Care Quality Measure for Medicaid and CHIP (Child Core Set), and the Healthcare Effectiveness Data and Information Set (HEDIS), or measures developed using Medi-Cal, Family Planning Access, Care, and Treatment (PACT), and other administrative and claims data codes. Categories of outcome data shall include, but not be limited to, all of the following:

      i. The total number and rate of youth who gave birth, the number of live births, and the number of live births weighing less than 2,500 grams, such as indicator National Quality Forum (NQF) 1382 from

the Child Core Set.

ii. Maternal health outcomes for youth, such as indicator NQF 0471 from the Child Core Set.

iii. Prenatal care received by youth, including, but not limited to, date of initiation of prenatal care by trimester, frequency of service delivery, and type of provider of care, such as indicator NQF 1517 from the Child Core Set.

iv. Postnatal care received by youth, including, but not limited to, frequency, type of service delivery, and type of provider of care.

v. The total number and rate of youth who received contraceptive counseling, initiated contraception, and contraception method selected, such as indicators NQF 2902, 2903, and 2904 from the Child Core Set.

vi. Testing and treatment for sexually transmitted infection in youth, such as indicator NQF 0033 from the Child Core Set or Chlamydia Screening in Women Ages 16-20 (CHL- CH) from HEDIS.

vii. Frequency with which treatment of youth for sexually transmitted infection was followed by testing the same youth for reinfection within a one- to six-month time span.

viii. Receipt of annual wellness exam, such as Adolescent Well-Care Visits (AWC) from HEDIS, and frequency with which a general health exam or annual exam was paired with contraceptive counseling, pregnancy testing, sexually transmitted infection testing, or contraceptive initiation.

ix. Outcome data shall be disaggregated and reported by age, race, ethnicity, sexual orientation, gender identity, county, and county placement type, if possible.

x. Outcome data shall be reported in a way that does not identify individual youth and complies with all applicable state and federal confidentiality and privacy laws and regulations.

2. The department shall consult the Healthy Sexual Development Workgroup in the selection of additional performance and outcome data categories and measures to include in the report and in the development of the report

framework. Every three years, or earlier if needed, the department shall consult with DHCS and DPH and revise measures, if necessary.

A. The report shall be completed annually, commencing on January 1, 2023, and shall be posted on the department's internet website in a manner that is publicly accessible.

B. For the purposes of this statute, "youth" means foster youth 10 years of age and older and nonminor dependents.

3. The department shall adopt regulations to implement this section.

Additional copies of this report can be obtained from:

Office of Legislation

California Department of Social Services

744 P Street, MS 8-16-32

Sacramento, CA 95814

(916) 657-2623

This report may also be obtained on the California Department of Social Services website: Children and Family Services Reports

Executive Summary

Assembly Bill (AB) 172 Human Services (Committee on Budget, Chapter 696, Statutes of 2021) amended Section 16521.5 of the Welfare and Institutions Code to add subsections (j) and (k) requiring CDSS to release an annual report of performance and outcome data on the implementation of The Foster Youth Sexual Health Education Act, Senate Bill 89 (2017), starting on January 1, 2023. AB 172 further required the categories included in the outcome data, as well as the specific indicators used within each category, to be determined in consultation with the workgroup convened. This annual report summarizes: (1) foster youth reproductive and sexual health training completion for Social Workers, Probation Officers, judges, group home administrators, and resource families, as well as (2) foster youth access to health care services. Due to limitations imposed by the existing data sharing agreement, the foster youth receipt of comprehensive sexual health education outcomes data was unable to be added to this report. The Department anticipates including these outcomes in the future.

Preliminary Findings

- *Barriers to Care:* Youth in foster care face barriers to accessing care, including lack of social worker training and Social Workers not prioritizing such conversations, the youths' lack of comfort and conflicting beliefs about the role of the social worker, and youths' conflicting personal values and beliefs.
- *Sexual and Reproductive Health Training:* eLearning and Instructor-Led Training (ILT) on sexual and reproductive health were completed by providers across the state, and all counties except Los Angeles County track the trainings delivered using the California Social Work Education Center (CalSWEC) or through the California Welfare Training (CACWT).
- *Completed Sexual and Reproductive Health Training:* A total of 967 providers completed eLearning trainings and 223 completed ILTs. Most providers who completed the training were Social Workers (1,169) and Short-Term Residential Therapeutic Program Administrators and Group Home Administrators (1,145). A significant number of participants identified themselves as newly appointed judges (220) and none (0) were identified as Probation Officers.
    - Los Angeles County does not use the same tracking methods as other counties and reported that their training was initially instructor-led before the pandemic and later offered online. While CDSS is unable to verify how many Social Workers completed their training (eLearning vs. online), Los Angeles County has reported that a total of 2,999 Children Social Workers (CSW) and Supervising Children's Social Workers (SCSW) from Los Angeles County have completed the training.

- *Reproductive Health Services:* Services were summarized using selected Centers for Medicare & Medicaid Services (CMS) Child Core Set measures. For some services, foster youth had higher (better) rates of utilization compared to non-foster youth counterparts, while utilization was lower (worse) for foster youth for other measures.
- Youth in foster care had:
  - higher rates of well-care visits, chlamydia screening, and postpartum receipt of contraception within three days of delivery;
  - lower rates of timely prenatal care, postpartum care, and postpartum contraception received between 3 and 60 days of delivery;
  - although the differences were not found to be statistically significant, foster youth higher rates of live births weighing less than 2,500 grams and lower rates of low-risk caesarian delivery.

Background

On June 27, 2017, three new requirements for child welfare agencies and others serving foster youth related to the reproductive and sexual health care of foster youth went into effect, per SB 89 (Committee on Budget and Fiscal Review, Chapter 24, Statutes of 2017). The three requirements include: (1) an annual case plan review and documentation for foster youth aged 10 years or older and Non-Minor Dependents (NMDs), (2) the development of Statewide curriculum containing information and guidance about pregnancy prevention and reproductive and sexual health, and (3) new training requirements for professionals and caregivers; specifically, county child welfare workers, juvenile court judges, resource families, foster parents, group home administrators, and Short-Term Residential Therapeutic Program (STRTP) administrators.

To meet the training requirements, CDSS contracted with CalSWEC and developed a training titled, Sexual and Reproductive Wellness for Youth in Foster Care. As required by SB 89, the training addresses topics such as the sexual and reproductive rights of youth and young adults in foster care, duties and responsibilities of the case management worker, how to document sensitive health information in the case plan, contraception methods, and how to engage with youth and young adults. Additionally, curriculum was developed specifically for Resource Families to fulfill their eight annual hours of training required post approval and is available to the Foster Kinship Care Education (FKCE) programs statewide.

The Sexual and Reproductive Wellness for Youth in Foster Care training is available in two formats: (1) a one-day, in-person classroom training which is available to Social Workers, Probation Officers, and public health nurses and may be scheduled through the four Regional Training Academies, and (2) an online e-Learning course. The Sexual and Reproductive Wellness for Youth in Foster Care curriculum can be found on the CDSS webpage for SB 89 Available Trainings (ca.gov).

To meet the case plan requirements, CDSS has released guidance, best practices, and materials which include some of the following:

1. New Health Rights and Social Worker and Probation Officer Responsibility to Educate Foster Children and NMDs on Foster Youth Personal Rights All County Letter (ACL) 14-38 (June 16, 2014)

2. Reproductive and Sexual Health Care and Related Rights of Youth and NMDs in Foster Care All County Letter (ACL) 16-82

3. California's Plan for the Prevention of Unintended Pregnancy for Youth and NMDs, and released All County Letter (ACL) 16-88

4. New Mandates Regarding Case Plan Documentation and Training Related to Reproductive and Sexual Health Care Needs All County Letter 18-61

5. New and Revised Resource Materials Regarding Healthy Sexual Development and Pregnancy Prevention for Youth in Foster Care All County Letter (ACL) 18-44.

Healthy Sexual Development Workgroup

Authorized by Welfare and Institutions Code section 16521.5, CDSS convened the Healthy Sexual Development workgroup in February 2016 to develop and implement the Pregnancy Prevention Plan that addresses the needs of adolescent foster youth and address the issues of pregnancy prevention and reproductive and sexual health care. Some of the issues addressed include unintended pregnancies, the prevention of sexually transmitted infections, and ensuring that foster youth have access to information about sexual and reproductive health and services.

The 2016 workgroup included partners representing the following state agencies and other organizations: CDSS, Department of Health Care Services (DHCS), Child Welfare Directors Association, Chief Probation Officers of California, Foster Care Public Health Nurses, California Planned Parenthood Education Fund, Planned Parenthood Mar Monte, National Center for Youth Law, Children's Law Center of California, John Burton Foundation, Child Welfare Council, Children Now, California Youth Connection, and the Independent Living Program. The current workgroup includes partners representing the CDSS, Child Welfare Directors Association, Chief Probation Officers of California, California Department of Public Health (CDPH), California Department of Education, Foster Care Public Health Nurses, California Planned Parenthood Education Fund, Planned Parenthood Mar Monte, National Center for Youth Law, Children's Law Center of California, John Burton Foundation, Child Welfare Council, Children Now, California Youth Connection, the Independent Living Program, Child Advocates, Family Builders, and representatives from the University of California, Davis and Berkeley. The current workgroup participants continue to be essential partners in creating many of the policies, material, and best practices guidance CDSS has released to support youth and NMDs access to reproductive and sexual health care.

Efforts to Address Access to Reproductive and Sexual Health Care for Youth in Foster Care

Youth and NMDs in foster care are entitled to certain reproductive and sexual health care rights. It is important that foster youth and the parties who serve these youth are aware of a youth's right to consent to sexual and reproductive healthcare and are informed of these rights in an age and developmentally appropriate way. Furthermore, youth should receive information on how to access reproductive and sexual health care services. Parties who serve foster youth should address barriers to sexual and reproductive health services and facilitate access to these services.

At ages 17, 19, and 21, female foster youth in California reported experiencing pregnancy at two to three times the rate of pregnancy among youth in the general population, according to the study, “Barriers to Degree Completion for College Students with Foster Care Histories: Results from a 10-Year Longitudinal Study,” published in August 2018. (Okpych, N. J., & Courtney, M. E. (2021). Barriers to Degree Completion for College Students With Foster Care Histories: Results From a 10-Year Longitudinal Study. Journal of College Student Retention: Research, Theory & Practice, 23(1), 28–54.). Among 17 year old females in foster care in California, 26 percent reported at least one pregnancy, compared with 10 percent of youth in the general population (Courtney, et al., 2021). By 21 years old about 60 percent of women who had been in foster care in California reported at least one pregnancy (Courtney, et al., 2018).

Youth in foster care face challenges and unique barriers to accessing sexual and reproductive health care. They often report receiving inadequate or delayed information about available options or services, having difficulty obtaining this information, and encountering barriers to accessing contraceptives, including condoms. Additional information on updated sexual health rights, and how to order rights-related materials can be found on the California Foster Care Ombudsperson website.

Social Worker and Probation Officer Responsibilities

It is the caseworker’s responsibility to inform youth and NMDs in foster care of their personal rights, provide them with information on how to access reproductive and sexual health care, and confirm that the youth has received comprehensive education on reproductive and sexual health in a manner that is medically accurate, developmentally and age appropriate, trauma informed, and strengths based, as well as address questions, concerns, and any barriers to accessing reproductive and sexual health care services. It is also the caseworker’s responsibility to document this information in the youth’s case plan and ensure they are respecting the youth or NMD’s confidentiality while doing so. Attachment A in All County Letter (ACL) 18-61 provides additional information and a “how to” on documenting SB 89 Requirements in the Case Plan in the Child Welfare Services/Case Management System.

Barriers to Accessing Reproductive and Sexual Health Care

Prior to 2018, there were limited policies, guidance, and training available to case workers and caregivers regarding the sexual and reproductive health needs of the youth in their care. Without these resources in place, Social Workers, caregivers, and residential placement staff were left with little guidance about how to have developmentally appropriate and strengths-based conversations with young people related to reproductive and sexual health.

The Reproductive Health Equity Project for Foster Youth at the National Center for Youth Law published a report in 2021 titled “Interview Survey of Adolescents in Foster Care in Los Angeles County Regarding Sexual and Reproductive Health Communication

and Access to Resources." The report described several barriers experienced by California Social Workers when trying to provide information and access to sexual and reproductive services for youth in care. In the same report, researcher, Bruce, J.S (2016) conducted interviews with child welfare professional representatives from 18 California counties in 2015. Those interviewed identified multiple barriers to engaging in meaningful conversations with young people about reproductive health, including lack of social worker training and not prioritizing such conversations, the youths' lack of comfort and conflicting beliefs about the role of the social worker, youths' conflicting personal values and beliefs, and the fact that sexual health outcomes of youth in foster care and conversations about that are not consistently tracked. Bruce also reviewed child welfare policies in 26 California counties and found that only two counties had "…publicly-accessible, stand-alone policies that explicitly detailed departmental guidelines and procedures for supporting youths' sexual and reproductive health needs."

Efforts to Address Barriers for Reproductive and Sexual Health Care

Efforts to remove challenges and barriers to reproductive and sexual health care for youth and NMDs in foster care include (effective dates in parentheses):

- The California Healthy Youth Act (2016)
- The State Plan for Unplanned Pregnancy (2016)
- Short-Term Residential Therapeutic Program (STRTP) Regulation Changes (2017)
- SB 89 California Foster Youth Sexual Health Education Act (2017)
- State policy and guidelines to clarify rules and obligations for Case Workers and Caregivers (2016-19)
- AB 158 Expectant Parent Payment (2021)
- AB 172 Healthy Futures for Foster Youth (2021)

Policy guidance and information related to reproductive and sexual health can be found on the CDSS Healthy Sexual Development Resources website.

Data Summary on Performance

1. Social Workers and Probation Officers who have completed the Sexual and Reproductive Health training and education

Tables 1-3 below contain results from two different delivery systems tracked between July 1, 2021, to June 30, 2022, and does not include training completions from Los Angeles County because they do not use CalSWEC to track their training and education completion.

All the results gathered from the CalSWEC website and California Child Welfare Training (CACWT) sources are for trainees who listed themselves as Social Workers. None of the data collected indicated completions for trainees who identified their role as Juvenile Probation worker.

A total of 1,169 Social Workers completed the Sexual and Reproductive Wellness Rights training between the dates July 1, 2021, to June 30, 2022.

Note: all five training modules/courses are required to fulfill legislative requirements; however, a participant does have the option to complete a single component.

Table 1: Social Workers and Probation Officers results from CACWT by each eLearning title for dates July 1, 2021 – June 30, 2022.

Duties and Responsibilities	Engaging with Young People About Sexual Wellness	Finding Resources, Safer Sex, and Contraception Methods	Case Plan Documentation	Sexual and Reproductive Wellness Rights
32	*49*	*35*	*32*	*94*

Table 2: Social Workers and Probation Officers results from CalSWEC website by each eLearning title for dates July 1, 2021 – June 30, 2022.

Duties and Responsibilities	Engaging with Young People About Sexual Wellness	Finding Resources, Safer Sex, and Contraception Methods	Case Plan Documentation	Sexual and Reproductive Wellness Rights
32	*49*	*35*	*32*	*94*

Table 3: Social Workers and Probation Officers results from the instructor-led training (ILT) for dates July 1, 2021 - June 30, 2022.

Results are solely from the CACWT delivery of ILT – Sexual and Reproductive Wellness in Foster Care and demonstrates results split between the four Regional Training Academies.

Bay Area Academy	Central California Training Academy	Northern California Training Academy	CWDS Southern Academy	Total
46	*65*	*46*	*66*	*223*

Although the tables display completion results, it's important to reiterate that the results may not be an accurate reflection of all SB 89 training delivered throughout the State within the provided date range due to it being newly implemented throughout counties in 2021.

2. **Los Angeles Children's Social Workers (CSWs) and Supervising Children's Social Workers (SCSW) who have completed the Sexual and Reproductive Health training and education**.

   The Sexual and Reproductive Wellness for Youth in Foster Care training was completed in-person before the pandemic and then later offered online. A timeline could not be provided because the training is ongoing for newly hired Social Workers.

   Between January 1, 2020, and June 30, 2022, Los Angeles County reported that 2,999 CSWs and SCSWs have completed the training.

3. **Judges who have completed the Sexual and Reproductive Health training and education.**

   Every Spring, the Judicial Council submits an annual report to the Legislature as required by Welfare and Institutions Code section 304.7 (c), to demonstrate compliance by judges, commissioners, and referees with the juvenile judicial officer training and education requirement of the statute. The information provided in their report is gathered from the courts by staff of the Judicial Council's Center for Judicial Education and Research and is shared with the Legislature annually, after being considered at a Judicial Council meeting. The report for calendar year 2021 was considered at the March 11, 2022, meeting; the meeting materials attached to the agenda for that meeting are available on the California Courts Meeting Information Center.

   According to the report dated February 1, 2022, there were 229 new judges appointed that year and 220 of those completed the required training.

4. **Group home administrators who have completed the Sexual and Reproductive Health training and education.**

   Currently, Group Home (GH) and Short-Term Residential Therapeutic Program (STRTP) Administrators are required to take one hour of Sexual and Reproductive Health Care and Information as part of their Initial Training Certification Program (ICTP).

   As of August 17, 2022, there are 591 active GH and 554 active STRTP Administrators who have completed the required training.

5. **Expectant Foster Youth who received the Expectant Parent Payment in 2022 (data pulled from the California Statewide Automated Welfare System (CalSAWS).**

   From January to September 2022, 83 foster youth received the Expectant Parent Payment.

6. **Foster youth who received the Infant Supplement in 2022 (data pulled from the California Statewide Automated Welfare System (CalSAWS).**

   From January to September 2022, 1,151 foster youth received the Infant Supplement.

Reproductive Health Services Received by Foster Youth

To explore the nature, extent, and quality of reproductive services provided to foster youth in the Medi-Cal program, and pursuant to the requirements of AB 172, DHCS provided data summarizing reproductive health services using selected Core Set Measures.

The CMS Core Set measures can be used to estimate the quality of Health Care across a selected measure in the Primary Care Access and Preventive Care and Maternal and Perinatal Health domains. The following Core Set measures are reported by foster care status and by foster care status by racial/ethnic groups.

1. Child and Adolescent Well-Care Visits (WCV-CH; National Quality Foundation [NQF] measure 1516)
2. Chlamydia Screening in Women Ages 16 to 20 (CHL-CH; NQF 0033)
3. Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH; NQF 1517)
4. Prenatal and Postpartum Care: Postpartum Care (PPC-AD; NQF 1517)
5. Contraceptive Care – All Women Ages 15 to 20 (CCW-CH; NQF 2902, 2903 and 2904)
6. Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH; NQF 2902, 2903 and 2904)
7. Live Births Weighing Less Than 2,500 Grams (LBW-CH; NQF 1382)
8. Low-Risk Cesarean Delivery (LRCD-CH; NQF 0471)

This first annual report on reproductive health services for California foster youth was primarily based on Medi-Cal claims data extracted from the DHCS Management Information System/Decision Support System (MIS/DSS) data warehouse in September 2021. Data was pulled for dates of service between January 1, 2020, to December 31, 2020 (Measurement Year 2020 [MY 2020)]). LBW-CH and LRCD-CH results are based on calendar year 2020 state vital records matched with the MIS/DSS database. Data suppression was applied to table cells if there were fewer than 11 (1-10) events/population reported or if complementary suppression was required to prohibit recalculation. Differences by foster care versus non-foster status for Medi-Cal overall and by race/ethnicity were tested for statistical significance. Chi-square p-values of 0.05 or smaller were considered statistically significant. Rate differences and gaps between foster and non-foster rates that were 5 or more percentage points different (wider or narrower) than overall Medi-Cal rate were also noted in this report.

Findings: Reproductive Health Services Provided to Youth in Foster Care (Overall)

Table 1 below summarizes the selected Core Set measures for: (1) all Medi-Cal beneficiaries, (2) foster youth beneficiaries, and (3) non-foster beneficiaries within the age groups specified in the Core Set measures. In some measures, foster youth had better (usually higher) utilization rates, while in others, utilization was lower for foster youth compared to their non-foster counterparts.

- Foster youth had significantly higher (better) rates of well-care visits and chlamydia screening (62.8% and 67.2%, respectively) compared to non-foster youth (46.7% and 55.2%, respectively).

- Foster youth had significantly lower (worse) rates of timely prenatal and postpartum care (55.2% and 52.9% respectively) compared to non-foster youth (64.1% and 67.0% respectively). Notably, only about half of foster youth had a postpartum visit on or between 7 and 84 days after delivery, compared to more than two- thirds of the non-foster youth population.

- Rates of being provided contraceptive care were mixed. Foster youth had significantly higher rates of being provided a most effective or moderately effective (MM) contraception method (21.7%) as well as long-acting reversible contraception (LARC) methods (5.0%) compared to non-foster youth counterparts (MM, 11.3%; LARC, 2.5%). Postpartum foster youth had higher rates of being provided both MM and LARC contraceptive methods within three days of delivery (5.5% and 4.3% compared to 4.8% and 2.7% for non-foster postpartum youth), but significantly lower rates of being provided contraception between 3 and 60 days after delivery for either MM60 or LARC60 methods (29.5% and 9.7%, compared to 35.4% and 13.4% for postpartum non-foster youth respectively).

- Foster youth had a slightly higher rate of low birthweight deliveries compared to non-foster youth (9.0% and 7.0%, respectively) and had a slightly lower rate of low-risk cesarean deliveries compared to non-foster youth (11.0% and 13.2%, respectively). However, the differences in rates by foster care status were not statistically significant for either measure.

Findings: Reproductive Health Services for Youth in Foster Care by Race/Ethnicity

Tables 2 - 13 show the Core Set measures by foster care status and race/ethnicity. The findings by race/ethnicity are generally consistent with the trends observed for the overall Medi-Cal rates. Across all racial/ethnic groups, foster youth had significantly higher rates of well-care, chlamydia screenings, and being provided postpartum contraception within three days of delivery (both MM and LARC), but significantly lower rates of prenatal care visits, postpartum care, and being provided postpartum contraception within 60 days of delivery. Racial/ethnic group rates that are 5 percentage points higher/lower than the overall Medi-Cal rate, gaps between foster and non-foster youth by racial/ethnic groups that are 5 percentage points wider/narrower than the size of the gap for foster and

non-foster youth in Medi-Cal overall, and racial/ethnic group rates that represent exceptions to the overall trends are highlighted below.

Table 1: Medi-Cal Quality Measures Related to Reproductive Health – by Foster Care Status for Youth Ages 10-20, Measure Year 2020

Quality Measure	Total Denominator	Numerator	Rate	Foster Care Denominator	Numerator	Rate	Not in Foster Care Denominator	Numerator	Rate
Well-Care Visits Ages 10-20	2,462,718	1,154,662	46.9%	31,164	19,557	62.8%	2,431,554	1,135,105	46.7%
Chlamydia Screening Ages 16-20 for Youth Who Were Identified as Sexually Active	208,186	115,434	55.4%	5,103	3,428	67.2%	203,083	112,006	55.2%
Timeliness of Prenatal Care [1] for expectant parents	13,015	8,303	63.8%	507	280	55.2%	12,508	8,023	64.1%
Postpartum Care for Parents Who Have Given Birth	13,015	8,647	66.4%	507	268	52.9%	12,508	8,379	67.0%
Contraception All Women (MM)[2]	685,514	78,719	11.5%	9,637	2,090	21.7%	675,877	76,629	11.3%
Contraception All Women (LARC)[3]	685,514	17,378	2.5%	9,637	482	5.0%	675,877	16,896	2.5%
Postpartum Contraception (MM3)[4]	12,014	581	4.8%	421	23	5.5%	11,593	558	4.8%
Postpartum Contracept (LARC3)[5]	12,014	328	2.7%	421	18	4.3%	11,593	310	2.7%

[1] Percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in Medicaid/CHIP.
[2] MM – Most effective or moderately effective (method of contraception).
[3] LARC – Long-Acting Reversible Contraceptive Method.
[4] MM3 – Most effective or moderately effective (method of contraception) – provided within 3 days of delivery.
[5] LARC3 – Long-Acting Reversible Contraceptive Method – provided within 3 days of delivery.

Quality Measure	Total Denominator	Numerator	Rate	Foster Care Denominator	Numerator	Rate	Not in Foster Care Denominator	Numerator	Rate
Postpartum Contraception (MM60)[6]	12,014	4,231	35.2%	421	124	29.5%	11,593	4,107	35.4%
Postpartum Contraception (LARC60)[7]	12,014	1,595	13.3%	421	41	9.7%	11,593	1,554	13.4%
Live Births Weighing Less Than 2,500 Grams[8]	12,510	885	7.1%	409	37	9.0%	12,101	848	7.0%
Low-Risk Cesarean Delivery[8]	9,344	1,224	13.1%	291	32	11.0%	9,053	1,192	13.2%

[6] MM60 – Most effective or moderately effective (method of contraception) – provided between 3 and 60 days of delivery.
[7] LARC60 – Long-Acting Reversible Contraceptive Method – provided within 3 and 60 days of delivery.
[8] A lower rate indicates better performance.

Table 2: Comprehensive Well-Care Visits (WCV-CH, Limited to Youth Ages 10 – 20), by Race/Ethnicity and Foster Care Status, Measure Year 2020

- Foster youth rates were significantly higher (better) than non-foster youth rates of receiving well-care visits than for Medi- Cal recipients overall and for all racial/ethnic groups.
- Foster youth rates by racial/ethnic group ranged from 52.4% for the Asian/Pacific Islander group to 72.4% for the American Indian/Alaskan Native group.
  - The Asian/Pacific Islander foster youth rate was 10.4 percentage points below the statewide rate (52.4 compared to 62.8).
  - The American Indian/Alaska Native foster youth rate was 9.6 percentage points above the statewide rate (72.4 compared to 62.8).
- Gap analysis: The overall foster youth rate was 16.1 percentage points higher than the overall non-foster rate. Compared to the Medi-Cal overall rate gap, the rate gaps between foster and non-foster youth rates that differed by 5 percentage points, or more were:
  - wider for American Indian/Alaska Native, Black/African American, Unknown, and White groups (foster youth rates were 21.7 percentage points or higher than non-foster youth rates),
  - narrower for the Asian/Pacific Islander group (the foster youth rate was only 7.5 percentage points higher than the non-foster youth rate).

Race/Ethnicity	Total Denominator	Numerator	Rate	Foster Care Denominator	Numerator	Rate	Not in Foster Care Denominator	Numerator	Rate
American Indian/Alaska Native	8,681	4,272	49.2%	319	231	72.4%	8,362	4,041	48.3%
Asian/Pacific Islander	173,444	77,857	44.9%	565	296	52.4%	172,879	77,561	44.9%
Black/African American	170,332	59,440	34.9%	6,120	3,649	59.6%	164,212	55,791	34.0%
Hispanic	1578884	786,291	49.8%	13,959	8,876	63.6%	1564925	777,415	49.7%
Other	121,687	54,689	44.9%	2,243	1,375	61.3%	119,444	53,314	44.6%
Unknown	83,698	33,472	40.0%	1,286	790	61.4%	82,412	32,682	39.7%
White	325,992	138,641	42.5%	6,672	4,340	65.0%	319,320	134,301	42.1%
Total	2,462,718	1,154,662	46.9%	31,164	19,557	62.8%	2,431,554	1,135,105	46.7%

Table 3: Percentage of Sexually Active Women with at Least One Test for Chlamydia (CHL-CH, Ages 16-20) by Race/Ethnicity and Foster Care Status, Measure Year 2020

- Foster youth rates were significantly higher (better) than non-foster youth rates for Medi-Cal overall and all racial/ethnic groups.
- Foster youth rates across racial/ethnic groups ranged from 61.3% for the White group to 73.7% for the American Indian/Alaskan Native group.
  - The White foster youth rate was 5.9 percentage points below the statewide foster youth rate.
  - The American Indian/Alaska Native foster youth rate was 6.5 percentage points above the statewide foster youth rate.
- Gap analysis: The foster youth rate was 12.0 percentage points higher than the non-foster youth rate for Medi-Cal overall. Compared to the Medi-Cal overall rate gap, the rate gaps between foster and non-foster youth rates that differed by 5 percentage points, or more were:
  - wider for the American Indian/Alaska Native group (the foster youth rate was 28.3 percentage points higher than the non-foster youth rate),
  - narrower for the Black/African American group (the foster youth rate was only 6.6 percentage points higher than the non-foster youth rate).

Race/Ethnicity	Total Denominator	Numerator	Rate	Foster Care Denominator	Numerator	Rate	Not in Foster Care Denominator	Numerator	Rate
American Indian/Alaska Native	978	460	47.0%	57	42	73.7%	921	418	45.4%
Asian/Pacific Islander	11,044	5,967	54.0%	94	62	66.0%	10,950	5,905	53.9%
Black/African American	15,543	9,693	62.4%	1,022	700	68.5%	14,521	8,993	61.9%
Hispanic	126,176	71,986	57.1%	1,966	1,364	69.4%	124,210	70,622	56.9%
Other	13,886	7,783	56.0%	597	407	68.2%	13,289	7,376	55.5%
Unknown	6,908	3,671	53.1%	263	176	66.9%	6,645	3,495	52.6%
White	33,651	15,874	47.2%	1,104	677	61.3%	32,547	15,197	46.7%
Total	208,186	115,434	55.4%	5,103	3,428	67.2%	203,083	112,006	55.2%

Table 4: Timeliness of Prenatal Care (PPC-CH, Limited to Mothers Ages 10 - 20)[9] by Race/Ethnicity and Foster Care Status, Measure Year 2020

- Table 4 shows the percentage of deliveries of live births (on or between October 8 of the year prior to the measurement year and October 7 of the measurement year) that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in Medicaid/CHIP.
- The foster youth rates for Medi-Cal overall, Hispanic, and White groups were significantly lower (worse) than the non-foster youth rate.
- Foster youth rates by reported racial/ethnic groups ranged from 44.4% for the Unknown group to 59.7% for the Other group.
    - The Unknown foster youth rate was 10.8 percentage points below the statewide foster youth rate.
    - None of the other racial/ethnic groups' foster youth rates differed by more than 5 percentage points from the statewide foster youth rate.
- Gap analysis: The foster youth rate was 8.9 percentage points lower (worse) than the non-foster rate for youth in Medi-Cal overall. Compared to the Medi-Cal overall rate gap, only the Black/African American group's rate gap differed from the statewide gap by 5 or more percentage points – it was narrower (the foster youth rate was slightly higher than the non-foster youth rate and the difference was only 1.3 percentage points).

Race/Ethnicity	Total Denominator	Numerator	Rate	Foster Care Denominator	Numerator	Rate	Not in Foster Care Denominator	Numerator	Rate
American Indian/Alaska Native	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Asian/Pacific Islander	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Black/African American	928	542	58.4%	99	59	59.6%	829	483	58.3%
Hispanic	8,789	5,669	64.5%	210	112	53.3%	8,579	5,557	64.8%
Other	1,232	836	67.9%	67	40	59.7%	1,165	796	68.3%
Unknown	510	275	53.9%	27	12	44.4%	483	263	54.5%
White	1,294	830	64.1%	89	46	51.7%	1,205	784	65.1%
Total	13,015	8,303	63.8%	507	280	55.2%	12,508	8,023	64.1%

[9] Data suppression due to fewer than 11 (1-10) events/population reported or complementary suppression required to prohibit recalculation.

Table 5: Timeliness of Postpartum Care (PPC-AD, Limited to Mothers Ages 10 - 20)[10,11], by Race/Ethnicity and Foster Care Status, Measure Year 2020

- The foster youth rates for Medi-Cal overall, Hispanic, and Other groups were significantly lower (worse) than the non-foster youth rate.
- Foster youth rates by reported racial/ethnic groups ranged from 45.5% for the Black/African American group to 58.4% for the White group.
    - The Black/African American foster youth rate was 7.4 percentage points below the statewide foster youth rate.
    - The White foster youth rate was 5.5 percentage points above the statewide foster youth rate.
- Gap analysis: The foster youth rate was 14.1 percentage points lower than the non-foster rate for youth in Medi-Cal overall. Compared to the Medi-Cal overall rate gap, no racial/ethnic groups had a gap 5 or more percentage points wider than the statewide gap; Black/African American, Unknown, and White groups had narrower rate gaps.

Race/Ethnicity	Total Denominator	Numerator	Rate	Foster Care Denominator	Numerator	Rate	Not in Foster Care Denominator	Numerator	Rate
American Indian/Alaska Native	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Asian/Pacific Islander	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Black/African American	928	477	51.4%	99	45	45.5%	829	432	52.1%
Hispanic	8,789	6,030	68.6%	210	112	53.3%	8,579	5,918	69.0%
Other	1,232	856	69.5%	67	37	55.2%	1,165	819	70.3%
Unknown	510	311	61.0%	27	15	55.6%	483	296	61.3%
White	1,294	815	63.0%	89	52	58.4%	1,205	763	63.3%
Total	13,015	8,647	66.4%	507	268	52.9%	12,508	8,379	67.0%

[10] Percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.
[11] Data suppression due to fewer than 11 (1-10) events/population reported or complementary suppression required to prohibit recalculation.

Table 6: Contraceptive Care – All Women That Were Provided a Most or Moderately Effective (MM) Contraceptive Method (CCW-CH-MM, Ages 15-20) by Race/Ethnicity and Foster Care Status, Measure Year 2020

- Foster youth rates were significantly higher (better) compared to non-foster youth rates for all reported racial/ethnic groups.
- Foster youth rates by racial/ethnic groups ranged from 16.0% for the Asian/Pacific Islander group to 30.5% for the American Indian/Alaska Native group.
- Gap analysis: The foster youth rate was 10.4 percentage points higher than the non-foster youth rate for those in Medi- Cal overall. Compared to the Medi-Cal overall rate gap, only the Other group had a gap between foster and non- foster youth rates that was 5 percentage points or more different (wider) than the statewide rate.

Race/Ethnicity	Total Denominator	Numerator	Rate	Foster Care Denominator	Numerator	Rate	Not in Foster Care Denominator	Numerator	Rate
American Indian/Alaska Native	2,592	474	18.3%	105	32	30.5%	2,487	442	17.8%
Asian/Pacific Islander	52,425	4,137	7.9%	219	35	16.0%	52,206	4,102	7.9%
Black/African American	45,885	5,785	12.6%	1,917	389	20.3%	43,968	5,396	12.3%
Hispanic	429,630	44,522	10.4%	4,012	806	20.1%	425,618	43,716	10.3%
Other	39,077	5,408	13.8%	864	246	28.5%	38,213	5,162	13.5%
Unknown	23,131	2,634	11.4%	469	104	22.2%	22,662	2,530	11.2%
White	92,774	15,759	17.0%	2,051	478	23.3%	90,723	15,281	16.8%
Total	685,514	78,719	11.5%	9,637	2,090	21.7%	675,877	76,629	11.3%

Table 7: Contraceptive Care – All Women That Were Provided Long-Acting Reversible Contraception (LARC) (CCW-CH-LARC, Ages 15-20)[12] by Race/Ethnicity and Foster Care Status, Measure Year 2020

- Foster youth rates were significantly higher (better) compared to non-foster youth rates for all reported race/ethnicities.
- Foster youth rates by reported racial/ethnic groups ranged from 4.1% for the Black/African American group to 7.5% for the Other race group.
- Gap analysis: The foster youth rate was 2.5 percentage points higher than the non-foster youth rate for those in Med-Cal overall. None of the reported racial/ethnic groups had a gap between foster and non-foster youth rates that differed 5 percentage points or more (either direction) than the statewide rate.

Race/Ethnicity	Total Denominator	Numerator	Rate	Foster Care Denominator	Numerator	Rate	Not in Foster Care Denominator	Numerator	Rate
American Indian/Alaska Native	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Asian/Pacific Islander	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Black/African American	45,885	991	2.2%	1,917	78	4.1%	43,968	913	2.1%
Hispanic	429,630	10,454	2.4%	4,012	199	5.0%	425,618	10,255	2.4%
Other	39,077	1,286	3.3%	864	65	7.5%	38,213	1,221	3.2%
Unknown	23,131	586	2.5%	469	24	5.1%	22,662	562	2.5%
White	92,774	3,246	3.5%	2,051	107	5.2%	90,723	3,139	3.5%
Total	685,514	17,378	2.5%	9,637	482	5.0%	675,877	16,896	2.5%

[12] Data suppression due to fewer than 11 (1-10) events/population reported or complementary suppression required to prohibit recalculation.

Table 8: Contraceptive Care – Postpartum Women That Were Provided a Most or Moderately Effective Contraceptive Method within Three Days Postpartum (CCP-CH-MM-3-Days, Ages 15 to 20)[13] by Race/Ethnicity and Foster Care Status, Measure Year 2020

- Rates by race/ethnicity were suppressed due to small cell sizes.

Race/Ethnicity	Total Denominator	Numerator	Rate	Foster Care Denominator	Numerator	Rate	Not in Foster Care Denominator	Numerator	Rate
American Indian/Alaska Native	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Asian/Pacific Islander	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Black/African American	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Hispanic	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Other	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Unknown	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
White	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Total	12,014	581	4.8%	421	23	5.5%	11,593	558	4.8%

[13] Data suppression due to fewer than 11 (1-10) events/population reported or complementary suppression required to prohibit recalculation.

Table 9: Contraceptive Care – Postpartum Women That Were Provided Long-Acting Reversible Contraception Within Three Days Postpartum (CCP-CH-LARC-3-Days, Ages 15 to 20) by Race/Ethnicity and Foster Care Status, Measure Year 2020

- Rates by race/ethnicity were suppressed due to small cell sizes.

Race/Ethnicity	Total Denominator	Numerator	Rate	Foster Care Denominator	Numerator	Rate	Not in Foster Care Denominator	Numerator	Rate
American Indian/Alaska Native	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Asian/Pacific Islander	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Black/African American	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Hispanic	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Other	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Unknown	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
White	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Total	12,014	328	2.7%	421	18	4.3%	11,593	310	2.7%

Table 10: Contraceptive Care – Postpartum Women That Were Provided a Most or Moderately Effective Contraceptive Method Within 60 Days Postpartum (CCP-CH-MM-60 Days, Ages 15 to 20)[14] by Race/Ethnicity and Foster Care Status, Measure Year 2020

- The foster youth rates for Medi-Cal overall and for the Hispanic group were significantly lower (worse) than the non-foster youth rate. Foster youth rates varied significantly by racial/ethnic groups, ranging from 19.8% for the Black/African American group to 42.9% for the White group.
  - The Black/African American foster youth rate was 9.7 percentage points below the statewide foster youth rate.
  - The Other and White group foster youth rates were 7.5 and 13.4 percentage points or more above the statewide foster youth rate.

[14] Data suppression due to fewer than 11 (1-10) events/population reported or complementary suppression required to prohibit recalculation.

- Gap analysis: The foster youth rate was 5.9 percentage points lower than the non-foster youth rate for Medi-Cal overall. Compared to the Medi-Cal overall rate gap, the gaps between foster and non-foster youth rates that differed by 5 percentage points or more were:
  - narrower for the Other group (foster youth and non-foster youth rates were similar);
  - wider for the White group (foster youth rates were 6.4 percentage points higher than the non-foster youth rates).

Race/Ethnicity	Total Denominator	Numerator	Rate	Foster Care Denominator	Numerator	Rate	Not in Foster Care Denominator	Numerator	Rate
American Indian/Alaska Native	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Asian/Pacific Islander	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Black/African American	849	228	26.9%	81	16	19.8%	768	212	27.6%
Hispanic	8,084	2,898	35.8%	172	44	25.6%	7,912	2,854	36.1%
Other	1,159	420	36.2%	54	20	37.0%	1,105	400	36.2%
Unknown	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
White	1,183	437	36.9%	77	33	42.9%	1,106	404	36.5%
Total	12,014	4,231	35.2%	421	124	29.5%	11,593	4,107	35.4%

Table 11: Contraceptive Care – Postpartum Women That Were provided Long-Acting Reversible Contraception Within 60 Days Postpartum (CCP-CH-LARC-60-Days, Ages 15 to 20)[15] by Race/Ethnicity and Foster Care Status, Measure Year 2020

- Rates for most racial/ethnic groups were suppressed due to small cell sizes.
- The foster youth rates reported for Medi-Cal overall and for the Hispanic group were significantly lower (worse) than the non- foster youth rate for each group.

[15] Data suppression due to fewer than 11 (1-10) events/population reported or complementary suppression required to prohibit recalculation.

- Gap analysis: The foster youth rate was 3.7 percentage points lower than the non-foster youth rate for Medi-Cal overall. The gap between the foster and non-foster youth rates for the Hispanic group did not differ from the Medi-Cal overall rate gap by 5 or more percentage points.

Race/Ethnicity	Total Denominator	Numerator	Rate	Foster Care Denominator	Numerator	Rate	Not in Foster Care Denominator	Numerator	Rate
American Indian/Alaska Native	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Asian/Pacific Islander	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Black/African American	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Hispanic	8,084	1,115	13.8%	172	13	7.6%	7,912	1,102	13.9%
Other	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Unknown	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
White	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Total	12,014	1,595	13.3%	421	41	9.7%	11,593	1,554	13.4%

Table 12: Live Births Weighing Less Than 2,500 Grams (LBW-CH, Limited to Mothers Ages 10 - 20)[16] by Race/Ethnicity and Foster Care Status, Measure Year 2020

- For this measure, a lower rate indicates better performance.
- Rates for most racial/ethnic groups were suppressed due to small cell sizes.
- Differences between foster and non-foster youth rates reported for Medi-Cal overall, the Black/African American group, and the Hispanic group, were not statistically significant.
- Gap analysis: The foster youth rate was 2.0 percentage points higher (worse) than the non-foster youth rate for Medi-Cal overall. The gap between the foster and non-foster youth rates for the Black/African American and Hispanic groups did not differ from the Medi-Cal overall rate gap by 5 or more percentage points.

[16] Data suppression due to fewer than 11 (1-10) events/population reported or complementary suppression required to prohibit recalculation.

Race/Ethnicity	Total Denominator	Numerator	Rate	Foster Care Denominator	Numerator	Rate	Not in Foster Care Denominator	Numerator	Rate
American Indian/Alaska Native	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Asian/Pacific Islander	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Black/African American	1,061	129	12.2%	97	12	12.4 %	964	117	12.1%
Hispanic	8,483	552	6.5%	175	13	7.4%	8,308	539	6.5%
Other	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Unknown	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
White	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Total	12,510	885	7.1%	409	37	9.0%	12,101	848	7.0%

Table 13: Low-Risk Cesarean Delivery (LRCD-CH, Limited to Mothers Ages 10 - 20)[17] by Race/Ethnicity and Foster Care Status, Measure Year 2020

- For this measure, a lower rate indicates better performance.
- Rates for most racial/ethnic groups were suppressed due to small cell sizes.
- Differences between foster and non-foster youth rates reported for Medi-Cal overall and for the Hispanic group, were not statistically significant. The foster care rate for the Other group was statistically unstable because of the small denominator.
- Gap analysis: The foster youth rate was 2.2 percentage points lower than the non-foster rate for Medi-Cal overall. The gap between the Hispanic foster and non-foster youth rate did not differ from the Medi-Cal overall rate gap by 5 or more percentage points.

[17] Data suppression due to fewer than 11 (1-10) events/population reported or complementary suppression required to prohibit recalculation.

Race/Ethnicity	Total Denominator	Numerator	Rate	Foster Care Denominator	Numerator	Rate	Not in Foster Care Denominator	Numerator	Rate
American Indian/Alaska Native	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Asian/Pacific Islander	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Black/African American	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Hispanic	6,310	816	12.9%	122	16	13.1%	6,188	800	12.9%
Other	562	54	9.6%	17	0	0.0%	545	54	9.9%
Unknown	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
White	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-	-X-
Total	9,344	1,224	13.1%	291	32	11.0%	9,053	1,192	13.2%

Summary

The intent of this report is to highlight the current status of sexual and reproductive health training, care, and service received by California youth in foster care, to ensure they have received comprehensive sexual health education and services, and to improve health outcomes. This first annual report on sexual and reproductive health of youth in foster care provides the initial baseline performance data from 2021 and 2022 on sexual and reproductive health trainings to group home and STRTP providers, Social Workers, Probation Officers, and judges, sexual and reproductive health education provided to youth, and Medi-Cal data from MY2020 on reproductive health services received by California foster youth ages 10 through 20.

Summary of Performance Measures

Sexual and reproductive health trainings of varying duration and topics were completed in Fiscal Year 2021-2022 by 1,145 group home and STRTP providers, 1,169 Social Workers plus 2,999 Social Workers and Supervising Children's Social Workers in Los Angeles County, Probation Officers and 220 of new judges (with none completed by Probation Officers). Improvement on this measure would include an increase in the number of individuals trained. Members of the Healthy Sexual Development workgroup suggest engaging with the Chief Probation Officers of California to discuss available trainings, outreach, and increased compliance with the training mandate. Trainings are available through CalSWEC for all providers, Social Workers, Probation Officers, caregivers, Court Appointed Special Advocates, etc.

AB 153 established the Expectant Parent Payment (EPP) to help youth in foster care prepare for a healthy delivery and birth. The EPP provides a direct payment of $2,700 to an expectant parent starting in the seventh month of pregnancy via a manual check, until payments are automated. Each county must enact their own local policy and practice to implement the payment until automation is fully complete, including establishing procedures for identifying and referring eligible foster youth and NMDs and training county caseworkers to identify eligible foster youth and refer them for benefits.

In 2021, a System Change Request (SCR) was submitted to California Statewide Automated Welfare System (CalSAWS) to request automation changes to be implemented into CalSAWS. Currently in CalSAWS, payments go directly to the provider for the Foster Care program and the provider needs to be designated as a payee in the program. Therefore, the Foster Care program had no process that allowed direct payment to the expectant foster youth who is preparing for the birth of a newborn. The SCR, once complete, will add a new Placement Type Expectant Foster Youth to indicate the expectant parent payee, issue and track the EPP benefits through Needs and Services Arrangements, and add a new Pay Code for the Expectance Parent Payment. The automation is schedule for release in 2023. Once

this automation project is completed the Department will release additional guidance (i.e. ACL or CFL).

In 2022, 83 expectant parents received the EPP. Youth who were eligible for EPP but did not receive it are entitled to retroactive payments should be identified by caseworkers to help expecting foster youth prepare for the birth of the child and to care for the infant. For additional information on the EPP refer to the ACL 21-123 and the Report & Toolkit: Expectant Parent Payment for California Foster Youth.

The California Healthy Youth Act, which took effect January 1, 2016, requires school districts to provide students with integrated, comprehensive, accurate, and inclusive comprehensive Sexual Health Education (CSE) once in middle school and once in high school. In July of 2017, Senate Bill 89, Statutes of 2017, went into effect requiring Social Workers and Probation Officers to review a foster youth or NMD's case plan annually and update it as needed to confirm that the youth or NMD has received CSE and if it has not been met, document how they will ensure that the foster youth will receive the instructions at least once before completing junior high or middle school and once before completing high school.

The CDSS was unable to obtain data regarding how many foster youth in care have completed CSE due to a lack of reporting and documentation of these practices in the case plan. The obtaining of CSE is typically completed by children who attend CSE learning opportunities that are provided during school. However, barriers such as a lack of provision of CSE by schools serving foster youth and/or foster youth missing the opportunity to attend due to frequent placement changes can also lead to low completion rates. This illustrates the ongoing need for case managers to document the provision of CSE, as required by SB 89.

Youth who have missed CSE in middle and high school may be referred to CSE through the following providers: Planned Parenthood, and Teen Talk YAS. Next steps include implementing the updated rules of court and forms policy established in Assembly Bill (AB) 153. Performance measures for youth in care who received comprehensive sexual health education will be included in the next legislative report.

Summary of Quality/Utilization Measures

Looking at Core Set measure rates for foster youth is an important first step in tracking their utilization of reproductive health services and the quality of care received. Compared to non-foster care youth, foster youth had significantly higher rates of well-care visits, chlamydia screenings, being provided contraceptive care in general, and higher rates of being provided postpartum contraception within three days of delivery (both MM and LARC). Foster youth had lower rates of prenatal care visits, postpartum care visits, and postpartum contraception within 60 days of delivery. Efforts to improve reproductive health services for foster youth should focus on increasing access to prenatal and postpartum care/contraceptive care for foster youth.

As seen above, foster youth were less likely to receive prenatal and postpartum care than non- foster youth and utilization rates and gaps between foster and non-foster youth varied by race/ethnicity. For example:

- Hispanic foster youth who were mothers had significantly lower rates of postpartum care, compared to Hispanic non-foster youth mothers (53.3% and 69.0%, respectively).
- Foster youth mothers who identified as White had a lower rate of prenatal care (51.7%) than both the statewide foster youth rate (55.2%) and White non-foster youth rate (65.1%).
- Of mothers who identified as Black/African American, fewer than half of foster youth mothers (45.5%) and slightly more than half (52.1%) of non-foster youth mothers received postpartum care. Rate differences by foster care status were not statistically significant. Because both foster and non-foster Black/African American mothers had low rates of care compared to overall Medi-Cal rates, efforts to increase postpartum care should focus on young Black/African American mothers overall, regardless of foster status.

Similarly, for low birthweight deliveries – a measure frequently used as an indicator of population health - this report did not find significant differences between foster and non-foster youth rates for Medi-Cal overall, or the Black/African American or Hispanic groups. However, although the low birthweight delivery rate for Black/African American foster youth and non-foster youth were similar (12.4% and 12.1%, respectively), both rates were 5 percentage points or more higher (worse) than the Hispanic and Medi-Cal overall non-foster youth rates (6.5% and 7.0%, respectively). This finding of a higher rate of low birthweight deliveries regardless of foster youth status among Black/African American mothers is consistent with research documenting worse birth outcomes for Black/African American women when compared to non-Hispanic White women (Ratnasiri, 2018). Given the correlation between birthweight and multiple adverse health outcomes, understanding, and addressing the causes of low birthweight deliveries, regardless of foster care status, is also a critical priority.

Limitations and Future Directions

Although survey research and the workgroup feedback suggest that there is a need for reproductive health training and services, there is little quantitative research regarding the level of need for services. Additional data regarding the extent to which foster youth are sexually active and need specific services would better inform levels of need for specific services and allow for implementation of more targeted and effective care.

This report presents initial findings based on selected Core Set measures from MY2020 that had been calculated using Medi-Cal data. Future reports will include more comprehensive data on sexually transmitted infections and treatment. Future analyses will also explore trends over time for utilization and quality of care and provide data disaggregated by age, sexual orientation, gender identity, county, and placement type as data are available.

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