

**2014 MCAH Needs Assessment
Community Health Status Report**

**EI Dorado County
Health and Human Services Agency
Public Health Division**

| Community Health Status Report Details | | | | | | | | | | | | | | | | | | | |
|--|--|--------|--------------------|---------------|-------|--------|------------------|---------------|---------------|--------------------|-----------------------------|-------------------|------------------------------|--|-----------|------------------|---------------|---------|--|
| Indicator | | | Local Period Start | | | | Local Period End | | | | Compare Local End Status to | | | Local Trend Line | | State Period End | | | |
| Description | HP 2020 Objective | Period | Rate | 95% Conf. Int | | Period | Rate | 95% Conf. Int | | Local Period Start | State Period End | HP 2020 Objective | Describe, explain non-linear | If Linear Trend, Compare Progress to HP 2020 | Period | Rate | 95% Conf. Int | | |
| | | | | Lower | Upper | | | Lower | Upper | | | | | | | | Lower | Upper | |
| 1. Access to and Utilization of Care Indicators | | | | | | | | | | | | | | | | | | | |
| 1 A | Uninsured per 100 population age 0 to 18 | 0.0 | 2006-2008 | 10.8 | 10.7 | 11.0 | 2009-2011 | 6.7 | 6.6 | 6.8 | ↓ | ↓ | ↑ | ↔ | 2009-2011 | 9.3 | 9.3 | 9.4 | |
| 1 B | Uninsured per 100 female population age 18 to 64 | 0.0 | 2006-2008 | 16.4 | 16.3 | 16.6 | 2009-2011 | 14.2 | 14.0 | 14.4 | ↓ | ↓ | ↑ | ↔ | 2009-2011 | 22.1 | 22.1 | 22.2 | |
| 1 C | MediCal insured deliveries per 100 live births | N/A | 2000-2002 | 29.7 | 28.5 | 31.0 | 2009-2011 | 37.7 | 36.3 | 39.0 | ↑ | ↓ | ↔ | ↑ | 2009-2011 | 47.3 | 47.2 | 47.4 | |
| 1 D | Prenatal care in the first trimester per 100 females delivering a live birth | 77.9 | 2000-2002 | 87.6 | 86.7 | 88.5 | 2009-2011 | 78.7 | 77.5 | 79.8 | ↓ | ↓ | ↔ | ↔ | 2009-2011 | 83.3 | 83.2 | 83.4 | |
| 2. Maternal and Women Health Indicators | | | | | | | | | | | | | | | | | | | |
| 2 A | Births within 24 months of a previous pregnancy per 100 females age 15 to 44 delivering a live birth | N/A | 2000-2002 | 30.1 | 28.6 | 31.7 | 2009-2011 | 31.8 | 30.2 | 33.5 | ↔ | ↑ | ↔ | ↔ | 2009-2011 | 28.7 | 28.6 | 28.8 | |
| 2 B | Cesarean delivery per 100 low risk women giving birth for the first time | N/A | 2005-2007 | 22.6 | 20.7 | 24.6 | 2009-2011 | 24.7 | 22.7 | 26.8 | ↔ | ↔ | ↔ | ↔ | 2009-2011 | 26.3 | 26.2 | 26.4 | |
| 2 C | Gestational diabetes per 100 females delivering an infant in-hospital | N/A | 2000-2002 | 2.7 | 2.2 | 3.1 | 2009-2011 | 6.5 | 5.8 | 7.2 | ↑ | ↓ | ↔ | ↑ | 2009-2011 | 7.6 | 7.5 | 7.6 | |
| 2 D | Substance use hospitalizations per 1000 pregnant females | N/A | 2000-2002 | 12.2 | 9.6 | 15.5 | 2009-2011 | 41.5 | 36.3 | 47.3 | ↑ | ↑ | ↔ | ↑ | 2009-2011 | 14.2 | 14.1 | 14.4 | |
| 2 E | Mood disorder hospitalizations per 100,000 female population age 15 to 44 | N/A | 2000-2002 | 810.3 | 754.6 | 870.1 | 2009-2011 | 1,531.5 | 1,452.7 | 1,614.5 | ↑ | ↑ | ↔ | ↑ | 2009-2011 | 1,026.6 | 1,022.6 | 1,030.7 | |
| 2 F | Assault hospitalizations per 100,000 females age 15 to 44 | N/A | 2000-2002 | 3.2 | 1.1 | 9.5 | 2009-2011 | 7.9 | 3.8 | 16.3 | □ | ↔ | ↔ | ↔ | 2009-2011 | 15.4 | 14.9 | 15.9 | |
| 2 G | Domestic Violence calls per 100,000 population | N/A | 2000-2002 | 452.9 | 434.2 | 472.4 | 2009-2011 | 731.9 | 709.3 | 755.3 | ↑ | ↑ | ↔ | ↔ | 2009-2011 | 450.5 | 449.2 | 451.8 | |
| 2 H | Any smoking during the 1st or 3rd trimester per 100 females with live births | N/A | No Data | | | | 2011 | 10.1+ | 7.1 | 13.2 | | | | | 2011 | 8.1 | 7.1 | 9.1 | |
| 3. Infant Health Indicators | | | | | | | | | | | | | | | | | | | |
| 3 A | Fetal and infant deaths during perinatal period per 1,000 live births and fetal deaths | 5.9 | 2000-2002 | 5.5 | 3.8 | 7.9 | 2009-2011 | 5.0 | 3.4 | 7.4 | ↔ | ↔ | ↔ | ↔ | 2009-2011 | 5.3 | 5.2 | 5.5 | |
| 3 B | Deaths at age less than 1 year per 1,000 live births | 6.0 | 2000-2002 | 4.7 | 3.2 | 7.0 | 2009-2011 | 3.8 | 2.5 | 6.0 | ↔ | ↔ | ★ | ↔ | 2009-2011 | 4.8 | 4.7 | 4.9 | |
| 3 C | Births less than 37 weeks gestation per 100 live births | 11.4 | 2000-2002 | 9.1 | 8.3 | 9.9 | 2009-2011 | 8.6 | 7.9 | 9.5 | ↔ | ↓ | ★ | ↔ | 2009-2011 | 10.1 | 10.0 | 10.1 | |
| 3 D | Births weighing less than 2,500 grams per 100 live births | 7.8 | 2000-2002 | 5.9 | 5.3 | 6.6 | 2009-2011 | 6.4 | 5.7 | 7.1 | ↔ | ↔ | ★ | ↔ | 2009-2011 | 6.8 | 6.7 | 6.8 | |
| 3 E | Births weighing less than 1,500 grams per 100 live births | 1.4 | 2000-2002 | 0.9 | 0.7 | 1.2 | 2009-2011 | 1.1 | 0.8 | 1.4 | ↔ | ↔ | ★ | ↔ | 2009-2011 | 1.1 | 1.1 | 1.2 | |
| 4. Nutrition and Physical Activity Indicators | | | | | | | | | | | | | | | | | | | |
| 4 A | Overweight and obese public school students per 100 population in grades 5, 7, 9, & 11 | N/A | 2008 | 26.0 | | | 2010 | 25.7 | | | | | | 2010 | 38.0 | | | | |
| 4 B | Overweight and obesity per 100 females age 15 to 44 | N/A | No Data | | | | 2011-2012 | 32.7 | (20.2 - 45.3) | | | | | | 2011-2012 | 43.1 | (41.1 - 44.8) | | |
| 4 C | Exclusive breastfeeding per 100 females delivering a live birth | N/A | No Data | | | | 2012 | 83.3 | (81.2 - 85.3) | | | | | | 2012 | 62.6 | (62.5 - 62.8) | | |

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| Indicator | | | Local Period Start | | | | Local Period End | | | | Compare Local End Status to | | | Local Trend Line | | State Period End | | | |
|---------------------------------------|--|--------|--------------------|---------|-------|---------------|------------------|---------|--------------------|------------------|-----------------------------|------------------------------|--|------------------|-----------|------------------|---------|---------|--|
| Description | HP 2020 Objective | Period | 95% Conf. Int | | | 95% Conf. Int | | | Local Period Start | State Period End | HP 2020 Objective | Describe, explain non-linear | If Linear Trend, Compare Progress to HP 2020 | 95% Conf. Int | | | | | |
| | | | Rate | Lower | Upper | Period | Rate | Lower | | | | | | Upper | Period | Rate | Lower | Upper | |
| 5. Child/Adolescent Indicators | | | | | | | | | | | | | | | | | | | |
| 5 A | Births per 1,000 female population age 15 to 17 | 25.7 | 2000-2002 | 10.8 | 9.0 | 12.9 | 2009-2011 | 5.6 | 4.4 | 7.1 | ↓ | ↓ | ★ | ⬇ | 2009-2011 | 16.8 | 16.7 | 17.0 | |
| 5 B | Births per 1,000 female population age 15 to 19 | N/A | 2000-2002 | 24.6 | 22.4 | 27.0 | 2009-2011 | 15.3 | 13.7 | 17.2 | ↓ | ↓ | | ⚡→ | 2009-2011 | 31.6 | 31.4 | 31.8 | |
| 5 C | Births within 24 months of a previous pregnancy per 100 females age less than 20 delivering a live birth | N/A | 2000-2002 | 63.9 | 53.1 | 73.4 | 2009-2011 | 64.6 | 50.4 | 76.6 | ↔ | ↔ | | ↔ | 2009-2011 | 61.7 | 61.1 | 62.3 | |
| 5 D | Deaths per 100,000 population age 1 to 4 years | 25.7 | 2000-2002 | 45.1 | 24.5 | 83.1 | 2009-2011 | 17.4 | 6.8 | 44.7 | ↔ | ↔ | ↔ | | 2009-2011 | 22.3 | 21.2 | 23.5 | |
| 5 E | Deaths per 100,000 population age 5 to 14 years | N/A | 2000-2002 | 17.6 | 10.3 | 30.1 | 2009-2011 | 11.2 | 5.7 | 22.0 | ↔ | ↔ | | | 2009-2011 | 11.0 | 10.5 | 11.6 | |
| 5 F | Deaths per 100,000 population age 15 to 19 years | 55.7 | 2000-2002 | 61.7 | 40.8 | 93.5 | 2009-2011 | 31.2 | 17.9 | 54.6 | ↔ | ↔ | ★ | ⬇ | 2009-2011 | 41.2 | 39.9 | 42.6 | |
| 5 G | Deaths per 100,000 population age 20 to 24 years | 88.5 | 2000-2002 | 113.7 | 75.1 | 172.1 | 2009-2011 | 82.0 | 54.2 | 124.2 | ↔ | ↔ | ↔ | ↔ | 2009-2011 | 68.9 | 67.1 | 70.7 | |
| 5 H | Motor vehicle injury hospitalizations per 100,000 population age 0 to 14 | N/A | 2000-2002 | 29.6 | 20.8 | 42.3 | 2009-2011 | 10.0 | 5.5 | 18.5 | ↓ | ↓ | | ↔ | 2009-2011 | 18.6 | 18.0 | 19.1 | |
| 5 I | Mental health hospitalizations per 100,000 population age 15 to 24 | N/A | 2000-2002 | 1,024.0 | 943.2 | 1,111.7 | 2009-2011 | 1,445.8 | 1,357.0 | 1,540.3 | ↑ | ↑ | | ↑ | 2009-2011 | 1,274.0 | 1,268.6 | 1,279.3 | |
| 5 J | Substance abuse hospitalizations per 100,000 population age 15 to 24 | N/A | 2000-2002 | 387.4 | 338.9 | 442.9 | 2009-2011 | 680.7 | 620.5 | 746.8 | ↑ | ↔ | | ↑ | 2009-2011 | 633.9 | 630.1 | 637.7 | |
| 7. Socioeconomic Determinants | | | | | | | | | | | | | | | | | | | |
| 7 A | Poverty (0-200% FPL) per 100 population age 18 to 64 | N/A | 2006-2008 | 21.1 | 20.9 | 21.3 | 2009-2011 | 21.4 | 21.2 | 21.6 | ↑ | ↓ | | ↔ | 2009-2011 | 33.8 | 33.8 | 33.8 | |
| 7 B | Poverty (0-200% FPL) per 100 population age 0 to 18 | N/A | 2006-2008 | 25.9 | 25.6 | 26.1 | 2009-2011 | 27.0 | 26.8 | 27.3 | ↑ | ↓ | | ⚡→ | 2009-2011 | 45.5 | 45.4 | 45.5 | |
| 7 C | Children in foster care per 1,000 children age 0 to 17 | N/A | 2000-2002 | 5.8 | 5.4 | 6.2 | 2009-2011 | 6.8 | 6.4 | 7.3 | ↑ | ↔ | | ⚡→ | 2009-2011 | 6.8 | 6.8 | 6.8 | |
| 7 D | Unemployment per 100 people in employment market | N/A | 2000-2002 | 4.6 | 4.5 | 4.7 | 2009-2011 | 11.8 | 11.7 | 11.9 | ↑ | ↓ | | ⚡→ | 2009-2011 | 12.3 | 12.3 | 12.3 | |

| | | | |
|------------|-------------------------|------------------------|------------------------|
| KEY | Higher is "Good" | Lower is "Good" | No Objective |
| Rates | Significantly higher | Significantly lower | Significantly higher |
| | Significantly lower | Significantly higher | Significantly lower |
| | NSD No sig. difference | NSD No sig. difference | NSD No sig. difference |
| | NSD No Events | NSD No Events | NSD No Events |
| | Insufficient Data | Insufficient Data | Insufficient Data |
| Trends | Linear Increasing | Linear Decreasing | Linear Increasing |
| | Linear Decreasing | Linear Increasing | Linear Decreasing |
| | Nonlinear - Explain | Nonlinear - Explain | Nonlinear - Explain |
| | Non-significant trend | Non-significant trend | Non-significant trend |
| | Insufficient Data | Insufficient Data | Insufficient Data |

| | | | |
|------------|-------------------------|------------------------|---------------------|
| KEY | Higher is "Good" | Lower is "Good" | No Objective |
| Objective | Objective Met | Objective Met | |
| | Below Objective | Above Objective | |
| | NSD No sig. difference | NSD No sig. difference | |

Maternal, Child, and Adolescent Health (MCAH) Local Health Jurisdictions (LHJ) Needs Assessment

Timeline and Deliverables:

E-mail deliverables by the due date listed below to CATitleV@cdph.ca.gov. *Instructions are included in each form.*

| Due Date | Deliverables |
|------------------------------------|---|
| October 16, 2013 | MCAH Strategic Question Surveys (separate survey sent September 16, 2013) |
| June 16, 2014 (in this package) | Deliverable Form A - Stakeholders/Community Partners Deliverable Form B - Problem Statements, Strategies, and Partners Deliverable Form C - Capacity Needs Deliverable Form D - Summary (data available Fall 2013) |
| May 15, 2015 | Deliverable Form E - 5-Year Action Plans (available Fall 2013) |

Resources:

Below are resources that LHJs can use to complete their deliverables.

| # | Resource | Description |
|---|---|---|
| 1 | Community Health Status Report (available February 2014) | A list of health indicators to assist in describing and identifying your local health jurisdiction's health status |
| 2 | FHOP Indicator Data Books (available February 2014) | Resource providing additional community health status data |
| 3 | Priority Problems List | Short list of MCAH SOW Goals and Problem Categories to provide guidance on State MCAH priorities for use in developing local problem statements. |
| 4 | MCAH Health Problem Prioritization Worksheet | Tool to assist in prioritizing identified problems |
| 5 | Sample Problem Analysis Diagrams (available Fall 2013) | Tools to assist in identifying potential causes of problems and possible intervention points |
| 6 | Sample 5-Year Action Plans (available February 2014) | Completed 5-Year Action Plan samples for MCAH Division priority problems in MCAH SOW Problem Categories. The 5-Year Action Plans identify sample objectives, best practice strategies/interventions and performance measures to assist LHJs in developing LHJ specific 5-Year Action Plans to address MCAH SOW goals. |

Completing Deliverable A through D (Due June 16, 2014)

To access Deliverable Forms A through D, identify your LHJ below. Once you identify your LHJ, this document will generate Deliverable Forms A through D on the following pages.

Local Health Jurisdiction **El Dorado**

Deliverable Form A - Stakeholders/Community Partners

Purpose

Deliverable Form A provides documentation that the process for the development of the local Needs Assessment includes participation of partners within and outside the local MCAH program that represent your community's populations and health challenges. Stakeholder/Community Partner input is recommended in completing this Needs Assessment. Stakeholders/Community Partners can help you to:

- Review data, identify and prioritize problems, and identify target populations
- Review problem analyses to identify causal pathways, intervention points and possible stakeholders/community partners and strategies, and to develop your 5-Year Action Plans
- Develop community support

Instructions:

List Stakeholders/Community Partners you consulted with to complete your Needs Assessment, the individual's initials, and the sector they represent. *Keeping a membership list or meeting attendance records can assist you in completing Deliverable Form A.* Sectors include:

- Community clinic or FQHC
- Community-based organization (local non-profit)
- Faith-based organization
- First 5
- Foundations
- Health care district
- Hospital
- Individual dental care provider (dentist, hygienist)
- Individual medical provider (nurse, doctor)
- Individual mental health care provider (counselor, psychologist, psychiatrist)
- Individual or family (community member)
- Individual youth
- MCAH advisory groups
- Medical group or independent practice association
- Medi-Cal Managed Care Plan
- Professional organization/association (American Medical Association, American Dental Association)
- School, academia (parent/teacher association, school board, university)
- State or nationally affiliated non-profit organization
- State/local health department (internal partners, parks and recreation)
- Other state/local agency (e.g., social services, justice)
- Other (trade and business sector, media)

Deliverable Form A - Stakeholders/Community Partners

List Stakeholders/Community Partners you consulted with to complete your Needs Assessment, the individual's initials, and the sector they represent. Choose the sector the stakeholder represents from the drop-down menu.

Office Only

09-A

| Stakeholder's/ Community Partner's Initials | Organization (Full Name; No Acronyms) | Sector Represented |
|---|---|-------------------------------|
| MC | El Dorado County Public Health, Public Health Nursing | State/local health department |
| ST | First 5 El Dorado | MCAH advisory group |
| LS | El Dorado County Public Health, MCAH | MCAH advisory group |
| OBC | El Dorado County Public Health, Epidemiology | MCAH advisory group |
| NC | California State University of Sacramento, School of Nursing | School, academia |
| VB | El Dorado County Public Health, El Dorado High School, MCAH | State/local health department |
| CG | El Dorado County Public Health, Divide Wellness Center, MCAH | State/local health department |
| LL | El Dorado County Mental Health, Alcohol and Drug Section, Perinatal Substance Abuse Program | State/local health department |
| CW | El Dorado County Health Promotion Section, Tobacco Prevention Program | State/local health department |
| CB | The Center for Violence Free Relationships | Community-based organization |
| MW | The Center for Violence Free Relationships | Community-based organization |
| KR | El Dorado County Public Health, Child Protective Services and MCAH | State/local health department |
| DT | El Dorado County Public Health, California Children's Services Program | State/local health department |
| TN | El Dorado Public Health, Community Corrections Center | State/local health department |
| SS | County Office of Education | School, academia |

Deliverable Form A - Stakeholders/Community Partners

| Stakeholder's/ Community Partner's Initials | Organization (Full Name; No Acronyms) | Sector Represented |
|---|--|--|
| TS | El Dorado County Public Health, Child Health Disability Prevention Program | State/local health department |
| TT | Placerville Union School District, Homeless Program | School, academia |
| JK | Prevention Works | Other |
| CD | El Dorado County Public Health, Immunization Coordinator | State/local health department |
| DS | El Dorado County Public Health, Communicable Disease Program | State/local health department |
| CM | Marshall Medical OB Unit | Hospital |
| JB | Marshall Medical OB Unit | Hospital |
| PS | New Arenas | Community-based organization |
| APP | El Dorado County Health Officer | MCAH advisory group |
| RS | El Dorado County Mental Health, Mental Health Services Act | State/local health department |
| KG | First 5 El Dorado | First 5 |
| AP | First 5 El Dorado | First 5 |
| DS | County Office of Education, Head Start Program | School, academia |
| LA | Tahoe Youth and Family Services | Community-based organization |
| JS | El Dorado County Public Health, South Lake Tahoe | State/local health department |
| SOB | El Dorado County Mental Health | State/local health department |
| KM | Live Violence Free | Community-based organization |
| DH | South Lake Tahoe Family Resource Center | Community-based organization |
| WW | University of CA Cooperative Extension CalFresh Nutrition Education | State or nationally affiliated non-profit organization |

Deliverable Form A - Stakeholders/Community Partners

| Stakeholder's/ Community Partner's Initials | Organization (Full Name; No Acronyms) | Sector Represented |
|---|--|--|
| KM | University of CA Cooperative Extension CalFresh Nutrition Education | State or nationally affiliated non-profit organization |
| NZ | Lake Tahoe Collaborative | First 5 |
| CT | El Dorado County Mental Health, Alcohol and Drug Program | State/local health department |
| LW | Barton Health, Communications | Hospital |
| PM | El Dorado County Public Health, MCAH & Communicable Disease | State/local health department |
| KS | Together We Grow | Community-based organization |
| KI | Together We Grow | Community-based organization |
| CC | Liliput Children's Services | Other state/local agency |
| RS | County Office of Education, Child Development | School, academia |
| LB | County Office of Education, Child Development | School, academia |

Deliverable Form B: Problem Statements, Strategies, and Partners

Purpose:

The purpose of this form is:

- To identify local problems, problem statements, best practice strategies and the stakeholders/community partners who will help address these problems, and
- To inform state and local decisions regarding resource allocation if more resources become available.

Instructions:

Complete Deliverable Form B for each local problem. **Identify all local problems, including those that your local health jurisdictions (LHJs) may not have the resources or capacity to address at this time.**

All LHJs must list at least one problem in each of the MCAH SOW Goals 1, 2, and 3. If resources allow, LHJs may also identify additional problems that they may place under any of the MCAH SOW Goals 1 through 6.

The Goals in the MCAH SOW provide a structure that LHJs use to address local problems identified by each LHJ's 5-Year Needs Assessment. Each LHJ's Title V 5-Year Needs Assessment identifies problems that may be addressed in their 5-Year Action Plans. Each LHJ's 5-Year Action Plans will then inform the development of the annual MCAH Scope of Work (SOW).

For each local problem, complete this form, doing the following:

| Step | Instructions | Form Entries | Details |
|------|--|--|---|
| 1 | Classify local problem | Problem Category Target Population Race/Ethnicity Other Subpopulation | Target Population - The primary population experiencing the problem, whose health you are affecting with the intervention Other Population - If you wish to further narrow and define your population group, complete the "Other Subpopulation" fields. |
| 2 | Describe a local problem | Problem Statement | The problem statement should clearly describe the health problem, which is defined as the difference between the desired and the actual health status of the population as measured by health status indicators. The problem statement should state the local problem, the population affected, and the cause. <i>Example: "X (population) is (having y problem) due to z (cause)".</i> |
| 3 | Determine if the problem will be addressed by your LHJ | Addressing Problem? Reason For Not Addressing Problem | Describe if you will address the problem. If not, indicate the main reason why you are not addressing this problem. You must address one problem in each of Goals 1-3, therefore the choice not to address a problem is not available until the second and subsequent problems in Goals 1-3. |
| 4 | Describe how to best address these problems | Best Practice Strategies | Best Practice Strategies/ Intervention Activities: The actions or interventions you implement to improve the target population's health outcome. Refer to sample Problem Analyses to identify possible intervention points. List activities you intend to use to address the problem. You may use the sample "5-Year Action Plans" (Resource 6), stakeholder/community partner input, existing programs or activities you are conducting and your expertise to identify best practice strategies/intervention activities If desired, you could also refer to the MCAH Policies and Procedures "Public Health Frameworks" section or FHOP Intervention Planning Resources and Tools for sources of additional evidence-based or knowledge-based strategies. |
| 5 | Describe who can address the problems | Stakeholders or Community Partners | List stakeholder or community partner organization(s) that will help to address the problem. |

Deliverable Form B: Problem Statements, Strategies, and Partners

Complete Deliverable Form B for *each* local problem. Identify all local problems, including those that your local health jurisdiction (LHJ) may not have the resources or capacity to address at this time. Identify your local problems, best practice strategies, and the stakeholders/community partners who will help address these problems.

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09-B-1-1

All LHJs must list and address at least one problem in each of the MCAH SOW Goals 1, 2, and 3. If resources allow, LHJs may also identify additional problems that they may place under any of the MCAH SOW Goals 1 through 6.

Problem # 1

MCAH SOW Goal

MCAH SOW Goal 1: Improve Outreach and Access to Quality Health and Human Services

(Required)

Step 1: Classify this local problem

Problem Category

Access to health care

Target Population(s) - the primary population experiencing the problem, whose health you are affecting with the intervention; choose one or more

Infants Children Adolescents Adult Women Pregnant Women Other

Race/Ethnicity(ies) - choose one or more

Asian/Pacific Islanders Blacks Latinos Native Americans Whites

Other Subpopulation - example: geographic area, socioeconomic status, Medi-Cal eligible, uninsured, undocumented residents

Other 1 - specify: socially-isolated communities Other 2 - specify: _____

Step 2: Describe a local problem (see Step 1 to assist with conceptualizing the problem statement)

Problem Statement - use the format: "X (population) is (having y problem) due to z (cause)"

Low rate of early prenatal care entry in females delivering a live birth due to substance use and mental health issues.

Step 3: Determine if problem can be addressed by your county

Are You Addressing This Problem? Yes

Step 4: Describe how to best address this problem

List best practice strategies or intervention activities you could use to address the problem.

- *Educate young women on the importance of early prenatal care, signs and symptoms of pregnancy.
- *Assist with access to care for pregnant women, helping to reduce any system barriers as appropriate.
- *Educate middle and high school populations on dangers of substance use, positive coping strategies, and conflict resolution skills.
- *Work with families in socially-isolated communities to provide early identification of mental health issues, substance use, and domestic violence problems. Provide resource connections for these families.

Step 5: Describe who will help address this problem

List stakeholder or community partner organization(s) who will help to address the problem:

County Office of Education, First 5 El Dorado, New Morning, Income Maintenance, PHNs from Field Nursing, The Center for Violence Free Relationships, Marshall Hospital and Outpatient Clinics, Barton Health, Mental Health Division, South Lake Tahoe Family Resource Center, Prevention Works, Infant Parent Center, Tahoe Youth and Family Services, El Dorado Community Health Center

Deliverable Form B: Problem Statements, Strategies, and Partners

Complete Deliverable Form B for *each* local problem. Identify all local problems, including those that your local health jurisdiction (LHJ) may not have the resources or capacity to address at this time. Identify your local problems, best practice strategies, and the stakeholders/community partners who will help address these problems.

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09-B-2-2

All LHJs must list and address at least one problem in each of the MCAH SOW Goals 1, 2, and 3. If resources allow, LHJs may also identify additional problems that they may place under any of the MCAH SOW Goals 1 through 6.

Problem # 2

MCAH SOW Goal

MCAH SOW Goal 2: Improve Maternal and Women's Health

(Required)

Step 1: Classify this local problem

Problem Category

Partner/ family violence

Target Population(s) - the primary population experiencing the problem, whose health you are affecting with the intervention; choose one or more

Infants Children Adolescents Adult Women Pregnant Women Other

Race/Ethnicity(ies) - choose one or more

Asian/Pacific Islanders Blacks Latinos Native Americans Whites

Other Subpopulation - example: geographic area, socioeconomic status, Medi-Cal eligible, uninsured, undocumented residents

Other 1 - specify: socially-isolated communities

Other 2 - specify: _____

Step 2: Describe a local problem (see Step 1 to assist with conceptualizing the problem statement)

Problem Statement - use the format: "X (population) is (having y problem) due to z (cause)"

High rate of domestic violence calls in the county due to lack of education, early identification of problem behaviors, and resource identification.

Step 3: Determine if problem can be addressed by your county

Are You Addressing This Problem? Yes

Step 4: Describe how to best address this problem

List best practice strategies or intervention activities you could use to address the problem.

*Educate middle and high school populations on dangers of substance use, positive coping strategies, and conflict resolution skills.

*Work with families in socially-isolated communities to provide early identification of mental health issues, substance use, and domestic violence problems. Provide resource connections for these families.

Step 5: Describe who will help address this problem

List stakeholder or community partner organization(s) who will help to address the problem:

County Office of Education, First 5 El Dorado, New Morning, Income Maintenance, PHNs from Field Nursing, The Center for Violence Free Relationships, Marshall Hospital and Outpatient Clinics, Barton Health, Mental Health Division, South Lake Tahoe Family Resource Center, Prevention Works, Infant Parent Center, Tahoe Youth and Family Services, El Dorado Community Health Center

Deliverable Form B: Problem Statements, Strategies, and Partners

Complete Deliverable Form B for *each* local problem. Identify all local problems, including those that your local health jurisdiction (LHJ) may not have the resources or capacity to address at this time. Identify your local problems, best practice strategies, and the stakeholders/community partners who will help address these problems.

Office Only

09-B-3-3

All LHJs must list and address at least one problem in each of the MCAH SOW Goals 1, 2, and 3. If resources allow, LHJs may also identify additional problems that they may place under any of the MCAH SOW Goals 1 through 6.

Problem # 3

MCAH SOW Goal

MCAH SOW Goal 3: Improve Infant Health

(Required)

Step 1: Classify this local problem

Problem Category - *prematurity/low birth weight and perinatal substance use will be available to select in subsequent Goal 3 problems*

SIDS/SUID

Target Population(s) - *the primary population experiencing the problem, whose health you are affecting with the intervention; choose one or more*

Infants Children Adolescents Adult Women Pregnant Women Other

Race/Ethnicity(ies) - *choose one or more*

Asian/Pacific Islanders Blacks Latinos Native Americans Whites

Other Subpopulation - *example: geographic area, socioeconomic status, Medi-Cal eligible, uninsured, undocumented residents*

Other 1 - specify: socially-isolated communities

Other 2 - specify: _____

Step 2: Describe a local problem (see Step 1 to assist with conceptualizing the problem statement)

Problem Statement - *use the format: "X (population) is (having y problem) due to z (cause)"*

High rate of substance use hospitalizations in pregnant women due to mental health issues, social isolation, inadequate problem solving skills, poor self-esteem, and limited knowledge on the effects of substance use during pregnancy.

Step 3: Determine if problem can be addressed by your county

Are You Addressing This Problem? Yes

Step 4: Describe how to best address this problem

List best practice strategies or intervention activities you could use to address the problem.

- *Educate middle and high school populations on dangers of substance use, positive coping strategies, and conflict resolution skills.
- *Work with families in socially-isolated communities to provide early identification of mental health issues, substance use, and domestic violence problems. Provide resource connections for these families.
- *Work with partners to develop a community resource directory for treatment and promote its use.
- *Work with area medical providers on routine screening for substance use during pregnancy in addition to appropriate education and referrals for identified individuals.

Step 5: Describe who will help address this problem

List stakeholder or community partner organization(s) who will help to address the problem:

County Office of Education, First 5 El Dorado, New Morning, PHNs from Field Nursing, The Center for Violence Free Relationships, Marshall Hospital and Outpatient Clinics, Barton Health, Mental Health Division, South Lake Tahoe Family Resource Center, Prevention Works, Infant Parent Center, Tahoe Youth and Family Services, local churches, El Dorado Community Health Center

Deliverable Form B: Problem Statements, Strategies, and Partners

Complete Deliverable Form B for *each* local problem. Identify all local problems, including those that your local health jurisdiction (LHJ) may not have the resources or capacity to address at this time. Identify your local problems, best practice strategies, and the stakeholders/community partners who will help address these problems.

Office Only

09-B-2-4

All LHJs must list and address at least one problem in each of the MCAH SOW Goals 1, 2, and 3. If resources allow, LHJs may also identify additional problems that they may place under any of the MCAH SOW Goals 1 through 6.

Problem # 4

MCAH SOW Goal

MCAH SOW Goal 2: Improve Maternal and Women's Health

Step 1: Classify this local problem

Problem Category

Perinatal mood/ anxiety disorders

Target Population(s) - the primary population experiencing the problem, whose health you are affecting with the intervention; choose one or more

Infants Children Adolescents Adult Women Pregnant Women Other

Race/Ethnicity(ies) - choose one or more

Asian/Pacific Islanders Blacks Latinos Native Americans Whites

Other Subpopulation - example: geographic area, socioeconomic status, Medi-Cal eligible, uninsured, undocumented residents

Other 1 - specify: socially-isolated communities Other 2 - specify: _____

Step 2: Describe a local problem (see Step 1 to assist with conceptualizing the problem statement)

Problem Statement - use the format: "X (population) is (having y problem) due to z (cause)"

High rate of mood disorder hospitalizations in pregnant women due to lack of early identification of mental health issues, provider screening, and resource identification.

Step 3: Determine if problem can be addressed by your county

Are You Addressing This Problem? Yes No

Step 4: Describe how to best address this problem

List best practice strategies or intervention activities you could use to address the problem.

- *Educate middle and high school populations on dangers of substance use, positive coping strategies, and conflict resolution skills.
- *Work with families in socially-isolated communities to provide early identification of mental health issues, substance use, and domestic violence problems. Provide resource connections for these families.
- * Work with providers caringfor pregnant and postpartum women to promote routine screening and referral process.

Step 5: Describe who will help address this problem

List stakeholder or community partner organization(s) who will help to address the problem:

County Office of Education, First 5 El Dorado, New Morning, PHNs from Field Nursing, The Center for Violence Free Relationships, Marshall Hospital and Outpatient Clinics, Barton Health, Mental Health Division, South Lake Tahoe Family Resource Center, Prevention Works, Infant Parent Center, Tahoe Youth and Family Services, local churches, El Dorado Community Health Center

Deliverable Form B: Problem Statements, Strategies, and Partners

Complete Deliverable Form B for *each* local problem. Identify all local problems, including those that your local health jurisdiction (LHJ) may not have the resources or capacity to address at this time. Identify your local problems, best practice strategies, and the stakeholders/community partners who will help address these problems.

Office Only

09-B-5-5

All LHJs must list and address at least one problem in each of the MCAH SOW Goals 1, 2, and 3. If resources allow, LHJs may also identify additional problems that they may place under any of the MCAH SOW Goals 1 through 6.

Problem # 5

MCAH SOW Goal

MCAH SOW Goal 5: Improve Child Health

Step 1: Classify this local problem

Problem Category

Other

Target Population(s) - the primary population experiencing the problem, whose health you are affecting with the intervention; choose one or more

Infants Children Adolescents Adult Women Pregnant Women Other

Race/Ethnicity(ies) - choose one or more

Asian/Pacific Islanders Blacks Latinos Native Americans Whites

Other Subpopulation - example: geographic area, socioeconomic status, Medi-Cal eligible, uninsured, undocumented residents

Other 1 - specify: socially-isolated communities

Other 2 - specify: _____

Step 2: Describe a local problem (see Step 1 to assist with conceptualizing the problem statement)

Problem Statement - use the format: "X (population) is (having y problem) due to z (cause)"

High Immunization Personal Belief Exemption rate in Kindergartens due to parental immunization safety concerns and lack of knowledge related to emerging Vaccine-Preventable Diseases.

Step 3: Determine if problem can be addressed by your county

Are You Addressing This Problem? Yes No

Step 4: Describe how to best address this problem

List best practice strategies or intervention activities you could use to address the problem.

- *Work with schools to train staff on immunization importance and how to comply with State immunization requirements.
- *Work with partners (community-based organizations, schools, County programs, media) to educate parents and providers about vaccine importance and safety.
- *Work with area providers to increase their knowledge on effective counseling regarding immunizations for parents and to help ensure safe and effective immunization policies and practices.

Step 5: Describe who will help address this problem

List stakeholder or community partner organization(s) who will help to address the problem:

County Office of Education, First 5 El Dorado, Income Maintenance, Public Health Division, Marshall Hospital and Outpatient Clinics, Barton Health, South Lake Tahoe Family Resource Center, Prevention Works, local media outlets, WIC, local churches, El Dorado Community Health Center

Deliverable Form B: Problem Statements, Strategies, and Partners

Complete Deliverable Form B for *each* local problem. Identify all local problems, including those that your local health jurisdiction (LHJ) may not have the resources or capacity to address at this time. Identify your local problems, best practice strategies, and the stakeholders/community partners who will help address these problems.

Office Only
09-B-6-6

All LHJs must list and address at least one problem in each of the MCAH SOW Goals 1, 2, and 3. If resources allow, LHJs may also identify additional problems that they may place under any of the MCAH SOW Goals 1 through 6.

Problem # 6

MCAH SOW Goal

MCAH SOW Goal 6: Improve Adolescent Health

Step 1: Classify this local problem

Problem Category

Adolescent mental health

Target Population(s) - the primary population experiencing the problem, whose health you are affecting with the intervention; choose one or more

Infants Children Adolescents Adult Women Pregnant Women Other

Race/Ethnicity(ies) - choose one or more

Asian/Pacific Islanders Blacks Latinos Native Americans Whites

Other Subpopulation - example: geographic area, socioeconomic status, Medi-Cal eligible, uninsured, undocumented residents

Other 1 - specify: socially-isolated communities Other 2 - specify: _____

Step 2: Describe a local problem (see Step 1 to assist with conceptualizing the problem statement)

Problem Statement - use the format: "X (population) is (having y problem) due to z (cause)"

High rate of mood disorder hospitalizations in 15 to 24 year-olds due to lack of early identification of mental health issues, provider screening, and resource identification.

Step 3: Determine if problem can be addressed by your county

Are You Addressing This Problem? Yes No

If you are not addressing this problem, what is the main reason? (choose 1 option)

- Insufficient capacity
- Other MCAH-funded programs addressing this problem
- Other community groups are addressing the problem
- Other

Identify other community groups that can address this problem:

Mental Health Services Act contracts with various community partners to address early identification and intervention of mental health issues.

Deliverable Form B: Problem Statements, Strategies, and Partners

Complete Deliverable Form B for *each* local problem. Identify all local problems, including those that your local health jurisdiction (LHJ) may not have the resources or capacity to address at this time. Identify your local problems, best practice strategies, and the stakeholders/community partners who will help address these problems.

Office Only

09-B-6-7

All LHJs must list and address at least one problem in each of the MCAH SOW Goals 1, 2, and 3. If resources allow, LHJs may also identify additional problems that they may place under any of the MCAH SOW Goals 1 through 6.

Problem # 7

Add Problem

Remove Problem

MCAH SOW Goal

MCAH SOW Goal 6: Improve Adolescent Health

Step 1: Classify this local problem

Problem Category

Other

Target Population(s) - the primary population experiencing the problem, whose health you are affecting with the intervention; choose one or more

Infants Children Adolescents Adult Women Pregnant Women Other

Race/Ethnicity(ies) - choose one or more

Asian/Pacific Islanders Blacks Latinos Native Americans Whites

Other Subpopulation - example: geographic area, socioeconomic status, Medi-Cal eligible, uninsured, undocumented residents

Other 1 - specify: socially-isolated communities

Other 2 - specify: _____

Step 2: Describe a local problem (see Step 1 to assist with conceptualizing the problem statement)

Problem Statement - use the format: "X (population) is (having y problem) due to z (cause)"

High rate of substance use hospitalizations in 15 to 24 year-olds due to mental health issues, social isolation, inadequate problem solving skills, poor self-esteem, and limited knowledge on the effects of substance use.

Step 3: Determine if problem can be addressed by your county

Are You Addressing This Problem? Yes No

If you are not addressing this problem, what is the main reason? (choose 1 option)

- Insufficient capacity
- Other MCAH-funded programs addressing this problem
- Other community groups are addressing the problem
- Other

Deliverable Form C: Capacity Needs

Office Only
09-C

Purpose:

Capacity needs are resources you require to better address the problems of your community. Capacity needs could include items such as staff training, information on best practices, additional staff, or improved data. The information on this form will help the MCAH Division identify how we can best support your efforts.

Instructions:

In the table below, please list capacity needs in the first column and how the MCAH Division can assist you in developing capacity in the second column. When describing the capacity need, if appropriate, state if the need is related to a particular problem.

| List Capacity Needs | How can the MCAH Division assist you in developing this capacity? |
|--|---|
| Difficulty in recruiting, training and retaining a Public Health Nurse in South Lake Tahoe | Increase funding allocations to provide resources for salary increase. Promote MCAH Program and its importance to the health of our communities. |
| Additional MCAH Staff | Increase funding allocations so more staff can be hired to do MCAH SOW and preventative health interventions in families. This includes making HRSA home visitation funds available to counties that weren't previously granted them. |
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Deliverable Form D: Summary

Purpose:

This Summary, also known as your Community Profile that is submitted annually with the Agreement Funding Application, provides a snapshot of the health status of your local community. You may use this Summary to share information with stakeholders/community partners and to educate your population. The Summary should provide key data, a description of the community, including major employers, health system, health status of the MCAH population and disparities, local problems, and strategies or programs to address these problems.

Instructions:

The Local and State data in Section 1 will be available in February 2014. Add your local data from your CHSR to this document and refer to your [Databook](#) for the State Infant Deaths per 1000 live births, and add this to the Demographic section. Complete Sections 2-4 using the instructions in each Section. Section 5 will automatically generate from your results in Deliverable Form B. Please limit the Summary to approximately two pages.

Office Only
09-D

Section 1 - Demographics

| | Local | State |
|--|---------|------------|
| Our Community | | |
| Total Population ¹ | 180,663 | 37,570,307 |
| Total Population, African American | 1,295 | 2,195,986 |
| Total Population, American Indian/ Alaskan Natives | 1,546 | 163,262 |
| Total Population, Asian/Pacific Islander | 7,044 | 4,994,232 |
| Total Population, Hispanic | 22,766 | 14,277,952 |
| Total Population, White | 143,168 | 14,995,619 |
| Total Live Births | 1,629 | 501,994 |
| Our Mothers and Babies | | |
| % of women delivering a baby who received prenatal care beginning in the first trimester of their pregnancy ² | 78.7 | 83.3 |
| % of births covered by Medi-Cal ² | 37.7 | 47.3 |
| % of women ages 18-64 without health insurance ³ | 14.2 | 22.1 |
| % of women giving birth to a second child within 24 months of a previous pregnancy ² | 31.8 | 28.7 |

| | Local | State |
|---|---------|----------|
| Our Mothers and Babies (continued) | | |
| Infant Deaths per 1,000 live births occurring at less than 1 year of age ^{2,4} | 5.0 | 5.3 |
| % live births less than 37 weeks gestation ² | 8.6 | 10.1 |
| % of women 15-44 years of age who are overweight or obese ⁵ | 32.7 | 43.1 |
| % of female population 18-64 living in poverty (0-200% FPL) ³ | 21.4 | 33.8 |
| % of single mother families living in poverty ⁶ | 18.3 | 39.4 |
| Unemployment Rate ⁷ | 11.8 | 12.3 |
| Our Children and Teens | | |
| Teen Birth Rate per 1,000 births (ages 15-19) ² | 15.3 | 31.6 |
| Reported cases of chlamydia per 100,000 female population age 15-24 ⁸ | 1,363.2 | 2,905.4C |
| % of children, ages 0-18 years living in poverty (0-200% FPL) ³ | 27.0 | 45.5 |
| % of children receiving free or reduced price meals at school ⁹ | 34.0 | 57.5 |
| Children in Foster Care per 1,000 children ¹⁰ | 6.8 | 6.8 |
| % High School dropout rate (grades 9-12) ¹¹ | 7.8 | 14.7 |

Data sources: ¹CA Dept. of Finance population estimates 2010, ²CA Birth Statistical Master Files 2009-2011, ³US Census Bureau - Small Area Health Insurance Estimates 2009-2011, ⁴CA Death Statistical Master Files, 2009-2011, ⁵CA Health Interview Survey, 2009, ⁶2012 American Community Survey 1-Year Estimates, ⁷CA Employment Development Dept. 2009-2011, ⁸CA Dept of Public Health, STD Control Branch 2012, ⁹CA Dept. of Education, Free/Reduced Price Meals Program & CalWORKS Data Files 2009-2011, ¹⁰Data from CA Child Welfare Indicators Project, UC Berkeley 2009-2011, ¹¹CA Dept. of Education, CA Basic Educational Data System (CBEDS) 2011.

Section 2 - About Our Community - Health Starts Where We Live, Learn, Work, and Play

Describe the following using brief narratives and bullets: 1) *Geography*, 2) *Major industries and employers (public/private)*, 3) *Walkability, open space*

El Dorado County includes 1,707.46 square miles of land. Although the western extremity is a Sacramento suburb, the majority of El Dorado County spans the Sierra Nevada Mountains, a rugged and remote region. Eighty-two percent of the county's population reside in unincorporated areas of the county. There are only two incorporated cities, Placerville and South Lake Tahoe, which are 60 miles apart and separated by the Sierra Nevada Mountain range. The population density in El Dorado County is estimated at 105.35 persons per square mile; 34.70% is considered rural. The rural nature of many unincorporated areas of the county results in challenges to obtaining health and human services. According to the U.S. Census Bureau Decennial Census, between 2000 and 2010 the population in the county grew by 24,759 persons, a change of 15.84%. The median age of El Dorado County residents is 43.10. Most of the population lives in a "Health Professional Shortage Area". Only 8.40% of all individuals residing in El Dorado County are living in households with income below the Federal Poverty Level but 37.6% of women residents giving birth are Medi-Cal eligible. The major employers in the county are Top of the Tram Monument Peak, County of El Dorado, Marshall Medical Center, Red Hawk Casino, and DST Output. Approximately 29% of employed workers in El Dorado County commute to Sacramento for work. Only 59% of residents work within the county.

Deliverable Form D: Summary

Section 3 - Health System - Access to health and human services for the MCAH population

Describe the following using brief narratives and bullets: Available resources that comprise the health system for your MCAH population. Include the numbers of hospitals where women give birth, Comprehensive Perinatal Services Program (CPSP) providers, and Denti-Cal providers for children. Discuss local challenges, key disparities and barriers to accessing medical, mental, dental, and social services. List Medi-Cal Managed Care plan that provide services to women and children, located at www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx.

El Dorado County has:

- *1 Federally-Qualified Health Center that has 3 sites on the Western Slope of the county
- *1 Tribal Health Center in Shingle Springs
- *3 Rural Health Centers - 1 in South Lake Tahoe, 1 in Camino, and 1 on the Divide
- *2 Hospitals that have primary care - both inpatient and outpatient, specialty care, and labor and delivery units
- *2 Denti-Cal offices and 1 Dental Van who serves medical eligible children and pregnant women throughout the county
- *1 CPSP Provider in South Lake Tahoe who is performing CPSP "like" services
- *2 Medi-Cal Managed Care Plans - California Health and Wellness and Anthem Blue Cross

Access issues:

Lack of sufficient Providers - dental care and mental health, substance abuse treatment, aging providers

Geographic distribution of medical resources not adequate for rural areas - clinics, urgent care, medical equipment, pharmacies

Transportation, language and cultural barriers

Section 4 - Health Status and Disparities for the MCAH Population

Describe the following using brief narratives and bullets: Key health disparities and how health behaviors, the physical environment and social determinants of health (social/economic factors) contribute to these disparities for specific populations. Highlight areas where progress has been made in improving health outcomes.

Certain communities within the county have higher concentrations of low-income individuals, those with no high-school diplomas, and a higher rate of female-headed families living in poverty. These particular communities also have higher rates of Emergency Department visits and hospitalization rates due to mental health issues, self-inflicted injuries, and substance abuse issues. El Dorado County as a whole has a higher benchmark for substance abuse than the state, at almost twice the state rate. Methamphetamines, marijuana, heroin, and prescription drugs continue to be a problem in the county, including the pregnant population. The rural nature of the county and lack of sufficient mass-transit infrastructure contributes to access problems for health services, human services, and healthy foods. There are considerable challenges associated with accessing care, especially Medi-Cal providers, specialty medical and follow-up care, mental health treatment, and dental services. The county has a significant Latino population but is lacking in culturally-appropriate care for these individuals.

An area of improvement for the county is the rate of uninsured children and adolescents. This can be attributed to a robust collaborative effort by First 5 El Dorado and Public Health. Finally, teen birth rates have decreased since the last MCAH Needs Assessment, especially in the 15-17 year-olds; the county's current rate meets the Healthy People 2020 objectives.

Section 5 - Local Problems

Below is a summary of the local problems and strategies identified by your LHM in its needs assessment. Results are automatically populated from the problem statement and best practice strategies identified in Deliverable Form B.

| # | Problem | Strategy | Office Only |
|---|---|---|-------------|
| 1 | Low rate of early prenatal care entry in females delivering a live birth due to substance use and mental health issues. | <ul style="list-style-type: none"> *Educate young women on the importance of early prenatal care, signs and symptoms of pregnancy. *Assist with access to care for pregnant women, helping to reduce any system barriers as appropriate. *Educate middle and high school populations on dangers of substance use, positive coping strategies, and conflict resolution skills. *Work with families in socially-isolated communities to provide early identification of mental health issues, substance use, and domestic | 09-B-1-1 |

Deliverable Form D: Summary

| # | Problem | Strategy | Office Only |
|---|---|--|-------------|
| | | violence problems. Provide resource connections for these families. | |
| 2 | High rate of domestic violence calls in the county due to lack of education, early identification of problem behaviors, and resource identification. | <p>*Educate middle and high school populations on dangers of substance use, positive coping strategies, and conflict resolution skills.</p> <p>*Work with families in socially-isolated communities to provide early identification of mental health issues, substance use, and domestic violence problems. Provide resource connections for these families.</p> | 09-B-2-2 |
| 3 | High rate of substance use hospitalizations in pregnant women due to mental health issues, social isolation, inadequate problem solving skills, poor self-esteem, and limited knowledge on the effects of substance use during pregnancy. | <p>*Educate middle and high school populations on dangers of substance use, positive coping strategies, and conflict resolution skills.</p> <p>*Work with families in socially-isolated communities to provide early identification of mental health issues, substance use, and domestic violence problems. Provide resource connections for these families.</p> <p>*Work with partners to develop a community resource directory for treatment and promote its use.</p> <p>*Work with area medical providers on routine screening for substance use during pregnancy in addition to appropriate education and referrals for identified individuals.</p> | 09-B-3-3 |
| 4 | High rate of mood disorder hospitalizations in pregnant women due to lack of early identification of mental health issues, provider screening, and resource identification. | <p>*Educate middle and high school populations on dangers of substance use, positive coping strategies, and conflict resolution skills.</p> <p>*Work with families in socially-isolated communities to provide early identification of mental health issues, substance use, and domestic violence problems. Provide resource connections for these families.</p> <p>* Work with providers caring for pregnant and postpartum women to promote routine screening and referral process.</p> | 09-B-2-4 |
| 5 | High Immunization Personal Belief Exemption rate in Kindergartens due to parental immunization safety concerns and lack of knowledge related to emerging Vaccine-Preventable Diseases. | <p>*Work with schools to train staff on immunization importance and how to comply with State immunization requirements.</p> <p>*Work with partners (community-based organizations, schools, County programs, media) to educate parents and providers about vaccine importance and safety.</p> <p>*Work with area providers to increase their knowledge on effective counseling regarding immunizations for parents and to help ensure safe and effective immunization policies and practices.</p> | 09-B-5-5 |
| 6 | High rate of mood disorder hospitalizations in 15 to 24 year-olds due to lack of early identification of mental health issues, provider screening, and resource identification. | N/A. Reason: Other community groups are addressing the problem. See form B for details. | 09-B-6-6 |

Deliverable Form D: Summary

| | | | |
|---|--|---|----------|
| 7 | High rate of substance use hospitalizations in 15 to 24 year-olds due to mental health issues, social isolation, inadequate problem solving skills, poor self-esteem, and limited knowledge on the effects of substance use. | N/A. Reason: Insufficient capacity. See form B for details. | 09-B-6-7 |
|---|--|---|----------|

Deliverable Form E – 5-Year Action Plans

| MCAH SOW Goal 1: Access to Health Care | |
|--|---|
| Problem Category | Access to health care, Partner/ family violence, SIDS/SUID, Perinatal mood/anxiety disorders, Child health |
| Problem Statement(s) | <p>Low rate of early prenatal care entry in females delivering a live birth due to substance abuse and mental health issues.</p> <p>High rate of domestic violence calls in the county due to lack of education, early identification of problem behaviors, and resource identification.</p> <p>High rate of substance abuse hospitalizations in pregnant women due to mental health issues, social isolation, inadequate problem solving skills, poor self-esteem, and limited knowledge on the effects of substance use during pregnancy.</p> <p>High rate of mood disorder hospitalizations in pregnant women due to lack of early identification of mental health issues, provider screening, and resource identification.</p> <p>High Immunization Personal Belief Exemption rate in Kindergartens due to parental immunization safety concerns and lack of knowledge related to emerging Vaccine-Preventable Diseases.</p> |
| Five Year Local Goal(s) | Decrease substance use in pregnant women and decrease domestic violence rates, improve maternal mental health, improve early childhood immunization levels, and maintain low SIDS/SUID incidence by implementing Community Hubs and mobile outreach to at-risk socially isolated families. |
| Risk/Contributing Factors | Exposure to violence and/or substance use in the home or community, cultural norms and beliefs that accept the use of violence in intimate relationships and model relationships based on power and control. Poor social emotional development/skills including low self –esteem, poor coping /problem solving skills, youth not connected to healthy adult/community, lack of knowledge and access to services, high rates of substance use and mental health issues, social isolation and low socioeconomic status, stress (external/internal), lack of system integration, lack of parental understanding of childhood brain development, impact of adverse childhood events on adult health and lack of parental understanding regarding vaccine importance and safety. |
| Best Practice Strategies/ Interventions | Collective impact approach, expanded stakeholder group to include broader representation including consumers, identify data sources to provide common measures across settings, identify best practice guidelines and provide leadership to help implement Community Hubs and mobile outreach to at-risk socially isolated families. |
| Intervention Population(s) | Medical providers, child welfare, treatment providers, hospitals, parents, adults, children, libraries, schools, Office of Education, child care providers. |

| Short and/or Intermediate Objective(s) | Inputs, including Community Partner involvement | Intervention Activities to Meet Objectives | Performance Measures Short and/or Intermediate | |
|--|--|--|---|--|
| | | | Process Description and Measure(s) including data source | Outcome Measure(s) including data source |
| <p>Fiscal Year 1 Assess Community Needs</p> <p>By June 30, 2016, develop a plan to provide primary prevention and early intervention services for pregnant women and families with young children through Community Hubs and mobile outreach.</p> | <p>Public Service Agencies, Community-based Agencies, Parents, First 5, County Office of Education & Schools, Early Care and Education Providers, Local Elected Officials, Civic Organizations, Hospitals and other Service Providers.</p> | <p>Define communities served by Hubs and mobile outreach.</p> <p>Convene potential partners in each community to:</p> <ul style="list-style-type: none"> Identify target populations Discuss prevention and early intervention needs Identify partners in providing collaborative services to address needs. <p>Set regular meetings with identified partners to provide primary prevention and early intervention services:</p> <ul style="list-style-type: none"> Assess issues/barriers when serving target populations. Share best practice/evidence based protocols for family support, education, and health screening and referral. Identify the local library as a Hub and describe services. Identify mobile outreach location(s) and describe services. Identify screening methods and a community referral process. <p>Develop a collaborative plan integrating services through a Hub and mobile outreach.</p> | <p><u>Briefly describe:</u></p> <p>Hub and mobile outreach targets and locations.</p> <p>Partners' roles, resources and responsibilities.</p> <p>How partners currently address primary prevention and early intervention strategies, issues in common, gaps and strategies to address them.</p> <p>Screening methods and referral processes.</p> | <p>At least 4 communities will be identified.</p> <p>At least 4 partners engage in primary prevention and early intervention services through Community Hubs and mobile outreach/potential partners.</p> <p>MOU developed.</p> <p>At least 3 community meetings will be held with Community Hub and mobile outreach partners.</p> <p>A plan is developed for each community.</p> |

| Short and/or Intermediate Objective(s) | Inputs, including Community Partner involvement | Intervention Activities to Meet Objectives | Performance Measures Short and/or Intermediate | |
|--|---|--|--|--|
| | | | Process Description and Measure(s) including data source | Outcome Measure(s) including data source |
| <p>Fiscal Years 2-4 Community Hubs (If partner buy-in and funding obtained)</p> <p>By June 30, 2017, implement a plan to provide primary prevention and early intervention services for pregnant women and families with young children through Community Hubs.</p> | <p>Public Service Agencies, Community-based Agencies, Parents, First 5, County Office of Education & Schools, Early Care and Education Providers, Local Elected Officials, Civic Organizations, Hospitals and other Health Services Providers</p> | <p>Convene partners in each community on a regular basis to monitor implementation and service coordination:</p> <ul style="list-style-type: none"> Identify prevention and early intervention strategies (i.e. family engagement activities, parent education, link to medical care and social services). Identify partners providing services to address needs. Coordinate and promote services. <p>Identify dates, times and locations for services.</p> <p>Develop a referral system:</p> <ul style="list-style-type: none"> Select screening tools for use with families (i.e. ACE, Edinburgh Postpartum Depression (PPD) Scale, etc.) Develop a referral system to ensure a warm handoff. <p>Establish a professional development plan for service providers:</p> <ul style="list-style-type: none"> Write policy and procedures to ensure integrity of model. Train staff who are working in Community Hubs. <p>Develop and implement a Continuous Quality Improvement/Quality Assurance (CQI/QA) process.</p> | <p><u>Briefly describe:</u></p> <p>Programmatic goals of partner agencies that link to delivery system issues associated with target population.</p> <p>Access to services.</p> <p>Referral system.</p> <p>Professional development plan.</p> <p>CQI/QA process developed.</p> <p>Evaluation plan.</p> | <p>At least 3 partners will engage in the Community Hub Model/potential partners.</p> <p>MOU executed.</p> <p>Number of clients served by Hubs.</p> <p>A referral system is developed.</p> <p>A professional development plan is developed.</p> <p>Describe the outcomes of the CQI/QA process.</p> <p>50% of Program participants will report an increase in child development knowledge, parenting knowledge and reduced social isolation as measured by First 5 EDC Client Satisfaction Survey.</p> |

| Short and/or Intermediate Objective(s) | Inputs, including Community Partner involvement | Intervention Activities to Meet Objectives | Performance Measures Short and/or Intermediate | |
|--|---|---|--|---|
| | | | Process Description and Measure(s) including data source | Outcome Measure(s) including data source |
| | | Monitor Community Hubs utilizing client satisfaction surveys. | | |
| <p>Fiscal Year 3 & 4 Mobile Outreach (If partner buy-in and funding obtained)</p> <p>By June 30, 2018, implement a plan to provide primary prevention and early intervention services for pregnant women and families with young children in socially isolated communities through mobile outreach.</p> | <p>Public Service Agencies, Community-based agencies, Parents, First 5, County Office of Education & Schools, Early Care and Education Providers, Local Elected Officials, Civic Organizations, Hospitals and other Health Services Providers</p> | <p>Convene partners in each community on a regular basis to monitor implementation and service coordination for mobile outreach:</p> <ul style="list-style-type: none"> Identify prevention and early intervention strategies (i.e. family engagement activities, parent education, link to medical care and social services). Identify partners providing services to address needs. Coordinate and promote services. <p>Identify dates, times and locations for services.</p> <p>Establish a professional development plan for service providers:</p> <ul style="list-style-type: none"> Write policy and procedures to ensure integrity of model. Train staff who are working in mobile outreach. <p>Develop a referral system:</p> <ul style="list-style-type: none"> Select screening tools for use with families (i.e. ACE, Edinburgh PPD Scale, etc.) Develop a referral system to ensure a warm handoff. <p>Develop and implement a Continuous Quality</p> | <p><u>Briefly describe:</u></p> <p>List the programmatic goals of partner agencies that link to delivery system issues associated with target population.</p> <p>Target neighborhoods services.</p> <p>Professional development plan.</p> <p>Referral system.</p> <p>CQI/QA process developed.</p> | <p>Number of partners that agree to engage in mobile outreach.</p> <p>Number of clients served by mobile outreach.</p> <p>A professional development plan is developed.</p> <p>A referral system is developed.</p> <p>Describe the outcomes of the CQI/QA process.</p> <p>50% of program participants will report an increase in child development knowledge, parenting knowledge and reduced social isolation as measured by First 5</p> |

| Short and/or Intermediate Objective(s) | Inputs, including Community Partner involvement | Intervention Activities to Meet Objectives | Performance Measures Short and/or Intermediate | |
|---|---|--|--|---|
| | | | Process Description and Measure(s) including data source | Outcome Measure(s) including data source |
| | | Improvement/Quality Assurance (CQI/QA) process. Monitor Community Hubs utilizing client satisfaction surveys. | Evaluation plan. | EDC Client Satisfaction Survey. |
| <p>Fiscal Year 5 Sustainability</p> <p>By June 30, 2020, produce a sustainability plan identifying additional resources and collaborations to sustain Community Hubs and mobile outreach to socially-isolated areas.</p> | <p>Public Service Agencies, Community-based Agencies, Parents, First 5, County Office of Education & Schools, Early Care and Education Providers, Local Elected Officials, Civic Organizations, Hospitals and other Health Services Providers</p> | <p>Meet with collaborative partners to discuss successes/challenges of program implementation.</p> <p>Identify funding sources and apply as appropriate.</p> <p>Identify other needed resources; human resources.</p> <p>Identify changes/modifications needed to existing program – reassessment.</p> <p>Continue to foster effective relationships with community.</p> <p>Identify goals, actions for next planning cycle.</p> | <p><u>Briefly describe:</u></p> <p>Meetings and their outcomes.</p> <p>Funding applied for and results.</p> <p>Resources identified.</p> <p>Changes to implemented activities.</p> <p>Actions and goals for sustainability of educational program.</p> | <p>Number of meetings.</p> <p>Funding awarded by at least one source to sustain implemented Hubs and mobile outreach.</p> <p>Conduct at least 3 meetings with community partners.</p> <p>Determine at least 3 changes to improve programs.</p> <p>Determine at least 3 goals for sustainability plan.</p> <p>Review of MOU completed.</p> |

Deliverable Form E – 5-Year Action Plans

| MCAH SOW Goals 2 & 3: Perinatal Mood Anxiety Disorders/SIDS | |
|---|---|
| Problem Category | Access to health care, Partner/family violence, SIDS/SUID, Perinatal mood/anxiety disorders |
| Problem Statement(s) | <p>Low rate of early prenatal care entry in females delivering a live birth due to substance abuse and mental health issues</p> <p>High rate of domestic violence calls in the county due to lack of education, early identification of problem behaviors, and resource identification</p> <p>High rate of substance abuse hospitalizations in pregnant women due to mental health issues, social isolation, inadequate problem solving skills, poor self-esteem, and limited knowledge on the effects of substance use during pregnancy</p> <p>High rate of mood disorder hospitalizations in pregnant women due to lack of early identification of mental health issues, provider screening, and resource identification.</p> |
| Five Year Local Goal(s) | Decrease substance use in youth and pregnant women and decrease domestic violence rates, improve maternal mental health and maintain low SIDS/SUID incidence by Increasing the proportion of primary care providers who screen pregnant and postpartum (up to one year) women for adverse childhood experiences. |
| Risk/Contributing Factors | Exposure to violence and/or substance abuse in the home or community and cultural norms and beliefs that accept the use of violence in intimate relationships and model relationships based on power and control. Poor social emotional development/skills including low self –esteem, poor coping /problem solving skills, youth not connected to healthy adult/community, lack of knowledge and access to services, high rates of substance use and mental health issues, social isolation and low socioeconomic status, stress (external/internal), lack of system integration, lack of parental understanding of the effect of trauma on early brain development, impact of adverse childhood events on adult health |
| Best Practice Strategies/ Interventions | Integration of screening for adverse childhood events into a range of clinical and community settings, such as Federally Qualified and Rural Health Centers, community clinics, health department, and other medical providers; increase client/population knowledge regarding adverse childhood events and the Adverse Childhood Events Study. Prevention efforts should ultimately reduce risk factors and promote resiliency and protective factors. Primary prevention will address all factors that influence domestic violence, substance use, and mental health: individual, relationships, community, and society (ecological model). Understanding the economic impact of domestic violence, substance use, mental health issues and efficiency/benefit of primary prevention. Understanding the impact of adverse childhood events on early childhood development. |

| | |
|-----------------------------------|---|
| Intervention Population(s) | Area medical providers; alcohol and drug programs; mental health, public health and social services programs, area hospital systems. |
|-----------------------------------|---|

| Short and/or Intermediate Objective(s) | Inputs, including Community Partner involvement | Intervention Activities to Meet Objectives | Performance Measures Short and/or Intermediate | |
|---|--|--|--|---|
| | | | Process Description and Measure(s) including data source | Outcome Measure(s) including data source |
| <p>Fiscal Year 1-2</p> <p>By June 30, 2016, a plan will be developed to integrate ACE screening in coordination with community partners and county programs.</p> | <p>Primary Care Providers, Behavioral Health, Social Services, Alcohol and Drug programs, Community-based organizations, HHSA Leadership</p> | <p>Identify and engage community partners/collaboratives, County programs and HHSA leadership.</p> <p>Provide information on ACE, ACE Study and impacts on social and health outcomes.</p> <ul style="list-style-type: none"> • Develop PowerPoint and other education materials. • Identify locations, dates and times of presentations. • Evaluation method for assessing intent to change practice and share information. <p>Collaborate with providers, community organizations, and support groups to establish a referral resource network.</p> | <p><u>Briefly describe:</u></p> <p>Collaborative relationships that support screening for ACE.</p> <p>PowerPoint, and collaborative meetings.</p> <p>Agendas, minutes, meeting materials and list of participants on file.</p> <p>Resources and support groups for ACE.</p> <p>Brief description of referral resource network.</p> | <p>Number of partners with intent to change practice and share information /potential partners.</p> <p>Referral resource network developed.</p> |

| Short and/or Intermediate Objective(s) | Inputs, including Community Partner involvement | Intervention Activities to Meet Objectives | Performance Measures Short and/or Intermediate | |
|---|---|---|---|--|
| | | | Process Description and Measure(s) including data source | Outcome Measure(s) including data source |
| <p>Fiscal Year 1</p> <p>By June 30, 2016, determine the number of primary care providers who screen pregnant and postpartum (up to one year) women for adverse childhood events (ACE) and, of those who screened, the number referring women who screen positive for follow-up care.</p> | <p>Primary Care Providers, Behavioral Health, Social Services, Alcohol and Drug programs, Community-based organizations</p> | <p>Engage existing medical community partners/collaboratives.</p> <p>Provide information on ACE, ACE Study and impacts on social and health outcomes.</p> <p>Develop and implement a survey of primary care providers to determine whether they screen none, all, or some pregnant and postpartum women for adverse childhood experiences, and refer women who screen positive for follow-up care. Include questions about policies implemented, referral processes, barriers/ challenges, and willingness to screen all women.</p> <p>Identify the providers screening all or some pregnant and postpartum women for ACE and referring positive screens.</p> | <p><u>Briefly describe:</u></p> <p>Collaborative relationships that support screening all pregnant and postpartum women for ACE.</p> <p>Survey developed and implemented. Number of completed surveys/number of surveys sent out.</p> <p>Number of providers with policies implemented to screen all pregnant and postpartum women for ACE.</p> <p>Opportunities, barriers, and challenges to screening and referral for follow-up.</p> | <p>Number of providers who screen pregnant and postpartum women for ACE/Number of providers who treat pregnant and postpartum women.</p> <p>Number of providers who refer positive screens for follow-up/Number of providers who screen pregnant and postpartum women.</p> <p>Number of providers who screen other patients for ACE/Number of providers who treat other patients.</p> <p>Number of providers who refer positive screens for follow-up/Number of providers who screen other patients.</p> |

| Short and/or Intermediate Objective(s) | Inputs, including Community Partner involvement | Intervention Activities to Meet Objectives | Performance Measures Short and/or Intermediate | |
|--|---|---|--|---|
| | | | Process Description and Measure(s) including data source | Outcome Measure(s) including data source |
| <p>Fiscal Year 2 -4</p> <p>By June 30, 2019, nine providers will screen all pregnant/postpartum women and other patients for ACE and refer women who screen positive for follow-up.</p> | <p>Primary Care Providers, Behavioral Health, Social Services, Alcohol and Drug programs, Community-based organizations</p> | <p>Assist providers to identify and implement the use of ACE screening tool.</p> <p>Encourage and assist providers to develop a protocol to incorporate ACE screening tool in OB and other medical visits.</p> <p>Develop and implement a continuous quality improvement/Quality Assurance (CQI/QA) process to promote ACE screening through webinars, workshops, and presentations at conferences/professional meetings.</p> <p>Continue to engage existing medical community partners/collaboratives and share referral resource network.</p> | <p><u>Briefly describe:</u></p> <p>Process of developing provider protocol.</p> <p>Process to measure knowledge change and intent to implement policies to screen all pregnant/postpartum women or other patients.</p> <p>Policies implemented to screen all pregnant/postpartum women and other patients for ACE.</p> <p>CQI/QA process developed</p> <p>Collaborative relationships that support screening all pregnant/postpartum women and other patients for ACE.</p> | <p>Number of providers screening all pregnant/postpartum women and other patients for ACE/9.</p> <p>Number of providers demonstrating increased knowledge of ACE and their effects/Number of providers trained.</p> <p>Number of providers who have developed and implemented policies/procedures for ACE screening and referral / Number of providers who see pregnant and postpartum women.</p> <p>Brief description of outcomes of the CQI/QA process.</p> |

| Short and/or Intermediate Objective(s) | Inputs, including Community Partner involvement | Intervention Activities to Meet Objectives | Performance Measures Short and/or Intermediate | |
|--|--|---|--|--|
| | | | Process Description and Measure(s) including data source | Outcome Measure(s) including data source |
| <p>Fiscal Year 5</p> <p>By June 30, 2020, all pregnant and postpartum women in MCAH programs will be screened for ACE, and those who screen positive will be referred for appropriate follow-up care.</p> | <p>PHN Section Staff, Primary Care Providers, Behavioral Health, Social Services, Alcohol and Drug programs, Community-based organizations</p> | <p>Develop and implement a screening protocol to screen all pregnant and postpartum women in MCAH Programs for ACE.</p> <p>Develop and implement processes that link women who screen positive for ACE to appropriate resources.</p> <p>Develop evaluation process.</p> <p>Develop and implement a Continuous Quality Improvement/Quality Assurance (CQI/QA).</p> <p>Continue to engage existing medical community partners and collaboratives.</p> | <p><u>Briefly describe:</u></p> <p>Access to care issues.</p> <p>Rationale for interventions, recommendations, and protocols developed.</p> <p>Evaluation process developed and implemented.</p> <p>CQI/QA process developed.</p> <p>Collaborative relationships that support screening all pregnant and postpartum women for ACE.</p> | <p>Number of pregnant and postpartum women in MCAH programs who are screened for ACE/All pregnant and postpartum women in MCAH programs.</p> <p>Number of pregnant and postpartum women who screened positive for ACE and were referred for follow-up/All pregnant and postpartum women who screened positive for ACE.</p> <p>Number of pregnant and postpartum women who screened positive for ACE and were referred to and saw a provider/All pregnant and postpartum women who screened positive and were referred.</p> <p>Brief description of outcomes of the CQI/QA process.</p> |

Deliverable Form E – 5-Year Action Plans

| MCAH SOW Goal 2: Partner Family Violence | |
|---|--|
| Problem Category | Access to health care, Partner/family violence, SIDS/SUID, Perinatal mood/anxiety disorders |
| Problem Statement(s) | <p>Low rate of early prenatal care entry in females delivering a live birth due to substance abuse and mental health issues.</p> <p>High rate of domestic violence calls in the county due to lack of education, early identification of problem behaviors, and resource identification.</p> <p>High rate of substance abuse hospitalizations in pregnant women due to mental health issues, social isolation, inadequate problem solving skills, poor self-esteem, and limited knowledge on the effects of substance use during pregnancy.</p> <p>High rate of mood disorder hospitalizations in pregnant women due to lack of early identification of mental health issues, provider screening, and resource identification.</p> |
| Five Year Local Goal(s) | Decrease substance use in youth and pregnant women and decrease domestic violence rates, improve maternal mental health and maintain low SIDS/SUID incidence by providing primary violence prevention and personal skill building in youth. |
| Risk/Contributing Factors | Exposure to violence and/or substance use in the home or community, cultural norms and beliefs that accept the use of violence in intimate relationships and model relationships based on power and control. Poor social emotional development/skills including low self –esteem, poor coping /problem solving skills, youth not connected to healthy adult/community, lack of knowledge and access to services, high rates of substance use and mental health issues, social isolation and low socioeconomic status, stress (external/internal), lack of system integration, lack understanding of childhood brain development, impact of adverse childhood events on adult health |
| Best Practice Strategies/ Interventions | Community collaboration and system integration, teen dating violence primary prevention education for youth, parent workshops, school staff trainings. Prevention efforts should ultimately reduce risk factors, increase resiliency and promote protective factors. Primary prevention will address all factors that influence teen dating violence, substance use, and mental health: individual, relationships, community, and society (ecological model), understanding economic impact of teen dating violence, substance use, mental health issues and efficiency/benefit of primary prevention, understanding impact of adverse childhood events on childhood development. |
| Intervention Population(s) | Youth in middle and high school, schools and support staff, parents and caregivers, faith-based organizations, alcohol and drug programs, staff and adolescents in foster care, juvenile justice, primary care providers, mental |

health and social services programs, businesses.

| Short and/or Intermediate Objective(s) | Inputs, including Community Partner involvement | Intervention Activities to Meet Objectives | Performance Measures Short and/or Intermediate | |
|---|--|---|--|---|
| | | | Process Description and Measure(s) including data source | Outcome Measure(s) including data source |
| <p>Fiscal Year 1 Capacity Building</p> <p>By June 30, 2016, identify potential funding sources, other resources and collaborative partners for primary violence prevention and personal skill building in youth.</p> | <p>Public Service Agencies, Community-based agencies, Parents, First 5, County Office of Education & Schools, Early Care and Education Providers, Local Businesses, Local Hospitals, Service Agencies, Law Enforcement, and other Interested Parties</p> | <p>Identify potential funding sources and apply as appropriate. (Medi-Cal LEA, Local funding, CDPH Rape Prevention monies, Violence Prevention Education monies, CDC Prevention dollars, etc.)</p> <p>Identify other resources such as primary prevention evidence-based curriculum, human resources (interns, student nurses, etc.)</p> <p>Identify partners and discuss opportunities to collaborate on primary violence prevention and personal skill building in youth.</p> <p>Develop community plan to address prevention strategies.</p> | <p><u>Briefly describe:</u></p> <p>Funding applied for and results.</p> <p>Other identified resources.</p> <p>Partners and outcomes of meetings.</p> | <p>Funding awarded by at least one funding source for youth education.</p> <p>Number of partners that agree to participate in primary violence prevention education and personal skill building in youth.</p> <p>Conduct at least 3 meetings with partners to collaborate on primary violence prevention education and personal skill building in youth.</p> <p>Community plan developed.</p> |

| Short and/or Intermediate Objective(s) | Inputs, including Community Partner involvement | Intervention Activities to Meet Objectives | Performance Measures Short and/or Intermediate | |
|--|--|--|--|--|
| | | | Process Description and Measure(s) including data source | Outcome Measure(s) including data source |
| <p>Fiscal Years 2-4 Program Implementation (if funding obtained)</p> <p>By June 30, 2017 implement a Bully Prevention and/or Teen Dating Violence and Personal Skill Building Primary Prevention Education Program in at least 3 schools and/or youth settings.</p> | <p>Public Service Agencies, Community-based agencies, Parents, First 5, County Office of Education & Schools, Early Care and Education Providers, Local Businesses, Local Hospitals, Service Agencies, Law Enforcement, and other interested parties</p> | <p>Identify schools and/or youth settings to implement Bully Prevention and/or Teen Dating Violence Prevention Education and Personal Skill Building program.</p> <p>Identify primary prevention educator(s) to run program.</p> <p>Identify evidence-based curricula; measurable outcomes, resources.</p> <p>Educate certified and classified school staff and other appropriate organizations, public service agency personnel on curricula, review and provide feedback on violence prevention policy.</p> <p>Educate youth on bully prevention and/or teen dating violence, dangers/unhealthy coping vs. healthy coping skills, conflict resolution/ healthy communication skills, resource identification and information on early development.</p> | <p><u>Briefly describe:</u></p> <p>Schools where program is implemented.</p> <p>Educator(s) to implement program.</p> <p>Curricula; short/long term goals, resources.</p> <p>Number of schools and individuals receiving training.</p> <p>Track presentations, Lesson plans, pre/post-tests/surveys and other data collection.</p> | <p>Commitment from at least three schools and/or youth settings willing to implement program.</p> <p>Give at least 10 skill knowledge/skill building presentations per course; administer two pre/post surveys per course.</p> <p>There will be a 50% increase in bully prevention and/or teen dating violence prevention knowledge and identification of red flags seen in abusive relationships in program recipients per pre/post-tests.</p> <p>There will be a 30% increase in healthy coping skills identification in program</p> |

| Short and/or Intermediate Objective(s) | Inputs, including Community Partner involvement | Intervention Activities to Meet Objectives | Performance Measures Short and/or Intermediate | |
|--|---|--|--|--|
| | | | Process Description and Measure(s) including data source | Outcome Measure(s) including data source |
| | | Develop and implement a Continuous Quality Improvement/Quality Assurance (CQI/QA) process including on-going meetings with partners. | <p>CQI/QA process developed.</p> <p>Partners and outcomes of meetings.</p> | <p>recipients.</p> <p>There will be a 30% increase in program recipients utilizing healthy conflict resolution and communication skills.</p> <p>There will be a 30% increase in program recipients understanding of childhood brain development.</p> <p>Program recipients will identify 3-5 community resources.</p> <p>School and or youth program policy will be consistent with trauma-informed practices.</p> <p>Describe the outcomes of the CQI/QA process.</p> |
| Fiscal Year 5 Sustainability Plan | | | <u>Briefly describe:</u> | |
| By June 30, 2020, produce | Public Service | Identify funding sources and apply as | Funding applied for and | Funding awarded by at |

| Short and/or Intermediate Objective(s) | Inputs, including Community Partner involvement | Intervention Activities to Meet Objectives | Performance Measures Short and/or Intermediate | |
|---|--|--|--|---|
| | | | Process Description and Measure(s) including data source | Outcome Measure(s) including data source |
| a sustainability plan identifying the resources needed to sustain collaborations and education for primary violence prevention and personal skill building in youth within schools and/or youth settings. | Agencies, Community-based agencies, Parents, First 5, County Office of Education & Schools, Early Care and Education Providers, Local Businesses, Local Hospitals, Service Agencies, Law Enforcement, and other interested parties | <p>appropriate.</p> <p>Identify other needed resources; human resources (ex. Youth leadership).</p> <p>Identify strategies used by other like counties.</p> <p>Identify changes/modifications needed to existing program – reassessment.</p> <p>Continue to foster effective, collaborative relationships.</p> <p>Identify goals, actions for next planning cycle.</p> | <p>results.</p> <p>Resources identified.</p> <p>Meetings and their outcomes.</p> <p>Strategies to adopt.</p> <p>Changes to implemented activities.</p> <p>Actions and goals for sustainability of educational program.</p> | <p>least one source to sustain implemented prevention education/skill building program.</p> <p>Conduct at least 3 meetings with community partners.</p> <p>Determine at least 3 strategies used by other counties.</p> <p>Determine at least 3 changes to improve educational program.</p> <p>Determine at least 3 goals for sustainability plan.</p> |

Deliverable Form E - 5-Year Action Plans

| MCAH SOW Goal 5: Child Health | | | | |
|---|--|--|---|---|
| Problem Category | | Child Health | | |
| Problem Statement(s) | | High Immunization Personal Belief Exemption rate in Kindergartens due to parental immunization safety concerns and lack of knowledge related to emerging Vaccine-Preventable Diseases. | | |
| Five Year Local Goal(s) | | Improve early childhood immunization levels by providing education to medical providers so that they can increase immunization rates within their practices. | | |
| Risk/Contributing Factors | | Lack of parental understanding regarding vaccine importance and safety. Lack of provider understanding on how to counsel parents effectively. Limited time in provider offices for vaccine counseling by licensed providers. | | |
| Best Practice Strategies/ Interventions | | Collective impact approach, identify best practice guidelines and provide training to assist medical providers in providing safe and effective childhood immunizations and immunization counseling. | | |
| Intervention Population(s) | | Medical providers and their staff, hospitals, parents, adults, children. | | |
| Short and/or Intermediate Objective(s) | Inputs, including Community Partner involvement | Intervention Activities to Meet Objectives | Performance Measures Short and/or Intermediate | |
| | | | Process Description and Measure(s) including data source | Outcome Measure(s) including data source |
| Fiscal Years 1-5 Medical Provider Education By June 30, 2020, ten medical providers who serve young children will demonstrate increased knowledge of Personal Belief Exemption (PBE) rates and implement at least one practice change to improve immunization (IZ) rates in their practice. | Medical Providers, Hospital Systems, Public Health Nursing Staff, Health Officer | Develop a PowerPoint presentation to include PBE rates, Public Health's immunization survey results, how to counsel parents effectively, and steps providers can take to increase vaccination rates in their practices. | <u>Briefly Describe:</u> Description of trainings. Agreed upon training strategies with providers. Evaluation results. | Number of medical providers that reported they implemented at least one practice change to improve IZ rates in their practices/10 |

| Short and/or Intermediate Objective(s) | Inputs, including Community Partner involvement | Intervention Activities to Meet Objectives | Performance Measures Short and/or Intermediate | |
|--|---|---|---|--|
| | | | Process Description and Measure(s) including data source | Outcome Measure(s) including data source |
| | | <p>Set up training in collaboration with local health systems: Determine date, time, location and who will be in attendance.</p> <p>Provide education and information to least 10 medical providers and their office staff on high PBE rates, Public Health's immunization survey results, how to counsel parents effectively and what they can do to increase immunization rates in their practices.</p> <p>Develop evaluation of presentation to administer after each training and include a question that asks what practice change they will implement to improve IZ rates at their site.</p> <p>Call providers and/or email their practice representative 3-6 months after training to determine if practice change occurred.</p> | Actual practice changes implemented by medical providers. | Brief description of the intent to change practice as noted by the evaluation question developed for this purpose. |