

Ventura County Public Health
Maternal Child Adolescent Health

Community Health Assessment
2010 – 2014

Megan L. Steffy, MSN, PHN
Daniel Jordan, PhD, ABPP
Barbara Spraktes-Wilkins, MPH, DrPHc

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Table of Contents

Section 1. Summary/Executive Report.....	2
Section 2. Mission Statement and Goals	2
Mission 2010-2014	3
Goals 2010-2014.....	3
Section 3. Planning Group and Process	3
Section 4. Community Health Profile	4
Section 5. Health Status Indicators	12
Section 6. Local MCAH Problems/Needs	12
1. Prenatal and Interconception Care and Maternal Health	13
2. Infant and Child Injury and Death Prevention	15
3. Maternal and Child Nutrition and Physical Activity	16
4. Access to Care.....	17
5. Family Violence.....	18
6. Teenage Births and Sexually Transmitted Infections (STIs)	19
Section 7. MCAH Priorities	20
Section 8. Capacity Assessment	20
Section 9. MCAH Capacity Needs.....	21
MCAH Capacity Needs Discussion	21
Section 10. MCAH Capacity Assets.....	22
Attachment A. Capacity Assessment Worksheet A.....	23
Attachment B. Capacity Indicators.....	25
Attachment C. Worksheet C2: Problem Prioritization Tool	29
Attachment D. Worksheet C3: Top Ranked Priorities.....	35
Attachment E. MCAH Capacity Needs: Worksheet D, mCAST 1-10 Results.....	36
Assessment of Essential Service #1 Process Indicators.....	36
Assessment of Essential Service #2 Process Indicators.....	41
Assessment of Essential Service #3 Process Indicators.....	45
Assessment of Essential Service #4 Process Indicators.....	49
Assessment of Essential Service #5 Process Indicators.....	54
Assessment of Essential Service #6 Process Indicators.....	59
Assessment of Essential Service #7 Process Indicators.....	64
Assessment of Essential Service #8 Process Indicators.....	69
Assessment of Essential Service #9 Process Indicators.....	73
Attachment F. Section 9. MCAH Capacity Needs Part B: Capacity Needs.....	79
Worksheet E.....	79

Section 1. Summary/Executive Report

The purpose of this five year needs assessment is to gather stakeholder input on MCAH priority areas for Ventura County and to explore our MCAH system's capacity to deliver 10 essential public health services. We engaged community partners in a review and discussion of current MCAH priority areas and an analysis of our capacities, in terms of strengths and weaknesses, to improve and better coordinate MCAH activities throughout the county. The process has been truly collaborative and has involved over 40 community stakeholders and MCAH key personnel who provide any or all of the 10 essential public health services to individuals and families living in Ventura County.

During our initial meetings with key personnel, the MCAH mission statement, goals and priority areas were reviewed and modified to reflect current areas of need. An in-depth analysis of 27 health indicators was performed, comparing local rates to state rates and HP 2010 goals. As a result, local focus areas were identified and ranked according to order of importance. Qualitative data collected for the needs assessment includes interviews with key informants representing interests in maternal and child health, family violence, perinatal and youth substance use, foster care, maternal and childhood nutrition, childhood obesity, and childhood injury prevention.

MCAH issues identified to be of increasing concern are the consistently low results in our local perinatal indicators; entry into prenatal care; low birth weights and decreased time between births. These outcomes contribute to compromised maternal and perinatal health and well-being. Childhood obesity is also of growing concern. Our childhood obesity rate has almost doubled over the last five years despite efforts to ameliorate.

In addition to identifying focus areas and health and well-being issues, community stakeholders were brought together for two meetings. The goal of the meetings was to gather qualitative and quantitative data on our collective ability to provide the 10 essential MCAH services in terms of strengths, weaknesses, opportunities and threats. A follow-up online survey was sent out to those who were unable to attend the second meeting. Stakeholders identified funding, insufficient provision of data, and imposed regulations as common threats to our community's ability to carry out services. All of these concerns are overshadowed by the current economic downturn. Much discussion focused on the states economic crisis and the consequences of budget cuts to our local programs and services. A focus group explored options of traditional funding approaches to sustain or increase service capacities.

In the face of these challenges, we will strive with our community partners to develop and implement appropriate plans utilizing our systems capacity to address all of our local areas of concern.

Section 2. Mission Statement and Goals

At one of the early steering committee planning meetings, the decision was made to re-evaluate the current MCAH mission prior to meeting with the community stakeholders.

The general consensus was that this endeavor could most efficiently be accomplished by the steering committee (see Attachment A for committee membership). After thorough discussion, the committee agreed that the mission statement closely reflects the mission of the Public Health Department and that no changes were necessary. After reviewing the goals, it was decided that goal number two should be modified to read “women of childbearing age” instead of “pregnant women”. This change will reflect our local goal to address maternal and interconception care. A fourth goal was developed to communicate our efforts attributing to improved birth outcomes.

Mission 2010-2014

The Ventura County Public Health Maternal Child and Adolescent Health program seeks to assure quality healthcare for all women of reproductive age, infants, children, adolescents, and their families, through the development of sound and comprehensive policies relating to health resources and capacity. These activities will be community-based, family-centered, and culturally-competent, integrated with existing services and will allow women and children to be healthy, safe, and to develop to their fullest potential.

Goals 2010-2014

1. All women and children in the county live in a safe, nurturing environment that promotes optimal health, growth and development.
2. All women of *childbearing age*, newborns, children and adolescents in the county have access to preventive, primary care services to ensure optimal health and well-being.
3. Agencies serving children and families, including county MCAH staff, engage in collaborative and county-wide planning to ensure provision of a comprehensive community-based health care system for this population.
4. Universal adoption of perinatal screening using standardized and research based tools.

Specific community-based, family-centered, culturally-competent integrated interventions will be developed and implemented with our community planning partners in order to achieve our goals. The next five years will bring many challenges for all who care for children and families in Ventura County. We are thankful for all of the active participation of our partners’ in this community endeavor.

Section 3. Planning Group and Process

The Ventura County Public Health Maternal Child Health Program began the assessment process by bringing together several MCAH representatives from within the organization to form a planning group. The group comprised the MCAH Director, MCAH Coordinator, FIMR/SIDS Coordinator, MCAH Epidemiologist, Perinatal Services Coordinator, MCAH Program Coordinator’s, Childhood Development Coordinator, Obesity Prevention Coordinator and the Child Injury Prevention Coordinator. The task of the group was to develop a work plan for the local needs assessment and to identify community partners to invite to the capacity assessment meetings.

With input from the steering committee, a list of 60 community stakeholders was compiled. Tremendous effort was made to include community partners from various backgrounds representing schools, child care, special needs children, faith community, children's social services, Foster Care, Head Start, Cal-Works, First Five Ventura, family violence prevention programs, community advocates, community organizations, medical and dental providers and the regional perinatal program. The intention was that the participant group would be inclusive, diverse and representative of the community in composition (see Attachment A).

An invitation letter was sent inviting the prospective community planning partners to be part of the MCAH Community Assessment process. Invitees were advised that there would be a commitment of two meetings to be held in January 2009. The goals of the two meetings and planned meeting dates were discussed in the invitation.

In the meetings, stakeholders were given a brief review of the MCAH program, an organizational chart, a list of current MCAH programs and service areas, a list and table of health data indicators, and mCAST forms. The proposed 2010-2014 mission and modified goals were presented and agreed upon. This was followed by a presentation, facilitated by the MCAH Epidemiologist, highlighting current county data, trends and comparisons to the California MCAH indicators and Healthy People 2010 goals. The group discussed in length the ability to provide and support needed health care and related components, activities, competencies, and capacities of the existing local MCAH system. Internal and external strengths and weaknesses encountered when delivering MCAH 10 essential services was also explored.

The work on this five year needs assessment has led to a new collaboration among community partners. The collaboration includes representatives from the Child Death Review Team, Perinatal Substance Abuse Taskforce, Partnership for Safe Families Domestic Violence Sub-Committee, Ventura County Healthy Interconception Project, Ventura County Schools, Obesity Taskforce, Youth and Family Engagement, Tri Counties Regional Center, Family Learning Centers, and local medical providers. Our first focus group met in June 2009 and has committed to meet quarterly in an effort to coordinate MCAH services efficiently and effectively.

Section 4. Community Health Profile

The MCAH emphasis within Ventura County Public Health is to utilize core public health functions of assessment, assurance and policy with community collaboration; program development; and provision of culturally competent services to individuals, families and the community to improve health outcomes for the MCAH population. The MCAH program analyzes vital record data to identify health needs of women, infant, children and adolescents, and coordinates and plans effective interventions for them. Specific local data used as indicators to measure success for our local MCAH program prenatal and dental care, infant birth weight and mortality, childhood unintentional/intentional injuries, breast feeding, domestic violence, substance use, and teenage birth and STI rates.

MCH funds the following programs in public health:

- Adolescent Family Life Program (AFLP)
- Community Health Nursing (CHN)
- Comprehensive Perinatal Services Program (CPSP)
- Children First Ventura County (CFVC)
- Child Abuse Prevention Program (CAPP)
- FIMR/SIDS Education and Prevention
- Childhood Injury Prevention Program (CIPP)
- New Parent Kit Outreach and Education (NPK)
- Perinatal Substance Use Prevention
- Childhood Oral Health Education
- Obesity Prevention
- Children with Special Health Care Needs
- Ventura County Healthy Interconception Project (VCHIP)
- Health Outreach and Program Education (HOPE)
- Health Care for Kids (HCK)

The local MCAH program engages the larger MCAH system in community surveillance efforts, identifying and implementing effective interventions, evaluations, and assessing system capacity to meet needs. Representatives from the local and larger MCAH system collaborate to form interdisciplinary teams, community outreach and education efforts that focus on MCAH issues. As a result of our collaborative efforts, countywide interventions are consistently evolving to meet emerging health needs.

Community partners (listed in Attachment A) have contributed to the data below.

Geography and General Population Information

Ventura County encompasses an area of 1,843 square miles, ranks 26th by land mass of California counties and 12th by population among California's 58 counties and 65th in the US^{1,2}. The total 2008 population of Ventura County was 827,267², a 10% increase from 2000 and 5% increase from the last MCAH local needs assessment conducted in 2003. From July 2004 to July 2008, natural increase (births less deaths) has accounted for all of the population increase in Ventura County. Over the same period, net migration has been a negative number, with more people migrating out of Ventura County than out of it. Of the net population increase from July 2004 to July 2008, natural increase accounted for 123% (29,449), and net migration for -23% (-5,505). Migration can be broken down into two parts, international and internal. Though net migration in Ventura County over the 2004 – 2008 period reflected a greater number of people moving out of Ventura County than moving in, it was made up of 20,433 residents moving out, and 14,928 moving in from other countries; this influx of new immigrants is one of the mechanisms by which the county population becomes more culturally diverse.

Sources:

1. http://www.dof.ca.gov/html/DEMOGRAP/ReportsPapers/documents/Ranking_Report_s_Jul08.xls
2. US Census Bureau, GCT-T1-R. Population Estimates (geographies ranked by estimate, Data Set: 2008 Population Estimates)
3. State of California, Department of Finance, E-1 population Estimates for Cities, Counties and the State with Annual Percent Change — January 1, 2008 and 2009. Sacramento, California, May 2009.
4. State of California, Department of Finance, Population Estimates and Components of Change by County, July 1, 2000-2008. Sacramento, California, December 2008. [E-6. Population Estimates and Components of Change by County — July 1, 2000–2008](#)

As of January 1, 2009 four Ventura County cities have over 100,000 in population according to the California Department of Finance. These are Oxnard, Thousand Oaks, Simi Valley, and San Buenaventura. Of these, Oxnard has the largest population at 197,067 ranking 21 out of all California cities⁵ and 121 out of 242 US cities with a population greater than 100,000 in 2007, the most recent year for which this ranking is available⁶.

Sources:

1. State of California, Department of Finance, January 2009 Cities and Counties ranked by Size, Numeric and Percent Change. Sacramento, California, May 2009.
2. US Census Bureau, Population Division, Table 1: Annual Estimates of the Population for Incorporated Places Over 100,000, Ranked by July 1, 2007 Population: April 1, 2000 to July 1, 2007 (SUB-EST2007-01)

The county is bordered on the north by Kern County, Santa Barbara County to the northwest, Los Angeles County to the southeast, and the Pacific Ocean on the southwest. Ventura County is composed of ten cities and unincorporated communities. The eastern portion consists of Simi Valley (adjacent to Los Angeles), Moorpark, and Thousand Oaks. The northern region encompasses Santa Paula, Fillmore, and Piru along Route 126. The southern region includes Oxnard, Port Hueneme, and Camarillo, while the western region includes Ventura and Ojai. An inner city bus transportation system has been established in the past four years between most of the major cities. Smaller communities such as Piru, located in the far northeast border of Fillmore, still have transportation access problems. Transit time to the Ventura County Medical Center in Ventura for obstetrical delivery can be as much as one hour from the far east end of the county. Camarillo has an access to care issue as a city with a population in excess of 75,000, no ambulatory care system, and no bus lines going to major clinic systems.

Demographics

In Ventura County, 88% of the population lives within incorporated cities. As of 2007, 47% of the population White, 42% Hispanic, 7% Asian American/Pacific Islander (AAPI), 2% African American, and <1% as Native American⁷. Race/ethnic minorities

comprise more than 51% of the county population with the distribution varying widely among the cities. The major population (at least 66%) of the county's three agriculturally based cities, Oxnard, Santa Paula, and Fillmore, is Hispanic. African-Americans make up less than 2% of the County population but over 5% in the city of Port Hueneme. Ojai, Camarillo, Thousand Oaks, and Simi Valley were at least 70% white in 2000. Hispanics and Asian American/Pacific Islanders made up the largest increase in growth in the County in the last decade. Hispanics comprised 26% of the population in 1990, and 42% in 2007. Asian American/Pacific Islanders went from 5% to 7% of the population. From 2000 to 2007, there has been a 12% decrease in the white population, a 26% increase in the Hispanic population, and a 30% increase in the Asian population. Owing to the diversity of the county, languages spoken at home vary as well.

Of the population five years of age and older, 33% speak a language other than English at home. Since 2004, more people have moved out of Ventura County than have moved in (above). Those leaving are predominantly US born, while those moving in are predominantly foreign born. This turnover has helped increase ethnic diversity in the county.

While Hispanics comprise 42% of the population in 2007, they make up 61% of the births overall and have a higher teen pregnancy rate. There is a higher fertility rate in this community with all its attendant need for prenatal care, and early childhood programs.

The age profile of the County also varies regionally. The median age of the population of Ventura County rose from 31.0 to 34.2 years. Fillmore, Oxnard, and Santa Paula all had a median age under 30 years in 2000. Port Hueneme's median age was 30.3 years. With the exception of Ojai, whose median age was 42 years, the other cities had median ages in the mid to high 30's.

Of the 135,000 children in the 5 to 15 age range in Ventura County, 7,015 were reported in the census to have a disability. In women of childbearing age (18 to 34 years) there were 11,516 out of 80,895 or 14% who reported some type of disability. There were 20,371 households in which grandparents were living in the household with children under 18 years of age. In 28% of these households, the grandparent was responsible for the care of the grandchildren.

Sources

1. State of California, Department of Finance, E-3 Race / Ethnic Population Estimates with Age and Sex Detail, 2000–2007. Sacramento, CA, May 2009.
2. Where more recent data are not available, 2000 Census reports.

Poverty

As of the 2005 – 2007 period, 6.4% of families, and 9% of individuals were known to live below at or below the federal poverty level in Ventura County. Those most at risk were families with a female householder and no husband present. The percent of this group living at or below the federal poverty level varied with the age of the children in the

home and ranged from 23.5% for those with children <18 years of age to 27.8% of those with children under 6 years of age. As of May 2004, 68,739 Medi-Cal recipients were in MCAH Programs. Fillmore, Oxnard, and Santa Paula all had median incomes well below the County average at \$40,000 to \$45,000 and poverty rates above the County average at 12-13%. (*Appendix G*).

Over the 2005-2007 period, the median family income was \$81,187⁸. This is a 28% increase when compared with 1998 income published in the Ventura County Economic Profile of \$63,100. At the 2000 Census, there were 26,528 female householders with no husband present; of these 15,085 have children of their own under 18 years of age. There is a gender disparity in earnings for full-time year workers with the median annual earnings for males at \$52,499 while females' median income was \$40,230. This income disparity is manifested in the high proportion of women with children in poverty noted above⁸.

Source:

US Census Bureau, 2005-2007 American Community Survey 3-Year Estimates, Ventura County, CA

In 2009 there has been a considerable downturn in the local, national, and global economies. The results have been high rates of lay offs in key employment sectors such as retail, auto, aerospace/DoD contracted employment, etc. Housing prices have tumbled to as low as 1980 prices in some cases, while financing to buy a new home is difficult to obtain, due to losses and continuing insecurity in the financial sector. While numbers for this are difficult to pin down, the recent economic situation is bound to be a factor over the next several years at least, making it difficult obtain funding to provide service to the underserved populations, while that population is growing quickly due to layoffs and business closures.

Industry

The service sector continues to be the largest industry, accounting for about 28% of all those employed. This includes health, childcare, and education. Of the ten fastest growing occupations in Ventura County, 60% are in the services and retail trade industries. Other employment is found in retail (17%), public sector (15%), durable manufacturing (9%), and agriculture (7%).

Education

According to the California State Department of Education, 69% of high school beginners actually graduated in 2008 in the Central Coast area (Ventura, Santa Barbara, San Luis Obispo, data are not available for individual Counties). The Statewide Average graduation rate is 64%. Large ethnic and sex differences do appear when comparing men and women and the State vs. the region. Overall, a much higher proportion of students complete high school in the Central Coast region than in the State. However, within that overall outcome, differences between ethnic groups and the sexes do exist. Asians appear to graduate at lower rates in the Central Coast than across the State, however, Latinos, for example, graduate at higher rates.

Ethnicity	Central Coast		State	
	Men	Women	Men	Women
Asian	75%	83%	86%	92%
Black	53%	68%	47%	59%
Filipino	83%	82%	82%	88%
Latino	52%	62%	46%	56%
Native American	68%	73%	61%	66%
Pacific Islanders	100%	65%	68%	72%
White	79%	81%	73%	80%
Overall Rate	83%	82%	64%	64%

Source: <http://www.cpec.ca.gov/StudentData/HSGradReport.ASP>

According to the 2000 U.S. Census (the most recent available census data), 6.2% of Ventura County residents 25 years and older have an eighth grade education or less. This totals to 49,085 residents of whom 24,145 were women in 2000. An additional 9.5% residents have a ninth to twelfth grade education but do not graduate from high school. In summary, 19.9% or 93,852 of County residents 25 years or older have not received a high school diploma. Of these 47,696 were women. In a high-skill job market such as Ventura County's, the 20% with low educational attainment are excluded, leaving them dependent on the low-skill, low paying jobs of seasonal and other agricultural work. The 2000 U.S. Census also found that of the population 25 years and older, 26.9% have attained a bachelor's degree or higher.

As County demographics have changed, so have the demographics of the school populations. The overall school population increased by 38% between 1987 and 2007 from 109,831 to 151,718 students.

Ethnicity	1987	2007	Change
Asian/Pac Islanders	3,627	6,401	76%
Black	3,022	2,812	-7%
Filipino	2,239	2,856	28%
Latino	32,706	68,354	109%
Native American	806	911	13%
White	67,431	55,586	-18%
No Response	0	14,798	**
Totals	109,831	151,718	38%

** In 1987, "No Response" was zero. In 2007, this represents nearly 10% of the total. This difference in coding could skew the comparisons in unknown ways. This may be related to the multi-race/ethnic categories added in the 2000 census.

Asian, Filipino, Native American and “No Response” all increased over these 20 years. Those who listed themselves as White declined by 18%. The Hispanic population in the schools increased by 109% over this time frame, while the white population declined by approximately 18%. By 2007, Ventura’s schools had become “minority majority” with Whites representing only 37% of the total k-12 students. (Even if all of the “No Response” students were White, this trend would still hold up.)

Source: <http://www.cpec.ca.gov/OnLineData/SelectFirstOptions.ASP?ReportType=K12>

According to the Children Now report 60% of Ventura County children three and four years of age were enrolled in preschool in 2000.

Source: http://eou.emt.org/SCALAR/documents/CountyProfile_Ventura.pdf

Access to Health Care for Pregnant Women, Mothers and Infants

The Ventura County Public Health Department is part of the Ventura County Health Care Agency (VCHCA) that comprises the Ventura County Medical Center (VCMC), Ambulatory Care System, Behavioral Health Department, Emergency Medical Services (EMS) and the Medical Examiner-Coroner’s office. As the largest health care system in Ventura County, the Ventura County Health Care Agency provides outpatient prenatal services through its 16 family care centers geographically situated throughout Ventura County. Patients with needs beyond primary care are referred to specialty medical services and clinics located at the VCMC campus in Ventura and the Mandalay Bay Clinic in Oxnard.

Other systems of health care in Ventura County include the non-profit Community Memorial Hospital and its system of nine family health centers, St. John’s Regional Medical Center/St. John’s Pleasant Valley Hospital (part of Catholic Healthcare West) and that includes a system that provides comprehensive perinatal services for 12 obstetrical providers in the Oxnard and Camarillo area and Clinicas del Camino Real, a system of ten federally qualified health centers, provides comprehensive medical, dental and mental health outpatient services.

All four systems provide bilingual (English & Spanish) services with several offering translation services for other languages. In addition, personnel staffing the facilities are culturally reflective of the community. Most of these facilities are located in the more densely populated sectors of the county and are accessible by public transportation.

At the present time there are six hospitals providing obstetrical delivery services. Two of the hospitals are located within a half mile of each other in Ventura, one private, and one public. The other hospitals are scattered throughout the county with locations in Santa Paula, Oxnard, Camarillo, Simi Valley and Thousand Oaks. All of the delivery hospitals accept Medi-Cal as a payment source for delivery. Five of the hospital/medical centers have neonatal intensive care units. According to California Children’s Services (CCS) designations, four are community or Level II facilities and one is an intermediate or Level I facility. Ventura County continues the traditional fee-for-service model for Medi-Cal health care services, while the private sector continues to move towards

managed care. Ventura County has approximately 90 medical providers delivering Comprehensive Perinatal Services at 26 sites throughout the county. Presumptive eligibility for Medi-Cal is offered at 20 of the 26 sites. There are 22 CPSP certified sites located throughout the county.

Access to Health Care for Children and Adolescents

Over 200,000 children reside in the County of Ventura. The majority of children access healthcare services through a fee-for-service network in both the private and public sectors. Approximately 11% are uninsured. Access to health care services in the private practice sector is extremely limited for low-income and uninsured families, with less than a handful of physicians in private practice in east Ventura County participating in the Medi-Cal program. Physicians in private practice in various locations in west Ventura County that do participate in the Medi-Cal program are primarily high volume, low acuity practices. The publicly funded Ventura County Health Care Agency anchors the safety net for low income families and individuals in Ventura County.

The Ambulatory Care System of the VCHCA has fifteen clinics staffed with 33 Family Practice physicians and two clinics staffed by three full-time and several part-time pediatricians. All of the pediatricians of the VCHCA are paneled by the California Children's Services program, and actively participate in the care of children with special health care needs. Community Memorial Hospital (CMH), a non-profit hospital in Ventura, has nine outpatient clinics with ten primary care physicians providing well-child screening examinations. Clinicas del Camino Real, funded in part as a federally qualified health center, also has ten outpatient clinics with 15 primary care physicians providing well-child care. Children with possible chronic diseases are referred to the county system of care as few of the primary care physicians within the Clinicas and CMH system of care are approved by CCS to provide care for children with special health care needs. Pediatric sub-specialists are available at the Pediatric Diagnostic Center, which is part of the VCHCA Ambulatory Care System. The closest pediatric intensive care units are out of the county, in Santa Barbara and Encino.

Challenges that were discussed among the stakeholders as affecting the MCAH population include:

- Transportation continues to be a problem for eastern parts of the county where travel to the Ventura County Medical Center can be an hour.
- Medi-Cal and CPSP providers in the eastern sector of the county are still few, despite a growing Medi-Cal population. A possible factor may be the number of individual providers versus large group practices. Additionally, there has been no movement of large clinic group practices into the area. There are plans to relocate the VCMC Ambulatory care clinic which is currently located in the more eastern part of the county to a more centralized location which will provide more access to resources for the population. The greatest concern for the CPSP Medi-Cal clients is delivery hospital.

- There continues to be a lack of comprehensive mental, culturally competent health services for pregnant women, postpartum women and their families; increasing pre-partum depression due to unstable living situations and economical issues.
- There remains a lack of dental providers that are willing to accept Medi-Cal prenatal patients.
- Our special needs population requiring CCS are required to apply to Medi-cal and/or Healthy Families (HF). The Medi-cal system is challenging for families and coordination of benefits between CCS and insurance plans, including HF, can be an issue.
- Few of the primary care pediatricians who provide ongoing care for children with special health care needs (CCS eligible) participate in the CCS program. This results in fragmentation of needed care.
- Families enrolled in Healthy Families that have children with medical problems eligible for authorized care through the CCS program are not referred to CCS in a timely manner or are not referred at all.
- Some families have been billed for services for which coverage through Healthy Families and the CCS carve-out is available.
- Children in foster care encounter unique challenges with respect to primary health care. According to Children and Family Services, approximately 30 children per month are placed into foster care. Few of the primary care physicians serving these children have the expertise and/or interest in addressing the special psychosocial problems many of these vulnerable children experience.
- There is a lack of housing resources for adolescents transitioning out of foster care.
- The high cost of living in Ventura County has taken its toll on the MCAH population. The lack of affordable housing and high number of female householder families has led to overcrowding and substandard living conditions for this vulnerable population.
- The continued lack of access to mental health services for children and adolescents was mentioned repeatedly by community partners, social services and foster parent focus groups.

Section 5. Health Status Indicators

See Attachment A and B.

Section 6. Local MCAH Problems/Needs

The MCAH planning group convened to identify through data analysis and discussion our local MCAH priority areas. Facilitated by the MCAH Epidemiologist, the group reviewed local and state rates for 27 health indicators in the HP 2010 goals. Local indicators significantly different from the state rate and/or below HP 2010 goals were chosen for further work. Six MCAH problems areas were named as a result of grouping data. Many of the community partners were involved in discussions pertaining to the various factors impacting each priority area (see Attachment A). Priority areas with quantitative and qualitative analysis are shown in the following tables and discussion.

1. Prenatal and Interconception Care and Maternal Health

#	Measure	HP 2010 Goal	Most Recent Statistic	Met HP 2010 Goal?	Difference from Past	Difference from State	Additional Information
1	Fertility per 1,000 Females Age 15 to 44	N/A	73.2	N/A	↔	↑	1995-2001 signif decreasing; 2001-2006 signif increasing. Fertility in VC is higher than State.
6A	Short Inter-Pregnancy Interval for Women Age 15-44 (%)	6%	12.6	↑	↔	↔	1995-2004 signif decreasing; 2004-2006 no signif change. NSD from State. VC more than 2x higher than HP2010 Goal
6B	Short Inter-Pregnancy Interval for Women Age 12-19 (%)	6%	10.1	↑	↔	↔	VC is 68% higher than HP 2010 Goal and NSD from State
	Women Using Alcohol, Drugs or cigarettes in the last month (after known pregnancy) (%)	N/A	8.4	N/A	N/A	N/A	
13	First Trimester Prenatal Care for Live Births (%)	90%	85.1	↓	↓	↔	1995-2003 signif increase; 2003-2006 signif decrease. NSD from State.
14	Adequate Prenatal Care (Kotelchuck Index) for Women Age 15 to 44	90%	77.8	↓	↓	↔	1995-2000 signif increase; 2000-2006 signif decrease
3	Low Birth Weight Live Births (%)	5%	6.7	↑	↑	↔	1995-2006 signif increase; NSD from state
4	Very Low Birth Weight Live Births (%)	0.9%	1.2	↑	↑	↔	1995-2006 signif increase (not so sharp)
5	Preterm Births < 37 Wks Gestation (%)	7.6%	10.7	↑	↔	↔	NSD from local period start; NSD from state; Higher than HP 2010 goal

From 2001 – 2006, females of childbearing age (15 – 44 years) in Ventura County had a significantly higher fertility rate at 73.2 births per 1,000, than California did at 70.5 per 1,000. The higher fertility rate in Ventura County is likely due to a combination of factors including the increase in the Hispanic population, which is younger than the White population and accounted for 45% of the total population, 48% of the women of childbearing age, and 61% of births in 2007. Additional factors may include the well-documented increase in fertility interventions and the broadening of the age at which women give birth up into the 50's. In 2007 Ventura County mother's age ranged from age 13 to 52, with those 40 and over accounting for 18% of all live births (Analysis of AVSS VC Births Download for 2007).

The higher fertility in Ventura County occurs within an environment of:

- 1) A short inter-pregnancy interval of 12.6% for women age 15 – 44 years, (more than double the HP 2010 goal of 6%)
- 2) An 8.4% rate of births to women using alcohol, drugs or cigarettes
- 3) A significant decline in first trimester prenatal care for live births from an average rate of 88.1% for 1995 – 1997 to an average rate of 85.1% for 2004 – 2006 (the HP 2010 goal is 90%)
- 4) A significant decline in adequate prenatal care for women age 15 – 44 from an average rate of 80.6% for 1995 – 1997 to 77.8% for 2004 – 2006 (the HP 2010 goal is 90%)

The decline in early and adequate prenatal care plus the presence of drug use in pregnancy and increases in maternal age, result in a significant increase in both low birth weight live births and very low birth weight births. The increase was from 6.4% of all live births for the 1995 – 1997 period to 7.9% for 2004 – 2006. Pre-term births remained static. They were 10.3% of all live births in 1995 – 1997 and 10.7% in 2004 – 2006.

Discussion of these trends led the group to be concerned that increased stressors related to our economic crisis, lack of health insurance and prevention education, and substance abuse are major contributing factors to adverse prenatal, interconception and maternal health outcomes.

2. Infant and Child Injury and Death Prevention

#	Measure	HP 2010 Goal	Most Recent Statistic	Met HP 2010 Goal?	Difference from Past	Difference from State	Additional Information
8	Perinatal Deaths per 1,000 Births	4.5	6.2	↑	↔	↔	Significantly higher than HP2010 Goal, NSD from state
9	Neonatal Deaths Age < 28 days per 1,000 births	2.9	4.6	↑	↔	↑	Significantly higher than HP2010 Goal, significantly higher than State
10	Post-Neonatal Deaths Age > 28 Days to 1 Year per 1,000 births	1.2	1.8	↑	↔	↔	Significantly higher than HP2010 Goal, NSD from State
11	Infant Deaths to 1 Year per 1,000 births	4.5	6.4	↑	↔	↑	Significantly higher than HP2010 Goal, significantly higher than State
12A	Deaths Age 1 to 14 per 100,000	N/A	15.2	N/A	↔	↔	NSD from State
12B	Deaths Age 15 to 19 per 100,000	39.8	43.3	↔	⬇	⬇	Signif lower than State, signif decrease from comparison period (1995 – 97)
23A	Non-Fatal Injury Hospitalizations Children Age 0 to 14 per 10,000	N/A	23.9	N/A	↔	⬇	Signif lower than State
24 A	Non-Fatal Motor Vehicle Accident Injuries Children Age 0 to 14 per 100,000	933	248	★	⬇	⬇	Meets HP 2010 Goal. Signif lower than State, signif decrease from comparison period (1997- 1999)

All four of the above indicators exceed the corresponding HP 2010 goal by 38% to 59% for the 2004 – 2006 period. The neonatal and infant death rates are higher than the corresponding State death rates. The indicators have remained static over the comparison time frames of 1995 – 1997 and 2004 – 2006. The apparent stability of these indicators is likely related to health care and health status factors examined in other priority areas.

Rates of injury and death in Ventura County have remained stable or improved in all categories. Decreasing rates of injuries due to motor vehicle accidents may be a reflection of the 1998 graduated license law in California, which put more restrictions on driving in those 15 – 19 years of age. Despite overall improvement in these variables, non-fatal motor vehicle accident injuries in those age 15 to 24 remain significantly higher in Ventura County than the HP2010 goal and the rate in California.

Injury and death rates in Ventura County all exceed the HP 2010 goals. There has been little change from past results for those measures where prior data exist.

- Non-fatal hospitalizations for injuries have remained steady.
- Non-fatal hospitalizations for motor vehicle accidents for young adults (15 to 24) have declined, yet the rate remains higher than the HP 2010 goal.

All four indicators describing death in Ventura County during the perinatal, neonatal, and post-neonatal periods; and infant death exceed the corresponding HP 2010 goal by 38% to 59% for the 2004 – 2006 period. Of these, neonatal death rate and infant death rate are significantly higher in Ventura County than they are in the State, while the perinatal death rate and post-neonatal death rate are not. None of the four have a significant increase or decrease locally over the comparison time frames of 1995 – 1997 and 2004 – 2006.

Child related injury and death rates in Ventura County all exceed the HP 2010 goals. Little change occurred from past results for measures where prior data exist. Non-fatal hospitalizations for injuries have remained steady. Non-fatal hospitalizations for motor vehicle accidents for young adults (15 to 24) have declined, yet the rate remains higher than the HP 2010 goal.

Although the fetal infant mortality rate has decreased in our County the neonatal mortality rate has increased. We had nine reported SIDS related deaths in 2008. Three of the deaths took place while in the care of childcare providers. Fortunately, we have not had any reported SIDS cases in 2009. The lack of injury prevention education provided throughout the community, with special focus on daycare centers, lack of family resources to purchase safety devices, and lack of child supervision are all thought to contribute to infant and child injury.

3. Maternal and Child Nutrition and Physical Activity

#	Measure	HP 2010 Goal	Most Recent Statistic	Met HP 2010 Goal?	Difference from Past	Difference from State	Additional Information
15	Women Exclusively Breastfeeding at the Time of Hospital Discharge (%)	75%	44.1%	↓	↓	↻	Signif decrease from comparison period (2001 – 2003), well below the 75% HP2010 Goal, though signif higher than State
19B	Children Age 5 to 19 Who Are Overweight (%)	5%	24.4%	↑	↑	↑	Signif higher (almost 5 times) than HP2010 Goal, signif increase from comparison period (1995 – 1997), and signif higher than State
19 A	Children < Age 5 Who Are Overweight (%)	N/A	15.4	N/A	↔	↻	Signif decrease from comparison period (1995 – 1997)

The rate of exclusive breastfeeding at time of hospital discharge was highest in 2000 at 49%, and has declined since that time to its present rate of 44%. Overweight in children age 5 – 19 years has increased significantly from 18% in 1995 – 1997 to 24% during the 2004 - 2006 period, is more than 4 times higher than the 5% HP 2010 goal, and significantly higher than the State. With close to a quarter of our young people overweight, there is elevated concern for both early onset and adult chronic diseases like diabetes and heart disease.

Ventura County's breastfeeding rate is much lower than the HP 2010 goals, and lower than the State average. Childhood obesity has reached crisis proportions in Ventura County. WIC has reported that 29% of low-income children ages 2-3 and 39% of 4-5 year olds are overweight with a BMI >85%. With the 2008 Obesity Forum report showing a 42% childhood obesity rate in Ventura County, concerns about diabetes, heart disease and other diet-related chronic diseases intensify. Inactivity in neighborhoods due to concerns of safety; lack of fresh foods in neighborhood stores; poor nutrition attributed to poverty, lack of indoor/outdoor activities and lack of knowledge regarding healthy food choices all contribute to our childhood obesity crisis.

4. Access to Care

#	Measure	HP 2010 Goal	Most Recent Statistic	Met HP 2010 Goal?	Difference from Past	Difference from State	Additional Information
16	Children and Adolescents Age 0 to 19 with Health Insurance (%)	100%	91.4	↓	↔	↔	Signif lower than HP2010 Goal of 100%
17	Children Age 2 to 11 with Dental Insurance (%)	N/A	85.2	N/A	↔	↔	NSD from State, NSD from Local Period start
18	Children Age 2 to 11 Who Have Been to the Dentist in the Past Year (%)	56%	82.2	⬆	↔	↔	NSD from State, meets HP2010 Goal
22 B	Mental Health Hospitalizations Adolescents Age 15 to 19 per 10,000	N/A	120.2	N/A	↑	↑	1995-2006 signif increase. Signif higher than State.
22 A	Mental Health Hospitalizations Children Age 5 to 14 per 10,000	N/A	25.3	N/A	↔	↑	Signif higher than State

Ventura County has an excellent record of providing health care coverage for its residents, though it falls short of the HP 2010 100% coverage goal for children and adolescents age 0 – 19 years at 91%. With the economic downturn, job loss, and threat

to public health and insurance programs, its likely insurance coverage among all groups will decline over the next 2 – 5 years.

Transportation remains a barrier to accessing care for many families. The county's geographical area is large with health services concentrated in areas that are difficult for many to access. In Eastern parts of the County, travel to the Ventura County Medical Center and the clinics for high-risk infant care can be up to an hour. Additionally, the county is largely in part an agricultural county with many migrant farm workers. Many of these workers are indigenous-language Mixtecs with immense barriers to health care. Public Health nurses receive many referrals to help this population access health services, especially for pregnant women.

5. Family Violence

#	Measure	HP 2010 Goal	Most Recent Statistic	Met HP 2010 Goal?	Difference from Past	Difference from State	Additional Information
27	Domestic Violence Related Calls for Assistance per 10,000	N/A	8.7	N/A	↓	↑	Signif decrease from comparison period (1999 – 2001), signif higher than State
25	Children Living in Foster Care each July per 1,000	N/A	3.0	N/A	⬇️	⬇️	Signif decrease from comparison period (1998 – 2000), signif lower than State
26	Children Age 0 to 17 Living in Poverty %	N/A	13.2	N/A	⬇️	⬇️	Signif decrease from comparison period (1995 – 1997), signif lower than State

The rate of domestic violence related calls for assistance has declined significantly since 1995 yet remains significantly higher than the State of California's rate. In 2001, Ventura County had a rate of about 8.7 calls per 1000 adult population versus California's rate of 4.9 calls per 1000 adult population. The number of children living in foster care has remained fairly stable, and is lower than the State rate. The number of children living in poverty has declined and is also lower than the State rate.

Children living in foster care and children living in poverty have had small but statistically significant decreases since the comparison period for rates of 3.0 per 1,000 and 13.2 percent respectively for the 2004 – 2006 period.

Community stakeholders discussed family violence at great length. The ongoing problem of violence was also confirmed by the Partnership for Safe Families Sub-Committee on Domestic Violence. Additionally, the community health nurses mentioned that they receive about 15-20 referrals a month from the Domestic Violence court. These referrals are for families with children who have witnessed a domestic violence incident that resulted in an arrest.

Violence becomes normalized and accepted across time in families and communities. Social norms are formed as children, youth and adults become desensitized to violence through their exposure to violence in the media, video games, television, witnessing violence at home, school and community, etc. Violence contributes to the lack of outdoor activity: Children are afraid to go out into their neighborhoods.

6. Teenage Births and Sexually Transmitted Infections (STIs)

#	Measure	HP 2010 Goal	Most Recent Statistic	Met HP 2010 Goal?	Difference from Past	Difference from State	Additional Information
2D	Births per 1,000 Females Age 15 to 19	N/A	34.2	N/A	⬇️	⬇️	1995-2004 signif decreasing; 2004-2006 no signif. Overall signif decrease from comparison period, signif lower than State.
6B	Short Inter-Pregnancy Interval for Women Age 12-19 (%)	6%	10.1	⬆️	↔️	↔️	Signif higher than HP2010 Goal of 6%, NSD from State
7	Women Age 12-19 who are already mothers (%)	N/A	17.7	N/A	↔️	⬆️	Signif higher than State
21	Reported Cases of Chlamydia per 1,000 Females Age 15 to 19	N/A	10.1	N/A	⬇️	⬇️	Signif lower than State, signif decrease from comparison period (1998 – 2000)
2 A	Births per 1,000 Females Age 10 to 14	N/A	0.4	N/A	⬇️	↔️	NSD from State, signif decrease from comparison period (1995 – 1997)
2 B	Births per 1,000 Females Age 15 to 17	43	17.8	★	⬇️	⬇️	1995-2002 signif decreasing; 2002-2006 no signif. Signif lower than State, signif decrease from comparison period (1995 – 1997). Meets HP2010 goal.
2 C	Births per 1,000 Females Age 18 to 19	N/A	60.2	N/A	⬇️	⬇️	1995-2004 signif decreasing; 2004-2006 no signif. Signif lower than State, signif decrease from comparison period (1995 – 1997)

Ventura County teen birth rates are generally better or no different than State rates. Short inter-pregnancy interval for women age 12-19 is higher than the HP 2010 goal. In general, this is an area that has improved across the US in recent decades.

Most teen birth and STI indicator rates in Ventura County meet HP 2010 goals, have improved or remain unchanged over the comparison period, and are significantly better than the corresponding State rates. The exceptions are:

- Short inter-pregnancy interval for women age 12 – 19 (at 10% is significantly higher than the HP2010 goal of 6%)
- Women age 12 – 19 are already mothers (at 18% is statistically significantly higher than the State's rate of 17%).

The discussion concluded that factors contributing to teenage pregnancy are:

- Lack of pregnancy and STI prevention education at the elementary and Junior High schools
- In most cases of teen pregnancy family support is lacking
- Prevention efforts that focus primarily on female sexuality and not male sexuality

According to our Communicable Disease manager, increases in STIs are cases of Chlamydia trachomatis (CT) syphilis, and co-infection with syphilis and HIV. Many cases of CT and syphilis do not get diagnosed prior to sexual transmission to others. Co-infected cases of syphilis and HIV frequently spread through unprotected sexual contact without disclosure.

Section 7. MCAH Priorities

See Attachment 4. Our planning group convened to rank the priority areas (See Attachments A, C and D). We assigned a ranking of 1 to 3 to each health indicator (1 = does not apply, 3 = strongly applies) according to the following criteria.

Criterion 1: Number Of Individuals Affected

Criterion 2: Seriousness Of Issue

Criterion 3: Economic Impact

Criterion 4: Whether Area Had An Indicator To Track And Measure Available To Address Problem

Criterion 5: Degree Of Demographic Disparity

Criterion 6: Whether Resources Are

Criterion 7: Level Of Priority For The Community

Totals were calculated for each grouping. Areas were assigned priority accordingly.

Section 8. Capacity Assessment

See Attachments A and E.

Section 9. MCAH Capacity Needs

MCAH Capacity Needs Discussion

Capacity needs were ranked according to time, cost and feasibility of being accomplished. The VCPH MCAH program invited about 60 stakeholders to participate (see Attachment A). About 45 came to the first meeting, however, only nine came to the second meeting. At the initial meeting, stakeholders were grouped into tables of six participants. Each group responded to the first two capacity needs. The nine participants who showed up at the second stakeholder meeting worked individually on the mCAST.

Because attendance dropped off so much, we developed an online survey tool and asked the rest of the participants to use it. Out of these participants we still had a very low response rate. A total of 27 participants at least started the surveys but only nine of them actually went through each question and completed the SWOTs.

When conducting the Capacity Needs stakeholder meetings, participants were confused about how to distinguish between “Notes” and the written sections of the SWOT analysis. They combined their narrative feedback into the SWOT analysis sections. They did not make notes on any of the other worksheets. We have used the results in the best way we could to meet the requirements (see Attachment E).

The major themes found in the capacity assessment were related to funding, data issues, and legislative and regulatory roadblocks. The themes were ranked beginning with funding, which drives the other capacity needs.

Capacity – Funding: Categorical type funding makes it difficult to serve children and families comprehensively as it defines participant eligibility and services in narrow terms. The State budget crisis is impacting our community in many ways. The county unemployment rate was 9.6% as of March, 2009 (Bureau of Labor Statistics). These factors threaten to increase the need for MCAH services at the same time that resources may be eliminated.

Capacity – Data Related Issues: Data are either difficult to obtain or simply unavailable. The lag time before data are available makes it difficult to keep up with changes in our community. We need more resources to analyze and interpret the data we do have. Lack of geographically detailed specificity in demographic data makes it difficult to target resources where needed.

Capacity – Regulatory Roadblocks. Regulations are burdensome, imposing restrictions on otherwise comprehensive services. HIPAA regulations make it difficult to collaborate across agencies.

Section 10. MCAH Capacity Assets

The stakeholders concluded that Ventura County has the following strengths, opportunities and assets (see Attachment A).

- Whenever possible, local agencies offer in-kind services. This is our primary strength as we go into a period of budget cuts.
- County-wide efforts are underway to establish a pool of volunteers to expand services.
- Focus groups are meeting regularly to discuss how to collaborate in these financially dire times to meet the needs of the MCAH population.
- There is a strong collaborative environment within public sector agencies and CBOs.
- We have an active community based organization network.
- There are three community colleges and three four-year colleges within the county.
- Our agricultural industry provides a wealth of fresh fruits and vegetables year round.
- There are an abundance of city/county parks and recreational activities available.
- We have ethnic/cultural celebrations and events that are well attended throughout the year.
- The county has several community committees that advocate for the MCAH population. Examples of these committees include: The Children's Oversight Committee, Partnership for Safe Families, Child Abuse Prevention Council, Juvenile Detention Alternative Action, Interagency Council, Intensive Case Management Council, Domestic Violence Committee, The Perinatal Substance Abuse Taskforce, Obesity Taskforce and many others.
- As the largest health care system in Ventura County, we provide comprehensive services to all populations, regardless of socio-economic status.

Attachment A. Capacity Assessment Worksheet A

Stakeholder Participant's Initials	Organizational Affiliation	Sector Represented	Section Provided Input On					
			Mission Statement & Goals	Community Health Profile	Health Status Indicators	Local MCAH Problems/Needs	MCAH Priorities	Capacity Assessment
DB	SIDS/FIMR	A	X			X	X	
NS	PAC LAC	F				X		X
RD	Child Development Resources	B				X		X
KR	WIC	A				X	X	X
MB	Miracles for Moms	E						X
EC	Child Health and Disability	A		X			X	
NM	Ventura School District	G		X				X
KB	Aspira Foster Care	E		X				X
LL	St Johns Regional Medical	C		X		X		X
SH	Mixteco/Indigena Project	E						X
LR	Adult and Drug Dependency	E				X		X
CT	First 5 Ventura County	B		X		X		X
FH	Casa Pacifica	B		X		X		X
PC	Santa Clara NFL	E						X
JB	VCMC NICU	C		X		X		X
LB	Children First	A	X			X	X	X
MC	Child Injury Prevention	A	X			X	X	X
LG	Coalition to End Family Violence	E				X		X
RN	Miracles for Moms	E				X		X
TK	Interface	B				X		X
MP	Casa Pacifica	B				X		X
CP	Ventura NFL	E				X		X
RF	Tenderlife Maternity Home	E						X
GF	Tri-Counties Regional Medical	C		X				X
JO	VCMC High Risk Infant follow up	C						X
NL	Coalition to End Violence	E		X				X
DO	Behavioral Health	A	X	X		X	X	X
SD	Child Abuse Prevention Program	A	X			X	X	X
BM	Community Action Partnership	E				X		X
PO	Juvenile Probation	B				X		X
CK	A New Start for Moms	E						X
CS	Casa Pacifica Medical Provider	C						X
LW	St Johns Regional High Risk	C		X				X
ML	VCMC Peds	C		X				X
PB	Conejo Valley Womens Resource	E						X
PK	Naval Base	C						X
MM	VCMC Maternal Child	C		X				X
RO	Action Foundation	I		X		X		X

Capacity Assessment Worksheet A, Continued

Stakeholder Participant's Initials	Organizational Affiliation	Sector Represented	Section Provided Input On					
			Mission Statement & Goals	Community Health Profile	Health Status Indicators	Local MCAH Problems/Needs	MCAH Priorities	Capacity Assessment
JR	Casa Pacifica	B						X
ES	Interface Children & Family Svcs	E						X
LR	EI Centrito Family Services	E				X		X
PC	Ventura Unified School District	G		X				X
NB	AFLP	A	X			X	X	
SS	Public Health Education	A	X			X	X	
SD	Child Abuse Prevention Program	A	X				X	
ST	New Parent Kit	A	X				X	
JD	Obesity Prevention	A	X	X		X	X	
SL	Community Health Nursing	A	X	X			X	
LA	Oral Care	A	X				X	
CC	CPSP	A	X				X	
SS	HealthCare for Kids	A	X				X	
DG	MCAH Epidemiologist	A			X			

Attachment B. Capacity Indicators

Indicator		Compare Local End Status to			Comment Explain
		Local Period Start	State Period End	HP 2010 Objective	
#	Description	HP 2010 Objective			
1	Fertility per 1,000 Females Age 15 to 44	N/A	↕	N/A	1995-2001 signif decreasing; 2001-2006 signif increasing
2 A	Births per 1,000 Females Age 10 to 14	N/A	↔	N/A	NSD from State
2 B	Births per 1,000 Females Age 15 to 17	43	↓	★	1995-2002 signif decreasing; 2002-2006 no signif
2 C	Births per 1,000 Females Age 18 to 19	N/A	↓	N/A	1995-2004 signif decreasing; 2004-2006 no signif
2 D	Births per 1,000 Females Age 15 to 19	N/A	↓	N/A	1995-2004 signif decreasing; 2004-2006 no signif
3	Low Birth Weight Live Births (%)	5%	↔	↑	1995-2006 signif increase; NSD from State
4	Very Low Birth Weight Live Births (%)	0.9%	↔	↑	1995-2006 signif increase (not so sharp)
5	Preterm Births < 37 Wks Gestation (%)	7.6%	↔	↑	NSD from State
6 A	Short Inter-Pregnancy Interval for Women Age 15-44 (%)	6%	↔	↑	1995-2004 signif decreasing; 2004-2006 no signif; NSD from State
6 B	Short Inter-Pregnancy Interval for Women Age 12-19 (%)	6%	↔	↑	NSD from State

7	Women Age 12-19 who are already mothers (%)	N/A	↔	↔	N/A	N/A	NSD from State
8	Perinatal Deaths per 1,000 Births	4.5	↔	↔	↑	nonsignif	NSD from State
9	Neonatal Deaths Age < 28 days per 1,000 births	2.9	↔	↑	↑	nonsignif	
10	Post-Neonatal Deaths Age > 28 Days to 1 Year per 1,000 births	1.2	↔	↑	↑	nonsignif	
11	Infant Deaths to 1 Year per 1,000 births	4.5	↔	↑	↑	nonsignif	
12 A	Deaths Age 1 to 14 per 100,000	N/A	↔	↔	N/A	N/A	NSD from State
12 B	Deaths Age 15 to 19 per 100,000	39.8	↓	↓	↔	nonsignif	
13	First Trimester Prenatal Care for Live Births (%)	90%	↓	↔	↓	nonlinear	1995-2003 signif increase; 2003-2006 signif decrease; NSD from State
14	Adequate Prenatal Care (Kotelchuck Index) for Women Age 15 to 44	90%	↓	↑	↓	nonlinear	1995-2000 signif increase; 2000-2006 signif decrease
15	Women Exclusively Breastfeeding at the Time of Hospital Discharge (%)	75%	↓	↑	↓	N/A	
16	Children and Adolescents Age 0 to 19 without Health Insurance (%)	0%	↔	↔	↓	N/A	
17	Children Age 2 to 11 without Dental Insurance (%)	N/A	↔	↔	N/A	N/A	NSD from local start to local end; NSD from State
18	Children Age 2 to 11 Who Have Been to the Dentist in the Past Year (%)	56%	↔	↔	★	N/A	NSD from State
19 A	Children less than Age 5 Who Are Overweight (%)	N/A	↔	↓	N/A	N/A	

19 B	Children Age 5 to 19 Who Are Overweight (%)	5%	↑	↑	↑	N/A	N/A	1995-2006 signif decrease
20 A	Asthma Hospitalizations Children Age 0 to 4 per 10,000	25	↓	↓	↓	surpassed HP 2010 objective	★	1995-2006 signif decrease
20 B	Asthma Hospitalizations Children Age 5 to 17 per 10,000	7.7	↓	↓	↓	surpassed HP 2010 objective	★	1995-2006 signif decrease
21	Reported Cases of Chlamydia per 1,000 Females Age 15 to 19	N/A	↓	↓	↓	N/A	N/A	
22 A	Mental Health Hospitalizations Children Age 5 to 14 per 10,000	N/A	↔	↑	↑	N/A	N/A	
22 B	Mental Health Hospitalizations Adolescents Age 15 to 19 per 10,000	N/A	↑	↑	↑	N/A	N/A	1995-2006 signif increase
23 A	Non-Fatal Injury Hospitalizations Children Age 0 to 14 per 10,000	N/A	↔	↓	↓	N/A	N/A	
23 B	Non-Fatal Injury Hospitalizations Age 15 to 24 per 10,000	N/A	↓	↓	↓	N/A	N/A	
24 A	Non-Fatal Motor Vehicle Accident Injuries Children Age 0 to 14 per 100,000	933	↓	↓	↓	N/A	★	
24 B	Non-Fatal Motor Vehicle Accident Injuries Age 15 to 24 per 100,000	933	↓	↔	↑	N/A	↑	NSD from State
24 C	Non-Fatal Injury Hospitalizations for Motor Vehicle Accidents Age 0 to 14 per 10,000	N/A	↓	↓	↓	N/A	N/A	1995-2006 signif decrease
24 D	Non-Fatal Injury Hospitalizations for Motor Vehicle Accidents Age 15 to 24 per 10,000	N/A	↓	↓	↓	N/A	N/A	

25	Children Living in Foster Care each July per 1,000	N/A	↓	↓	N/A	N/A	N/A
26	Children Age 0 to 17 Living in Poverty %	N/A	↓	↓	N/A	N/A	N/A
27	Domestic Violence Related Calls for Assistance per 10,000	N/A	↓	↑	N/A	N/A	N/A

Attachment C. Worksheet C2: Problem Prioritization Tool

		Criterion #5: DEGREE OF DEMOGRAPHIC DISPARITY							
		Criterion #6: WHETHER RESOURCES ARE AVAILABLE TO ADDRESS PROBLEM							
		Criterion #7: LEVEL OF PRIORITY FOR THE COMMUNITY							
		Criterion #8:							
		Rating Using Prioritization Criteria: C1 below corresponds to Criterion #1 above, C2 to Criterion #2, etc. If using a "weighted" method, record the agreed upon weights in the line below each criterion number. Assess each indicator using each criterion. Enter your score (1=does not apply, 2=applies, 3= strongly applies) in the box corresponding to the indicator and its criterion. If using a weighted method, multiply the score by the criterion weight and then enter the weighted score in the box.							
Indicator	C1	C2	C3	C4	C5	C6	C7	C8	Total Scores
First Trimester Prenatal Care	2	3	3	3	1	3	3		18
Low and Very Low BW	2	3	3	3	1	2	2		16
Adequate Prenatal Care	2	3	3	3	1	3	3		18
Preterm Births	2	3	3	3	1	3	2		17
Short Inter-Pregnancy Interval for women 12-19 & 15-44	2	3	3	3	1	3	2		17
Women using substances during pregnancy	2	3	3	3	1	3	3		18
Priority Area: Prenatal and Interconception Care and Maternal Health									104

Criterion #1: NUMBER OF INDIVIDUALS AFFECTED		Criterion #5: DEGREE OF DEMOGRAPHIC DISPARITY								
Criterion #2: SERIOUSNESS OF ISSUE		Criterion #6: WHETHER RESOURCES ARE AVAILABLE TO ADDRESS PROBLEM								
Criterion #3: ECONOMIC IMPACT		Criterion #7: LEVEL OF PRIORITY FOR THE COMMUNITY								
Criterion #4: WHETHER AREA HAD AN INDICATOR TO TRACK AND MEASURE		Criterion #8:								
Indicator	Rating Using Prioritization Criteria: C1 below corresponds to Criterion #1 above, C2 to Criterion #2, etc. If using a "weighted" method, record the agreed upon weights in the line below each criterion number. Assess each indicator using each criterion. Enter your score (1=does not apply, 2=applies, 3= strongly applies) in the box corresponding to the indicator and its criterion. If using a weighted method, multiply the score by the criterion weight and then enter the weighted score in the box.								Total Scores	
	C1	C2	C3	C4	C5	C6	C7	C8		
Perinatal Deaths	2	3	2	3	2	2	2	2	2	16
Neonatal Deaths	2	3	2	3	2	2	2	2	3	17
Post-Neonatal Deaths	2	3	2	3	2	2	2	2	3	17
Infant Deaths	2	3	2	3	2	2	2	2	3	17
Priority Area: Infant and Child Injury and Death Prevention										67

Criterion #1: NUMBER OF INDIVIDUALS AFFECTED		Criterion #5: DEGREE OF DEOMOGRAPHIC DISPARITY							
Criterion #2: SERIOUSNESS OF ISSUE		Criterion #6: WHETHER RESOURCES ARE AVAILABLE TO ADDRESS PROBLEM							
Criterion #3: ECONOMIC IMPACT		Criterion #7: LEVEL OF PRIORITY FOR THE COMMUNITY							
Criterion #4: WHETHER AREA HAD AN INDICATOR TO TRACK AND MEASURE		Criterion #8:							
Indicator	Rating Using Prioritization Criteria: C1 below corresponds to Criterion #1 above, C2 to Criterion #2, etc. If using a "weighted" method, record the agreed upon weights in the line below each criterion number. Assess each indicator using each criterion. Enter your score (1=does not apply, 2=applies, 3= strongly applies) in the box corresponding to the indicator and its criterion. If using a weighted method, multiply the score by the criterion weight and then enter the weighted score in the box.								Total Scores
	C1	C2	C3	C4	C5	C6	C7	C8	
Women exclusively breastfeeding at the time of hospital discharge	3	3	2	3	2	3	3	3	19
Children 5-19 who are overweight	3	3	3	3	3	3	3	3	21
Children Less than age 5 who are overweight	2	3	3	3	3	3	3	3	20
Priority Area: Maternal and Child Nutrition and Physical Activity									60

Criterion #1: NUMBER OF INDIVIDUALS AFFECTED		Criterion #5: DEGREE OF DEOMOGRAPHIC DISPARITY								
Criterion #2: SERIOUSNESS OF ISSUE		Criterion #6: WHETHER RESOURCES ARE AVAILABLE TO ADDRESS PROBLEM								
Criterion #3: ECONOMIC IMPACT		Criterion #7: LEVEL OF PRIORITY FOR THE COMMUNITY								
Criterion #4: WHETHER AREA HAD AN INDICATOR TO TRACK AND MEASURE		Criterion #8:								
Indicator	Rating Using Prioritization Criteria: C1 below corresponds to Criterion #1 above, C2 to Criterion #2, etc. If using a "weighted" method, record the agreed upon weights in the line below each criterion number. Assess each indicator using each criterion. Enter your score (1=does not apply, 2=applies, 3= strongly applies) in the box corresponding to the indicator and its criterion. If using a weighted method, multiply the score by the criterion weight and then enter the weighted score in the box.								Total Scores	
	C1	C2	C3	C4	C5	C6	C7	C8		
Children age 0-19 without health insurance	2	3	3	2	3	2	3	2	3	18
Children age 2-11 without dental insurance	2	3	2	2	2	2	3	2	3	16
Children age 2-11 who have not seen the dentist over past year	2	3	2	2	2	2	3	2	3	16
Priority Area: Access to Health Care										50

Criterion #1: NUMBER OF INDIVIDUALS AFFECTED		Criterion #5: DEGREE OF DEMOGRAPHIC DISPARITY								
Criterion #2: SERIOUSNESS OF ISSUE		Criterion #6: WHETHER RESOURCES ARE AVAILABLE TO ADDRESS PROBLEM								
Criterion #3: ECONOMIC IMPACT		Criterion #7: LEVEL OF PRIORITY FOR THE COMMUNITY								
Criterion #4: WHETHER AREA HAD AN INDICATOR TO TRACK AND MEASURE		Criterion #8:								
Indicator		Rating Using Prioritization Criteria: C1 below corresponds to Criterion #1 above, C2 to Criterion #2, etc. If using a "weighted" method, record the agreed upon weights in the line below each criterion number. Assess each indicator using each criterion. Enter your score (1=does not apply, 2=applies, 3= strongly applies) in the box corresponding to the indicator and its criterion. If using a weighted method, multiply the score by the criterion weight and then enter the weighted score in the box.								Total Scores
		C1	C2	C3	C4	C5	C6	C7	C8	
Domestic Violence Related calls		2	3	3	2	2	2	3		17
Children Living in Foster Care		2	2	3	2	2	2	3		16
Children 0-17 living in poverty		2	3	3	2	2	2	3		17
Priority Area: Family Violence										50

Criterion #1: NUMBER OF INDIVIDUALS AFFECTED		Criterion #5: DEGREE OF DEMOGRAPHIC DISPARITY								
Criterion #2: SERIOUSNESS OF ISSUE		Criterion #6: WHETHER RESOURCES ARE AVAILABLE TO ADDRESS PROBLEM								
Criterion #3: ECONOMIC IMPACT		Criterion #7: LEVEL OF PRIORITY FOR THE COMMUNITY								
Criterion #4: WHETHER AREA HAD AN INDICATOR TO TRACK AND MEASURE		Criterion #8:								
Indicator	Rating Using Prioritization Criteria: C1 below corresponds to Criterion #1 above, C2 to Criterion #2, etc. If using a "weighted" method, record the agreed upon weights in the line below each criterion number. Assess each indicator using each criterion. Enter your score (1=does not apply, 2=applies, 3= strongly applies) in the box corresponding to the indicator and its criterion. If using a weighted method, multiply the score by the criterion weight and then enter the weighted score in the box.								Total Scores	
	C1	C2	C3	C4	C5	C6	C7	C8		
Births to females 15-19	2	2	2	2	1	2	2			13
Short Inter-Pregnancy interval 12-19	2	2	2	2	1	2	2			13
Women age 12-19 who are mothers	2	2	2	2	1	2	2			13
Reported cases of Chlamydia for females 15-19	1	2	1	2	1	2	2			11
Priority Area: Teenage Births and Sexually Transmitted Infections										50

Attachment D. Worksheet C3: Top Ranked Priorities

Top ranked priorities from Part A that Ventura County will allocate time and resources to work on in the next five years.

Priority 1.	Improve prenatal and interconception care and maternal health.
Priority 2.	Reduce infant and child injury and death.
Priority 3.	Improve maternal and child nutrition and physical activity.
Priority 4.	Improve access to health care.
Priority 5.	Reduce family violence.
Priority 6.	Reduce teenage births and sexually transmitted infections.
Priority 7.	
Priority 8.	
Priority 9.	
Priority 10.	

Attachment E. MCAH Capacity Needs: Worksheet D, mCAST 1-10 Results

Assessment of Essential Service #1 Process Indicators

Essential Service #1: Assess and monitor maternal and child health status to identify and address problems.	Level of Adequacy	Notes
<p>1.1 Data Use</p> <p>Key Ideas:</p> <ul style="list-style-type: none"> — Use up-to-date MCAH public health and related population data — Generate and use data in planning cycle activities (e.g., planning and policy development) <p>1.1.1 Do you use public health data sets to prepare basic descriptive analyses related to priority health issues (e.g., MIHA; CHIS; live birth, fetal death, abortion, linked live birth/infant death data; community health surveys; disease surveillance data, census data; etc.)?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, have access to documentation (e.g., users' guide/list of variables, contact information for the entity generating the data) for data sources? have access to raw data from these sources? refer to these data sources when it becomes aware of emergent MCAH problems? have the capacity to use these data sources to generate information? use geographic information systems?</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>	

Assessment of Essential Service #1 Process Indicators (continued)

Essential Service #1: Assess and monitor maternal and child health status to identify and address problems.		Level of Adequacy	Notes
Process Indicator			
<p>1.1 Data Use (continued)</p> <p>1.1.2 Do you conduct analyses of public health data sets that go beyond descriptive statistics?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, analyze existing data sets/conduct significance tests to identify associations among risk factors, environmental and other contextual factors, and outcomes? compare health status measures across populations or against the state's measures or Healthy People 2010 objectives? track trends over time?</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/></p> <p>1 2 3 4</p> <p>1=weak.....4=strong</p>		
<p>1.1.3 Do you generate and analyze primary data to address state- and local-specific knowledge base gaps?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, have established and routinely used procedures for identifying knowledge gaps (e.g., community or professional advisory boards)? collaborate with local agencies to collect and analyze data related to these knowledge gaps? use field surveys, focus groups, key informant interviews or otherwise collect data on the local MCAH populations and the health care delivery system? use that data to examine relationships among risk factors, environmental/contextual factors, and outcomes?</p>	<p><input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>1 2 3 4</p> <p>1=weak.....4=strong</p>		

Assessment of Essential Service #1 Process Indicators (continued)

Essential Service #1: Assess and monitor maternal and child health status to identify and address problems.		
Process Indicator	Level of Adequacy	Notes
1.1 Data Use (continued)		
<p>1.1.4 Do you report on primary and secondary data analysis for use in policy and program development?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, routinely review the current science base, standards of care, and the results of current research for use in planning and policy development? contribute to the production of briefs or updates on selected, timely MCAH issues to distribute to appropriate policy and program-related staff members?</p>	<p><input type="checkbox"/> X <input type="checkbox"/> <input type="checkbox"/></p> <p>1 2 3 4</p> <p>1=weak.....4=strong</p>	
1.2. Data-Related Technical Assistance		
<p>Key Idea: — Enhance local data capacity</p>		
<p>1.2.1 Do you establish framework/standards about core data expectations for local health jurisdictions and other MCAH providers/programs?</p> <p>For example: Has the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, established (or participated in the development of) maternal and child health status indicators and disseminated them to local agencies/programs? disseminated maternal, child and youth health status indicators to local stakeholders?</p>	<p><input type="checkbox"/> X <input type="checkbox"/> <input type="checkbox"/></p> <p>1 2 3 4</p> <p>1=weak.....4=strong</p>	

Assessment of Essential Service #1 Process Indicators (continued)

Essential Service #1: Assess and monitor maternal and child health status to identify and address problems.		Level of Adequacy	Notes
Process Indicator			
1.2. Data-Related Technical Assistance (continued)			
1.2.2	<p>Do you provide training/expertise about the collection and use of MCAH data to local health agencies or other constituents for MCAH populations?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, have an identified staff person(s) responsible for assistance on data-related matters? assist local health agencies and other providers/ programs in developing standardized data collection methods related to established MCAH indicators?</p>	<p><input checked="" type="checkbox"/> X <input type="checkbox"/> <input type="checkbox"/></p> <p>1 2 3 4</p> <p>1=weak.....4=strong</p>	
1.2.3	<p>Do you assist local health agencies in data system development and coordination across geographic areas so that MCAH data outputs can be compared?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, provide resources to enhance local data capacity through data systems development and coordination?</p>	<p><input checked="" type="checkbox"/> X <input type="checkbox"/> <input type="checkbox"/></p> <p>1 2 3 4</p> <p>1=weak.....4=strong</p>	

SWOT Analysis for Essential Service #1: Assess and monitor maternal and child health status to identify and address problems.

Strengths: (e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)

- Use data resources, state, FHOP, and other research data bases.
- Data sharing at meetings
- Local health department has access to several maternal child health statistics
- Various pertinent health journals are shared amongst staff
- County report card shared with other agencies

Weaknesses: (e.g., human resources; budgetary restrictions and fiscal resources; technological resources; state-local relationships; organizational culture; organizational structure)

- Within Public Health Agency, data is not immediately available
- Time constraints
- Staff and funding constraints

Opportunities: (e.g., human, fiscal, or technological resources; statutory/regulatory changes; community/business resources; social/political changes; technological developments)

- When public health data report is sent out via email then data is accessible

Threats: (e.g., statutory/regulatory change; organizational change/reorganization; social/political factors; demographic trends)

- Time constraints which limit ability to research where to find data

Assessment of Essential Service #2 Process Indicators

Essential Service #2: Diagnose* and investigate health problems and health hazards affecting women, children, and youth.		Notes
Process Indicator	Level of Adequacy	
<p>2.1 Do you study factors that affect health and illness to respond to MCAH issues?</p> <p>For example: Has the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, undertaken a study of and/or analysis of existing data on an MCAH issue at the request of local health administrators, Board of Supervisors, or community or professional groups, or in response to media coverage of an issue?</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>	
<p>2.2 Do you engage in collaborative investigation and monitoring of environmental hazards (e.g., physical surroundings and other issues of context) in schools, day care facilities, housing, and other places affecting MCAH populations, to identify threats to maternal, child, and adolescent health?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, work with agencies responsible for monitoring environmental conditions affecting MCAH populations to jointly produce or sponsor reports or recommendations to local legislative bodies? establish interagency agreements with these agencies for collecting, reporting on, and sharing data related to environments affecting MCAH populations?</p>	<p><input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>	

Assessment of Essential Service #2 Process Indicators (continued)

Essential Service #2: Diagnose* and investigate health problems and health hazards affecting women, children, and youth.	Level of Adequacy	Notes
Process Indicator		
<p>2.3 Do you develop and enhance ongoing surveillance systems/population risk surveys and disseminate the results at the state and local levels?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, maintain ongoing surveillance systems/populations risk surveys to address gaps in knowledge? regularly evaluate the quality of the data collected by existing surveillance systems or population-based surveys? have a routine means of reporting the results of these surveillance systems/surveys to localities?</p>	<p><input type="checkbox"/> X <input type="checkbox"/> <input type="checkbox"/></p> <p>1 2 3 4</p> <p>1=weak.....4=strong</p>	
<p>2.4 Do you serve as the local expert resource for interpretation of data related to MCAH issues?</p> <p>For example: Has the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, been regularly consulted on MCAH issues by the local public health administrators, by other agencies and programs, and by local legislators? been asked to participate with other local health agencies in the planning process on non-MCAH issues?</p>	<p><input type="checkbox"/> X <input type="checkbox"/> <input type="checkbox"/></p> <p>1 2 3 4</p> <p>1=weak.....4=strong</p>	

Assessment of Essential Service #2 Process Indicators (continued)

Essential Service #2: Diagnose* and investigate health problems and health hazards affecting women, children, and youth.	Level of Adequacy	Notes
<p>2.5 Do you provide leadership in reviews of fetal, infant, child, and maternal deaths and provide direction and technical assistance for local systems improvements based on their findings?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, participate in or provide resources for any fetal, infant, or child death review processes, if they exist in your LHJ? provide technical assistance to localities in conducting FIMR and/or child fatality reviews? participate in or provide leadership for a local maternal mortality review program? produce an annual report consolidating the findings of local mortality reviews as appropriate?</p>	<p> <input type="checkbox"/> X <input type="checkbox"/> <input type="checkbox"/> 1 2 3 4 1=weak.....4=strong </p>	
<p>2.6 Do you study factors that affect health and illness to forecast emerging MCAH threats that must be addressed in strategic planning?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, conduct surveillance or other process to identify emerging changes in the MCAH system of care and/or in the demographics or health status of local MCAH populations? use the results of that process to plan for data collection and/or analysis to identify avenues for intervention?</p>	<p> <input type="checkbox"/> <input type="checkbox"/> X <input type="checkbox"/> <input type="checkbox"/> 1 2 3 4 1=weak.....4=strong </p>	

SWOT Analysis for Essential Service # 2: Diagnose* and investigate health problems and health hazards affecting women, children, and youth.

Strengths: (e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)

- No Response

Weaknesses: (e.g., human resources; budgetary restrictions and fiscal resources; technological resources; state-local relationships; organizational culture; organizational structure)

- No Response

Opportunities: (e.g., human, fiscal, or technological resources; statutory/regulatory changes; community/business resources; social/political changes, technological developments)

- No Response

Threats: (e.g., statutory/regulatory change; organizational change/reorganization; social/political factors; demographic trends)

- No Response

Assessment of Essential Service #3 Process Indicators

Essential Service #3: Inform and educate the public and families about maternal and child health issues.		Level of Adequacy	Notes
3.1 Individual-Based Health Education			
Key Idea: Assure the provision and quality of personal health education services			
<p>3.1.1 Do you identify existing and emerging health education needs and appropriate MCAH target audiences?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, use the information from the Title V needs assessment in determining priorities for health education services in the community? know of existing resources related to these health education needs? assess what health education programs and services are already in place when determining priorities for developing new programs?</p>	<p><input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>		
<p>3.1.2 Do you conduct and/or fund health education programs/services on MCAH topics directed to specific audiences to promote the health of MCAH populations?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, offer resources, technical assistance, funding, or other incentives to local organizations to implement MCAH education activities? use other funds to support existing health education programs? collaborate with other public and private agencies/organizations in implementing MCAH education services (e.g., establishing partnerships with community based organizations or businesses)?</p>	<p><input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>		

Assessment of Essential Service #3 Process Indicators (continued)

Essential Service #3: Inform and educate the public and families about maternal and child health issues.		Level of Adequacy	Notes
Process Indicator			
3.2 Population-Based Health Information Services			
Key Idea: — Provide health information to broad audiences			
<p>3.2.1 Do you identify existing and emerging MCAH population-based health information needs?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, use information from the Title V needs assessment in determining priorities for MCAH population-based disease prevention/health promotion campaigns? know of a wide range of disease prevention/health promotion resources? assess what disease prevention/health promotion campaigns are already in place when determining priorities for developing new ones?</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>		
<p>3.2.2 Do you design and implement public awareness campaigns on specific MCAH issues to promote behavior change?</p> <p>For example: Has the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, contracted for a public awareness campaign using evidence-based media and communication methods? used MCAH funds to support public awareness campaigns? identified, educated, and collaborated with other public and private entities in implementing evidence-based public awareness campaigns and health behavior change messages? communicated timely information on MCAH topics (e.g., current local, state, and national research findings, MCAH programs and services) through press releases, newsletters, and other local media and community channels?</p>	<p><input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>		

Assessment of Essential Service #3 Process Indicators (continued)

Essential Service #3: Inform and educate the public and families about maternal and child health issues.	Level of Adequacy	Notes
<p>3.2.3 Do you develop, fund, and/or otherwise support the dissemination of MCAH information and education resources?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, provide readily accessible MCAH information and education resources to local communities, policy makers, and stakeholders? Have access to information regarding current national, state, and local MCAH data reports? get approached by policymakers, consumers, and others to provide descriptive information about MCAH populations and health status indicators? have a regular means of publicizing its toll-free MCAH line that targets a full range of MCAH constituents in the jurisdiction?</p>	<p><input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>	
<p>3.2.4 Do you release evaluative reports on the effectiveness of public awareness campaigns and other population-based health information services?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, collect information on the individuals and organizations reached by health information campaigns and other methods of disseminating health information? collect data on changes in knowledge and behavior resulting from its population-based health information services? analyze data on outcomes of these services?</p> <ul style="list-style-type: none"> disseminate results of these analyses to provider organizations or other interested parties? <p>use this information to make decisions about continuation of funding or changes in programming?</p>	<p><input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>	

SWOT Analysis for Essential Service # 3: Inform and educate the public and families about maternal and child health issues.

Strengths: (e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)

- Strong collaboration among service providers
- Using current information to provide for specific needs of community
- Strong commitment to community health education

Weaknesses: (e.g., human resources; budgetary restrictions and fiscal resources; technological resources; state-local relationships; organizational culture; organizational structure)

- Funding
- Staff
- Service coordination
- Does MCAH actively seek collaboration for “special populations”? Or remotely located populations?
- Public Health bureaucracy appears to be unapproachable
- Difficult to navigate resources

Opportunities: (e.g., human, fiscal, or technological resources; statutory/regulatory changes; community/business resources; social/political changes, technological developments)

- So many programs/agencies (public/private) that could collaborate/coordinate services e.g. Shared grants
- Abundance of need and growing
- Improved community/business resources e.g. Shared rent for nonprofit organizations

Threats: (e.g., statutory/regulatory change; organizational change/reorganization; social/political factors; demographic trends)

- State budget
- Shifting funding priorities
- Program Elimination
- Community perception of problem/needs interferes with service delivery
- Immigration laws prevent undocumented people from receiving services

Assessment of Essential Service #4 Process Indicators

Essential Service #4: Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal, child and adolescent health problems.		Level of Adequacy	Notes
Process Indicator			
<p>4.1 Do you respond to community MCAH concerns as they arise?</p> <p>For example: Are community organizations aware of how to and to whom within the local MCAH program to communicate their concerns? Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, regularly hear from community organizations about their concerns and interests? respond actively to community concerns through changes in policies, programs, or other means?</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input checked="" type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>		
<p>4.2 Do you identify community geographic boundaries and/or stakeholders for use in targeting interventions and services?</p> <p>For example: Do needs assessments and planning activities incorporate detailed assessments of the segments of the community to which services and programs are targeted? Are community boundaries and/or identities determined with input from community members and/or stakeholder groups?</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input checked="" type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>		
<p>4.3 Do you provide trend information to targeted community audiences on local MCAH status and needs?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, provide current information about public health trends that are disseminated to provider associations, elected officials, and community organizations?</p>	<p><input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>		

Assessment of Essential Service #4 Process Indicators (continued)

Essential Service #4: Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal, child and adolescent health problems.		Level of Adequacy	Notes
Process Indicator			
<p>4.4 Do you provide trend information to targeted community audiences on local MCAH status and needs?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, provide current information about public health trends that are disseminated to provider associations, elected officials, and community organizations?</p>	<p><input type="checkbox"/> X <input type="checkbox"/> <input type="checkbox"/></p> <p>1 2 3 4</p> <p>1=weak.....4=strong</p>		
<p>4.5 Do you actively solicit and use community input about MCAH needs?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, have a mechanism for including the perspectives of community members/ organizations in identifying needs? provide technical assistance on collaborating with community organizations in identifying needs?</p>	<p><input type="checkbox"/> <input type="checkbox"/> X <input type="checkbox"/></p> <p>1 2 3 4</p> <p>1=weak.....4=strong</p>		
<p>4.6 Do you provide resources for community generated initiatives and partnerships among public and/or private community stakeholders (e.g., CBOs, hospital associations, parent groups)?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, provide funding and/or assistance for CBOs, stakeholders, and other local providers of MCAH services? collaborate with community initiatives addressing problems/needs identified by the community?</p>	<p><input type="checkbox"/> <input type="checkbox"/> X <input type="checkbox"/></p> <p>1 2 3 4</p> <p>1=weak.....4=strong</p>		

Assessment of Essential Service #4 Process Indicators (continued)

Essential Service #4: Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal, child and adolescent health problems.	Process Indicator	Level of Adequacy	Notes
	<p>4.7 Do you provide resources for community generated initiatives and partnerships among public and/or private community stakeholders (e.g., CBOs, hospital associations, parent groups)?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, provide funding and/or assistance for CBOs, stakeholders, and other local providers of MCAH services? collaborate with community initiatives addressing problems/needs identified by the community?</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/></p> <p>1 2 3 4</p> <p>1=weak.....4=strong</p>	
	<p>4.8 Do you collaborate with coalitions and/or professional organizations to develop strategic plans to address health status and health systems issues?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, provide assistance to coalitions? obtain funding from grants for convening or participating in coalitions or similar collaborative activities?</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/></p> <p>1 2 3 4</p> <p>1=weak.....4=strong</p>	

SWOT Analysis for Essential Service #4: Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal, child and adolescent health problems.

Strengths: e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)

- Community organization
- Collaboration
- Provision of free materials
- Maintaining networking with stakeholders keeps me current
- Strong staff with years of experience and excellent contacts

Weaknesses: (e.g., human resources; budgetary restrictions and fiscal resources; technological resources; state-local relationships; organizational culture; organizational structure)

- Reciprocity among organizations and those receiving & delivering services
- Lack of specificity in demographic data collected
- Trend information is available but not necessarily disseminated
- Community input
- Caseloads and lack of time
- Lack of services out in East county
- Lack of ability to communicate to live people in the system
- Lack of communication of issues thoroughly and in a timely manner
- Stuck in the “we have always done it this way” mentality

Opportunities: (e.g., human, fiscal, or technological resources; statutory/regulatory changes; community/business resource; social/political changes, technological developments)

- Community task force to collaborate on needs e.g. Networking
- Increased community input=more tailored/responsive programs
- Economics of scale how can we work together most effectively
- Universal healthcare
- Networking, resources, relationships with health care agencies
- Strong ties to the community
- National, state and local reports on timely issues

Threats: (e.g., statutory/regulatory change; organizational change/reorganization; social/political factors; demographic trends)

- State budget
- HIPPA=>threatens type of information collected and disseminated
- Changes in leadership and prioritization of issues
- Partners are busy operating their own programs to participate fully in partnership projects
- Lack of available services to the extent needed
- Lack of information, misinformation, programs that don't develop into their fullest potential

Assessment of Essential Service #5 Process Indicators

Essential Service #5: Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth and their families.	Process Indicator	Level of Adequacy	Notes
<p>5.1 Data-Driven Decision Making/Planning Key Ideas: – Routine use of population-based quantitative and qualitative data, including stakeholder concerns – Dissemination of timely data for planning purposes</p>		<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input checked="" type="checkbox"/> 4 1=weak.....4=strong</p>	
<p>5.1.1 Do you actively promote the use of the scientific knowledge base in the development, evaluation, and allocation of resources for MCAH policies, services, and programs? For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, have a systematic process for evaluating current data pertaining to proposed policies, services, and programs? regularly consult with expert advisory panels in the formulation of policies, services, and programs? use health status indicators and/or other data to establish MCAH objectives and program plans?</p>		<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input checked="" type="checkbox"/> 4 1=weak.....4=strong</p>	
<p>5.1.2 Do you support the production and dissemination of an annual local report on MCAH status, objectives, and programs? For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, contribute resources to the production and dissemination of an annual MCAH local report? contribute data and/or analysis in the production of an annual MCAH local report? provide leadership for the production of an annual MCAH local report?</p>		<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input checked="" type="checkbox"/> 4 1=weak.....4=strong</p>	

Assessment of Essential Service #5 Process Indicators (continued)

Essential Service #5: Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth and their families.	Level of Adequacy	Notes
<p>Process Indicator</p> <p>5.1.3 Do you establish and routinely use formal mechanisms to gather stakeholders' guidance on MCAH concerns?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population routinely consult with an advisory structure(s) in the prioritization of health issues and the development of health policies and programs? Does the advisory structure(s) include representatives of professional associations, community groups, and consumers/families? Does the advisory structure(s) refer to current data in formulating policy stances? Do members of the advisory structure(s) feel their input is valued and used in shaping policy?</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>	
<p>5.1.4 Do you use diverse data and perspectives for data-driven planning and priority-setting?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, regularly use data from other agencies (state, regional, local, and/or national)? have a systematic process for using these data to inform local and state MCAH health objectives and planning?</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>	

Assessment of Essential Service #5 Process Indicators (continued)

Essential Service #5: Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth and their families.	Process Indicator	Level of Adequacy	Notes
<p>5.2 Negotiating Program and Policy Development Key Ideas: – Collaboration – Leadership in promoting the MCAH mission</p>			
<p>5.2.1 Do you participate in and provide consultation to ongoing state initiatives to address MCAH issues and coordination needs? For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, participate, as a member, with two or more local or state level advisory councils or working committees? routinely partner with other agencies or programs in activities related to training and education, program and policy development, and/or evaluation? serve as agency representative for one or more private sector community projects or professional associations? have involvement in activities that influence or inform the public health policy process? Are there key issue areas for which agency partnerships are lacking?</p>	<p> <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 1=weak.....4=strong </p>		
<p>5.2.2 Do you develop, review, and routinely update formal interagency agreements for collaborative roles in established public programs (e.g., WIC, family planning, Medi-Cal, First Five)? For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, participate in interagency agreements for joint needs assessment and/or program planning and evaluation? review and update these interagency agreements on a reasonable routine schedule? Are there programs or issue areas for which there are no interagency agreements but there should be?</p>	<p> <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 1=weak.....4=strong </p>		

Assessment of Essential Service #5 Process Indicators (continued)

Essential Service #5: Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth and their families.	Essential Service Indicator	Level of Adequacy	Notes
	<p>5.2.3 Do you serve as a consultant to and cultivate collaborative roles in new local or state initiatives through either informal mechanisms or formal interagency agreements?</p> <p>For example: Has the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, contributed to the planning process of a new local or state initiative affecting the MCAH population? been part of the implementation of a joint local or state initiative? been routinely consulted by the leadership of other programs to provide insight into the impact of policies and procedures on MCAH populations?</p>	<p> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4 1=weak.....4=strong </p>	

SWOT Analysis for Essential Service #5: Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth and their families.

Strengths: (e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)

- Some strong programs with passionate people (perinatal, oral health, injury prevention, CCS, CHDP)
- Interagency agreements are in place in most cases
- Administrative Support
- Agency collaboration

Weaknesses: (e.g., human resources; budgetary restrictions and fiscal resources; technological resources; state-local relationships; organizational culture; organizational structure)

- Lack of continuity/staff turnover
- Getting private sector more involved
- Communication and publicizing successes
- Lack of understanding about issues, financial costs of initiatives and programs
- Time constraints

Opportunities: (e.g., human, fiscal, or technological resources; statutory/regulatory changes; community/business resources; social/political changes, technological developments)

- Universal healthcare
- Better collaboration with private sector
- Increased visibility
- Recognition of value of volunteers
- Resource experts in the field
- Ability to collaborate with outside agencies, good networking opportunities
- Well crafted state and federal policies

Threats: (e.g., statutory/regulatory change; organizational change/reorganization; social/political factors; demographic trends)

- State/private budgets
- Anti-IZ group
- Conflicting information from various entities

Assessment of Essential Service #6 Process Indicators

Essential Service #6: Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being.	Level of Adequacy	Notes
<p>6.1 Legislative and Regulatory Advocacy Key idea: — Assure legislative and regulatory adequacy</p>		
<p>6.1.2 Do you monitor proposed legislation, regulations, and local ordinances that might impact MCAH and participate in discussions about its appropriateness and effects? For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, communicate with legislators, regulatory officials, or other policymakers regarding proposed legislation, regulations, or ordinances? participate in the drafting, development, or modification of proposed legislation, regulations, or ordinances for current MCAH public health issues and issues that are not adequately addressed? Does the Local MCAH Director participate in MCAH Action meetings to receive updates on current legislation and communicate with other MCAH leaders on legal or regulatory MCAH issues?</p>	<p><input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> 1 2 3 4 1=weak.....4=strong</p>	
<p>6.1.3 Do you devise and promote a strategy for informing elected officials about legislative/regulatory needs for MCAH? For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, identify MCAH public health issues that can only be addressed through new laws, regulations, or ordinances? communicate or advocate to local, state, or national elected officials or to regulatory agencies by meeting, calling, faxing, e-mailing or writing to them about current and proposed legislation/ regulations affecting the MCAH population? indirectly influence public opinion and policy affecting the MCAH population by writing a letter to the editor or an opinion piece in a newspaper, talking to a reporter or editor, doing radio call-ins, distributing action flyers, and/or bringing up issues at meeting of other groups you belong to and enlist other support in letter writing, signing petitions or grassroots advocacy?</p>	<p><input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> 1 2 3 4 1=weak.....4=strong</p>	

Assessment of Essential Service #6 Process Indicators (continued)

Essential Service #6: Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being.	Process Indicator	Level of Adequacy	Notes
<p>6.2 Certification and Standards Key idea: — Provide leadership in promoting standards-based care</p>			
<p>6.2.1 Do you disseminate information about MCAH related legislation and local ordinances to the individuals and organizations who are required to comply with them?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, disseminate information about new MCAH related legislation and local ordinances to individuals and organizations as appropriate? integrate new legislation and ordinances with existing MCAH programs and activities?</p>	<p><input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>		
<p>6.2.2 Do you provide leadership to develop and publicize harmonious and complementary standards that promote excellence in quality care for women, infants, and children, in collaboration with professional organizations and other local agencies?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, provide leadership and MCAH expertise in a standards-setting process for programs serving MCAH populations (e.g., school health services, family planning/reproductive health care, WIC, child care, CSHCN)? regularly review standards for consistency and appropriateness, based on current advances in the field? promote interagency consistency in standards?</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input checked="" type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>		

Assessment of Essential Service #6 Process Indicators (continued)

Essential Service #6: Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being.		Level of Adequacy	Notes
Process Indicator			
<p>6.2.3 Do you integrate standards of quality care into MCAH-funded activities and other publicly or privately funded services?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, collaborate with other funded entities to incorporate MCAH standards of quality care and outcomes objectives into their grant/contract? provide resources and information to assist local agencies, providers, and CBOs to incorporate MCAH standards of quality care and outcome objectives into their protocols?</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input checked="" type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>		
<p>6.2.4 Do you develop, enhance, and promote protocols, instruments, and methodologies for use by local agencies that promote MCAH quality assurance?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, lead or participate in a process to promote maternal, neonatal, perinatal, and children’s services and conduct outcome analysis? provide leadership in promoting the implementation of existing MCAH standards-based protocols and instruments across the LHJ? promote and develop a process to identify quality issues pertaining to MCAH (e.g., infant, maternal, and child deaths, etc.)?</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input checked="" type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>		
<p>6.2.5 Do you participate in or provide oversight for quality assurance efforts among local health agencies and systems and contribute resources for correcting identified problems?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, conduct record and site reviews of local health care providers, CBOs and subcontracts? allocate resources for addressing deficiencies identified in such reviews?</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>		

SWOT Analysis for Essential Service #6: Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being.

Strengths: (e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)

- Existing services are clearly delineated and regulated by the State
- Some cross-discipline review teams exist (i.e. child death review team)
- Public Health can share referrals and best ideas between programs
- Funding expectations encourage collaborations
- The Partnership for Safe Families...has used matching funds to extend resources
- Public Health has good reputation – partnering with PH shows credibility
- Partnership with Public Health increases fiscal and personnel capacity
- Supportive Senior Management
- Evaluate processes for effectiveness
- Working with professionals who are bound by strict guideline

Weaknesses: (e.g., human resources; budgetary restrictions and fiscal resources; technological resources; state-local relationships; organizational culture; organizational structure)

- Because Public Health is so regulated, there often isn't capacity for flexibility
- Because funding sources are so categorical, it's difficult to blend it into or collaborate with other programs
- Time constraints
- Lack of MCH understanding amongst Senior Management
- Lack of understanding the extreme number of requirements and legalities
- Lack of time for leadership of health services due to too many other job duties

Opportunities: (e.g., human, fiscal, or technological resources; statutory/regulatory changes; community/business resources; social/political changes, technological developments)

- New administration (U.S.) may provide new opportunities
- Wide access to public provides opportunities for:
 - information and education on legal requirements
 - Access to support
 - PSA's and media
 - Professional community organizations

- Ensuring families feel safe in communication with agencies and with accessing resources
- Federal and state support, direction and information

Threats: (e.g., statutory/regulatory change; organizational change/reorganization; social/political factors; demographic trends)

- Constant organizational change
- Lack of knowledge and communication about resource availability
- No budget at State level
- Economic uncertainty
- Lobbying to perpetuate known Public Health **Threats:**
- tobacco lobby
- pesticide lobby

Assessment of Essential Service #7 Process Indicators

Essential Service #7: Link women, children, and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.		Level of Adequacy	Notes
Process Indicator			
<p>7.1 Assure access to services Key ideas: — Provide oversight and technical assistance — Ensure access to comprehensive and culturally appropriate services</p>			
<p>7.1.1 Do you develop, publicize, and routinely update a toll-free line and other resources for public access to information about health services availability? For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the MCAH population, run ongoing TV, radio, print, and/or online advertisements publicizing its toll-free MCAH line? provide information to consumers about private health insurance coverage and publicly funded MCAH services (e.g., family planning clinics, WIC)? assist localities in promoting awareness about local MCAH services? routinely evaluate the effectiveness and appropriateness of information about MCAH services availability?</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input checked="" type="checkbox"/> 4 1=weak.....4=strong</p>		
<p>7.1.2 Do you provide resources and technical assistance for outreach, improved enrollment procedures, and service delivery methods for unserved and underserved populations? For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the MCAH population, promote the development of subcontracts, partnerships, and collaboratives to enhance outreach and link people to health care services? provide leadership and resources for developing and implementing effective methods of health care delivery (e.g., off-site services such as mobile vans and health centers)? provide technical assistance to local agencies, providers, and health plans in identifying and serving unserved and underserved MCAH populations? disseminate information on best practices among local agencies, providers, and health plans across LHJs?</p>	<p><input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 1=weak.....4=strong</p>		

Assessment of Essential Service #7 Process Indicators (continued)

Essential Service #7: Link women, children, and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.	Process Indicator	Level of Adequacy	Notes
<p>7.1.3 Do you assist unserved and underserved MCAH populations in accessing health care services?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the MCAH population, provide information and assistance to link vulnerable MCAH populations to health services? provide information and assistance to link eligible women and children to Medi-Cal, WIC, or Healthy Families? work with local agencies to develop recommendations and implement improvements in identification, outreach, and follow-up of high risk, unserved, and underserved MCAH populations?</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input checked="" type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>		
<p>7.1.4 Do you provide resources to strengthen the cultural and linguistic appropriateness of providers and services to enhance their accessibility and effectiveness?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the MCAH population, train its own staff in cultural and linguistic competence for interacting with clients? sponsor continuing education opportunities for providers on cultural competence and health issues specific to racial/ethnic/cultural groups living in the LHJ? provide resources to culturally representative community groups and their local health agency for outreach materials and media messages targeted to specific audiences? provide leadership and resources for the recruitment and retention of culturally and linguistically appropriate staff to assist population groups in obtaining maternal and child health services?</p>	<p><input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>		

Assessment of Essential Service #7 Process Indicators (continued)

Essential Service #7: Link women, children, and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.	Process Indicator	Level of Adequacy	Notes
<p>7.1.5 Do you collaborate with other local agencies to expand the capacity of the health and social services systems, and establish interagency agreements for capacity-building initiatives/access to services?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the MCAH population, collaborate with other agencies in developing proposals for enhanced MCAH services? submit or support proposals for private foundation grants for enhanced MCAH services? routinely review interagency agreements for effectiveness and meet with professional organizations and other local agencies to assess needs and capacity-building opportunities? routinely assess system barriers and successes and develop strategies for making improvements?</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 1 2 3 4</p> <p>1=weak.....4=strong</p>		
<p>7.1.6 Do you actively participate in appropriate provider enrollment procedures and provision of services for new enrollees?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the MCAH population, update their enrollment screening protocols to comply with state MCAH program requirements? oversee CPSP provider enrollment procedures and ensure compliance with program requirements? interact with eligibility workers administering Medi-Cal enrollment protocols? develop guides and/or other materials and protocols for assisting consumers in navigating the health care system?</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> 1 2 3 4</p> <p>1=weak.....4=strong</p>		

Assessment of Essential Service #7 Process Indicators (continued)

Essential Service #7: Link women, children, and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.		Level of Adequacy	Notes
Process Indicator			
<p>7.2 Coordinate a system of comprehensive care Key Idea: — Provide leadership and oversight</p>			
<p>7.2.1 Do you provide leadership and resources for a system of case management and coordination of services?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the MCAH population, work with community service providers and health plan administrators to develop contracts that link and coordinate health services? compile and distribute information on best practices of case management and coordination of services across localities?</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input checked="" type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>		
<p>7.2.2 Do you provide leadership and oversight for systems of risk-appropriate perinatal and children's care?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the MCAH population, support the establishment of cross-agency review teams? support and promote the routine evaluation of systems of risk-appropriate perinatal and children's care?</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>		

SWOT Analysis for Essential Service #7: Link women, children, and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.

Strengths: (e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)

- Many programs and services exist
- Strong collaboration with other local agencies
- Strong Public Health commitment to link and improve access to services
- Commitment to serve unserved and underserved population in accessing healthcare
- Some funding mandates to refer to other programs
- Consistent and thorough case management
- Training and mandates

Weaknesses: (e.g., human resources; budgetary restrictions and fiscal resources; technological resources; state-local relationships; organizational culture; organizational structure)

- Linkage and access varies among geographic locations
- Transportation
- Large case loads for direct service providers
- Fiscal and resource restraint

Opportunities: (e.g., human, fiscal, or technological resources; statutory/regulatory changes; community/business resources; social/political changes, technological developments)

- Increased access to technological resources
- New administration (U.S.) commitment for improvement
- New funding i.e. Prop 63
- Strong collaboration with other health and community agencies
- Networking, cross agency referral

Threats: (e.g., statutory/regulatory change; organizational change/reorganization; social/political factors; demographic trends)

- State budget
- Lack of resource capacity and availability
- Economic uncertainty
- Lack of political will
- Inconsistent funding (programs come and go)
- Immigration issues

Assessment of Essential Service #8 Process Indicators

Essential Service #8: Assure the capacity and competency of the public health and personal health* workforce to effectively and efficiently address maternal and child health needs.		Level of Adequacy	Notes
Process Indicator			
<p>8.1 Capacity Key Ideas: — Assure workforce capacity and distribution — Assure competency across a wide range of skill areas (e.g., technical, cultural, content-related)</p> <p>8.1.1 Do you develop and enhance formal and informal relationships with outside analysts, such as students of public health schools or professionals from other agencies, to enhance local public agency analytic capacity? For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, collaborate with outside analysts to conduct analyses as a part of needs assessment, program planning, evaluation, or other planning cycle activities? seek out internship/practicum students for mentoring and collaboration? seek out and support academic partnerships with professional schools in the state (e.g., joint appointments, adjunct appointments, Memoranda of Understanding between the agency and the school, sabbatical placements)? provide leadership opportunities for outside analysts in areas where their expertise can provide insight, direction, or resources?</p>		<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>	
<p>8.1.2 Do you monitor the numbers, types, and skills of the MCAH labor force available at the local level? For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, assess existing workforce size, skills and experience? collaborate with universities/schools/professional organizations to identify education and training needs and encourage opportunities for workforce development? regularly obtain updated workforce data?</p>		<p><input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>	

*This refers to professionals who provide health-related services to individuals on a one-on-one basis.

Assessment of Essential Service #8 Process Indicators (continued)

Essential Service #8: Assure the capacity and competency of the public health and personal health* workforce to effectively and efficiently address maternal and child health needs.	Process Indicator	Level of Adequacy	Notes
<p>8.1.3 Do you monitor provider and program distribution throughout the LHJ? For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, maintain or have access to a complete resource inventory of relevant programs and providers reaching MCAH populations? assess the geographic coverage/availability of programs and providers?</p>	<p><input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 1=weak.....4=strong</p>		
<p>8.1.4 Do you integrate information on workforce and program distribution with ongoing health status needs assessment in order to address identified gaps and areas of concerns? For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, consider workforce capacity to address identified needs in the five year needs assessment? consider workforce gaps as part of ongoing program planning?</p>	<p><input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 1=weak.....4=strong</p>		
<p>8.1.5 Do you create financial and/or other incentives and program strategies to address identified clinical professional and/or public health workforce shortages? For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, provide financial and/or other incentives to encourage a career in public health? actively recruit graduates of public health and other professional schools?</p>	<p><input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 1=weak.....4=strong</p>		

*This refers to professionals who provide health-related services to individuals on a one-on-one basis.

Assessment of Essential Service #8 Process Indicators (continued)

Essential Service #8: Assure the capacity and competency of the public health and personal health* workforce to effectively and efficiently address maternal and child health needs.	Process Indicator	Level of Adequacy	Notes
<p>8.2 Competency Key Ideas: — Provide and support continuing professional education — Participate in pre-service and in-service training</p>			
<p>8.2.1 Do you make available and/or support continuing education on clinical and public health skills, emerging MCAH issues, and other topics pertaining to MCAH populations (e.g., cultural competence, availability of ancillary services and community resources, the community development process)? For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, collaborate with state professional associations, universities, and others in providing continuing education courses (face-to-face or distance learning)? provide training, workshops, or conferences for local public health professionals and others on key emerging MCAH issues? provide or support in-service training for program staff?</p>	<p><input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>		
<p>8.2.2 Do you play a leadership role in establishing professional competencies for MCAH programs? For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, collaborate with LHJ personnel/human resources in establishing job competencies, qualifications, and hiring policies? include job competencies and qualifications in contract requirements with local agencies and in Title V grants to community-based organizations and others?</p>	<p><input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p>1=weak.....4=strong</p>		

*This refers to professionals who provide health-related services to individuals on a one-on-one basis.

SWOT Analysis for Essential Service #8: Assure the capacity and competency of the public health and personal health* workforce to effectively and efficiently address maternal and child health needs.

Strengths: (e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)

- Many different individual groups involved in education
- Opportunities provided by MCAH for education to community groups
- Agencies support ongoing participation in education
- Agencies maintain ongoing competencies
- Informal networks and relationships, trainings
- Required nursing certificates for practice

Weaknesses: (e.g., human resources; budgetary restrictions and fiscal resources; technological resources; state-local relationships; organizational culture; organizational structure)

- MCAH as an entity has limited resources (with exceptions) to provide resources
- Not much systematic review of distribution of resources
- Lack of funds
- Lack of focus within MCAH on this issue

Opportunities: (e.g., human, fiscal, or technological resources; statutory/regulatory changes; community/business resources; social/political changes, technological developments)

- Collaborative inter-agency communication
- Medi-Cal managed care to universal healthcare
- Bring in universities to encourage opportunities for workforce development
- Education availability for staff

Threats: (e.g., statutory/regulatory change; organizational change/reorganization; social/political factors; demographic trends)

- State and Federal budgets
- Agency budgets
- Recession (needs increase and resources decrease)
- Competition for personnel
- Not our main mission

Assessment of Essential Service #9 Process Indicators

Essential Service #9: Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal, child and adolescent health services.	Process Indicator	Level of Adequacy	Notes
9.1	<p>Do you support and/or assure routine monitoring and structured evaluations of MCAH services and programs?</p> <p>For example: Are routine process evaluations built into the planning, implementation, and funding cycles of local MCAH programs? Are routine outcome evaluations built into the planning, implementation, and funding cycles of local MCAH programs? Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, have contracts with local providers that require monitoring and evaluation strategies? identify gaps in the provision of MCAH services and programs? establish criteria (goals, quality standards, target rates, etc.) to evaluate MCAH services and programs?</p>	<p> <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 1=weak.....4=strong </p>	

Assessment of Essential Service #9 Process Indicators (continued)

Essential Service #9: Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal, child and adolescent health services.	Process Indicator	Level of Adequacy	Notes
<p>9.2 Do you collaborate with local or community based organizations in collecting and analyzing data on consumer satisfaction with services/programs and on perceptions of health needs, access issues, and quality of care?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, allocate and/or advocate for funding for state and local efforts to collect information on consumer satisfaction with services and/or programs? allocate and/or advocate for funding for state and local efforts to collect information on community constituents' perceptions of health and health services systems needs? assist localities in study design, data collection, and analysis (including surveys, focus groups, town meetings, and other mechanisms) for the purpose of obtaining community input on programs and services? regularly receive and use input from an advisory structure(s) composed of parents, community members, and/or other constituents?</p>	<p><input type="checkbox"/> X <input type="checkbox"/> <input type="checkbox"/> 1 2 3 4</p> <p>1=weak.....4=strong</p>		
<p>9.3 Do you perform comparative analyses of programs and services?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, perform analyses comparing the effectiveness of programs/services across different populations or service arrangements? compare local data on program effectiveness with data from other health jurisdictions or the state as a whole?</p>	<p>X <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 1 2 3 4</p> <p>1=weak.....4=strong</p>		

Assessment of Essential Service #9 Process Indicators (continued)

Essential Service #9: Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal, child and adolescent health services.	Essential Service Indicator	Level of Adequacy	Notes
<p>9.4 Do you disseminate information about the effectiveness, accessibility, and quality of personal health and population-based MCAH services? For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, report the results of monitoring and evaluation activities to program managers, policy-makers, communities, and families/consumers? Disseminate information on “best practices” in the local jurisdiction, other LHJs or the state?</p>	<p><input type="checkbox"/> X <input type="checkbox"/> <input type="checkbox"/> 1 2 3 4 1=weak.....4=strong</p>		
<p>9.5 Do you use data for quality improvement at the state and local levels? For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, provide data to local agencies for quality improvement activities? Communicate to local agencies about national, state, or local (public and/or non-governmental) quality improvement efforts, activities, or resources? Translate information from evaluation activities and best practices reports into local-level programs and policies to improve services and programs?</p>	<p><input type="checkbox"/> <input type="checkbox"/> X <input type="checkbox"/> <input type="checkbox"/> 1 2 3 4 1=weak.....4=strong</p>		
<p>9.6 Do you assume a leadership role in disseminating information on private sector MCAH outcomes? For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, identify a core set of indicators for monitoring the outcomes of private providers? “come to the table” in discussions with insurance agencies, provider plans, etc. about the use of these MCAH outcome indicators in their own assessment tools?</p>	<p><input type="checkbox"/> X <input type="checkbox"/> <input type="checkbox"/> 1 2 3 4 1=weak.....4=strong</p>		

SWOT Analysis for Essential Service #9: Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal, child and adolescent health services.

Strengths: (e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)

- Many programs evaluate outcomes
- The presence of a continuous quality improvement group

Weaknesses: (e.g., human resources; budgetary restrictions and fiscal resources; technological resources; state-local relationships; organizational culture; organizational structure)

- Customer satisfaction is often excluded from evaluation
- Data lacking to perform comparative analysis of programs and services
- Best practices not always shared
- Lack of adequate methods for data collection

Opportunities: (e.g., human, fiscal, or technological resources; statutory/regulatory changes; community/business resources; social/political changes, technological developments)

- Develop tools to utilize comparative analysis evaluation among programs
- Improve sharing of best practices
- Collaboration with other agencies collecting similar or other comprehensive data

Threats: (e.g., statutory/regulatory change; organizational change/reorganization; social/political factors; demographic trends)

- HIPPA – prevents some evaluation and dissemination of information
- Shortage of funding for evaluators
- Inability to access certain data areas
- Not our Mission

Assessment of Essential Service #10 Process Indicators

Essential Service #10: Support research* and demonstrations to gain new insights and innovative solutions to maternal child and adolescent health-related problems.		Level of Adequacy	Notes
Process Indicator			
<p>10.1 Do you encourage staff to develop new solutions to MCAH-related problems in Local Health Jurisdictions (LHJ)?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, provide time and/or resources for staff to pilot test, review best/promising practices or conduct studies to determine better solutions? identify activities and barriers to the implementation of better solutions to health-related problems? implement activities most likely to improve maternal, child, and adolescent health-related conditions?</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/></p> <p>1 2 3 4</p> <p>1=weak.....4=strong</p>		
<p>10.2 Do you serve as a source for expert consultations to MCAH research endeavors at the local level?</p> <p>For example: Is the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, viewed by local agencies and organizations as a leading and important source of information on MCAH population characteristics (e.g., health status, health service use, access to care)? consulted by other agencies when they plan MCAH research?</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/></p> <p>1 2 3 4</p> <p>1=weak.....4=strong</p>		
<p>10.3 Do you conduct and/or provide resources for state and local studies of MCAH issues/priorities?</p> <p>For example: Does the local MCAH program, including other agencies that contribute to the health and well-being of the local MCAH population, provide resources for local demonstration projects and special studies of longstanding and/or emerging MCAH problems? respond to RFAs or otherwise seek funding for state and local studies? participate in demonstrations and “best practices” research beyond the LHJ boundaries? coordinate multi-site studies within the state?</p>	<p><input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>1 2 3 4</p> <p>1=weak.....4=strong</p>		

*This refers to systematic information gathering and analyses.

SWOT Analysis for Essential Service #10: Support research* and demonstrations to gain new insights and innovative solutions to maternal child and adolescent health-related problems.

Strengths: (e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)

- Provide resources to wide variety of groups and agencies
- Quality Improvement projects funded by state or federal dollars
- Good data collection system mined by researchers in the field of developmental disabilities

Weaknesses: (e.g., human resources; budgetary restrictions and fiscal resources; technological resources; state-local relationships; organizational culture; organizational structure)

- Not initiating our own research to answer our own questions
- Fiscal and resource constraints

Opportunities: (e.g., human, fiscal, or technological resources; statutory/ regulatory changes; community/business resources; social/political changes, technological developments)

- NCS
- Collaborate with universities
- Public Health advisories at neighborhood level
- Shared statewide client database

Threats: (e.g., statutory/regulatory change; organizational change/reorganization; social/political factors; demographic trends)

- Budgets
- Vision
- Energy
- Global warming
- Not our main mission

Attachment F. Section 9. MCAH Capacity Needs Part B: Capacity Needs

Worksheet E

Capacity Need	How this capacity could be improved (include any short term or long term strategies)	Potential challenges on improving this capacity (e.g., impact on local MCAH services, stakeholder concerns, availability of resources)	How other local organizations, local jurisdictions, or the State MCAH Program can help improve this capacity
<ul style="list-style-type: none"> Lack of Funding 	<ul style="list-style-type: none"> Advocate for the needs of the MCAH population Redistribute available funds 	<ul style="list-style-type: none"> Opposition to higher taxes Competition from other program domains 	<ul style="list-style-type: none"> State and partner advocacy for more funding to meet the needs of the MCAH population
<ul style="list-style-type: none"> Categorical Funding 	<ul style="list-style-type: none"> More flexibility in funding to meet local needs. Get away from categorical funding because it does not allow agencies to meet local needs. 	<ul style="list-style-type: none"> Changing legislative requirements Advocate for policy changes 	<ul style="list-style-type: none"> Develop policy changes
<ul style="list-style-type: none"> Legislation and Regulations 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> Funding 	<ul style="list-style-type: none"> Advocate for funding
<ul style="list-style-type: none"> The need for specificity in demographic data collected 	<ul style="list-style-type: none"> Data development meetings Update the California Lutheran University Ventura County Community Profile (VCCP) data collection system 	<ul style="list-style-type: none"> Data availability Lag time before data is available Labor to analyze and interpret data Finding best ways to disseminate data Funding Lack of geographically detailed specificity in demographic data collected VCCP data system: Lack of funding 	<ul style="list-style-type: none"> Develop central, statewide repositories of relevant data Increase access to data resources, state, FHOP, and other research data bases
<ul style="list-style-type: none"> Trend information is available but not necessarily disseminated 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> All agencies collaborate on developing shared information Advocate for funding
<ul style="list-style-type: none"> Data lacking to perform comparative analysis of programs and services 	<ul style="list-style-type: none"> Need to develop a comprehensive data system Data development meetings 	<ul style="list-style-type: none"> Funding 	<ul style="list-style-type: none">
<ul style="list-style-type: none"> Not initiating our own research to answer our own questions 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> Funding 	<ul style="list-style-type: none"> Advocate for funding