County of San Diego

Health and Human Services Agency

Maternal & Child Health Needs Assessment

June 2009

I. Summary/Executive Report

San Diego County's Maternal, Child and Adolescent Health (MCAH) needs assessment provides an opportunity for the Health & Human Services Agency (HHSA) MCAH program, as well as its Agency and community partners to assess the health status of pregnant and parenting women, infants, children and adolescents. The needs assessment also allows a thorough examination of the local MCAH system's strengths and weaknesses, as well as opportunities for improvement and threats to its programs. This assessment creates a framework for implementing strategies to improve program capacities and, ultimately, the health status of San Diego's pregnant women, infants, children, and adolescents.

Description of San Diego County's Needs Assessment Process

■ Key partners including directors of other Title V programs, the local Healthy Start project, March of Dimes, and the Deputy Public Health Officer joined MCAH staff to serve as a core planning group.

■ The core planning group reviewed the 27 health status indicators; made recommendations concerning possible updates to the previous needs assessment including program goals, the community profile, and health needs priorities; and provided input and assistance to complete the capacity assessment process.

■ A broad cross section of community MCAH stakeholders rated the local MCAH system's current level of adequacy and identified strengths, weaknesses, opportunities, and threats (SWOT) for the 10 essential public health services using the mCAST tools.

■ MCAH staff, with core planning group input, developed summary statements of four broad areas of capacity needs based on stakeholder responses.

■ The stakeholder group then rated the four capacity needs based on importance and feasibility to implement and provided potential strategies to improve community-wide capacity.

Highlights of the 27 Health Status Indicators

The data show that the top five problem areas for the 2004 assessment persist and remain San Diego County's top priority areas:

♦ **Children and Weight:** The number of overweight children under age 19 continues to rise and is alarming because of its long term health consequences.

♦ **Low/Very Low Birth Weight and Prematurity:** Rates for low and very low birth weights and premature births continue to rise and far exceed Healthy People 2010 goals.

♦ **Health and Dental Insurance for Children:** The rate of children without health insurance has declined slightly. However, the fact that a strong correlation exists between having health insurance and good health status will keep this as a priority.

♦ **Prenatal Care Access and Utilization:** While the rates of women receiving first trimester care and adequate prenatal care are improving, San Diego County's rates are below Healthy People 2010 goals.

♦ **Infant, Fetal, and Perinatal Mortality:** Slight improvement has occurred in rates of infant, fetal, and perinatal mortality. However, San Diego County's rates are below Healthy People 2010 goals.

Indicators where the current status is *worse* than the 2004 assessment include:

- Low and very low birth weight live births (%)
- Preterm births < 37 weeks gestations (%)
- Women exclusively breastfeeding at the time of hospital discharge
- Reported cases of chlamydia per 1000 females ages 15 – 19
- Non-fatal injury hospitalizations age 15-24 per 10,000
- Non-fatal injury hospitalizations for motor vehicle accident (MVA) ages 15 – 24 per 10,000

Indicators where the local end status is *better* than the local start status include:

- Births per 1000 females age 10-14, 15-17, 18-19, and 15-19
- Short inter-pregnancy interval for women age 14-44 and 12-19

• Women age 12-19 who are already mothers
• Death age 1-14 per 100,000
• First trimester prenatal care for live births (%)
• Adequate prenatal care (Kotelchuck Index) for women age 15-44
• Asthma hospitalizations children age 0-4 and age 5-17 per 10,000
• Non-fatal injury hospitalizations children age 0-14 per 10,000
• Non–fatal MVA injuries children age 0-14 per 100,000
• Non-fatal injury hospitalizations for MVA age 0-14 per 10,000
• Children living in foster care each July per 1,000
• Children age 0-17 living in poverty (%)

Highlights of the Capacity Assessment

■ The core planning group coordinated a one day community forum in November 2008 to obtain Agency and community stakeholder input on the 10 essential public health services

■ Stakeholders rated the local MCAH system's current level of adequacy and identified strengths, weaknesses, opportunities, and threats (SWOT) for the 10 essential public health services.

■ Numerous capacity needs were identified during the meeting. MCAH staff collapsed the identified needs into four broad areas of capacity needs.

■ MCAH staff surveyed the core planning group asking them to rate the four capacity needs based on importance and feasibility to implement.

Capacity Needs (listed in order of priority)

1. Systematically coordinate and collaborate to prioritize, fund, plan and deliver services for the MCAH population, including hospitals and medical professionals, as well as public health and community based organizations.
2. Share, coordinate and publicize resources* among all sectors that serve the MCAH population, capitalizing on technology when possible to enhance information sharing and communication.
3. Monitor and improve the availability and competence of the local public health and health care workforce to address MCAH needs, particularly for our diverse populations.
4. Support coordinated outreach and multimedia health education/promotion campaigns, including information about available services to reach diverse populations.

Emerging Public Health Issues

♦**Economy:** The deteriorating fiscal situation nationwide, statewide and locally continues to impact the women, infants, children, and adolescents of San Diego County. As the unemployment rate climbs, the need for services among our most disadvantaged populations increases. Proposals for changes to the eligibility requirements in the Healthy Families Program or for eliminating the program would mean that 20,000 – 80,000 children in San Diego County will lose access to a medical home.

♦ **Infectious Diseases:** The recent outbreak of Influenza A H1N1 infections (swine flu) Nationwide and in our County reminds us of the need to be ever vigilant to emerging infectious diseases. Influenza viruses such as H1N1 and H5N1 (avian flu) spread rapidly. Other infectious childhood diseases such as chicken pox and pertussis continue to persist and impact the community. The need to educate families about these viruses, how to prevent them and their spread, remains a priority.

♦ **Risk Factors for Chronic Diseases:** Cancer and heart disease are the top two causes of death, respectively, in San Diego County. Inequities for certain health issues persist among different populations in the county. Some of the risk factors for chronic diseases are also on the rise. Education about risk factors that lead to chronic diseases and available health care services continue to be needed along with policy and system changes.

II. Mission Statement and Goals

The previous mission statement and goals have been updated slightly

MCAH Vision: A community *dedicated to ensuring* women, children, youth and families are healthy in mind, body, and spirit.

MCAH Goals: For <u>all</u>…

- Strive for optimal physical, mental *and emotional* health for all *women*, children, youth and families
- Create a safe environment for all *women*, children, youth and families
- Prevent illness, injury, abuse, and disability
- Provide health services that are accessible, affordable, cost effective, culturally appropriate, and consumer satisfying
- Empower *individuals* and families to develop healthy lifestyles, health literacy, and self advocacy in the health care system
- *Institute policies, systems and infrastructure that support the above goals*

III. Planning Group and Process

County MCAH staff reviewed current needs assessment guidelines, the 2004 needs assessment document, and current data to begin planning for the 2009 needs assessment. Decisions included:

• Not to convene a large group of community stakeholders to review and reprioritize health needs. Substantial input on priorities was received in 2004, and current data did not support changing priorities.

• To invite a few Agency and community partners to join the core planning group to provide input and overall guidance for planning and implementing the needs assessment process. Members external to MCAH are identified in Worksheet A and included directors/managers of other Title V programs, local Healthy Start project, March of Dimes, and the Deputy Public Health Officer.

• To invite a broad group of community stakeholders to participate in the capacity assessment process.

♦ The core planning group:

• Met in person on an as-needed basis to discuss the needs assessment process and content supplemented by communicating via e-mail for tasks such as reviewing draft documents.
• Reviewed and updated the mission statement and goals.
• Considered whether Health Status Indicator data supported revising health priorities from the previous needs assessment and determined the priorities are still appropriate.
• Provided extensive support for meeting planning, group facilitation and note taking, and follow up documentation of the capacity assessment process.

♦ Capacity Assessment Planning and Process:

• Core planning group determined that a series of meetings to discuss one or two essential MCAH services at a time would not be feasible in San Diego.

• One meeting was held in November 2008 to obtain input from a broad range of stakeholders working throughout the local MCAH system; input was gathered later from other key stakeholders who could not attend. (Stakeholders are identified on Worksheet A.) Sixty-two people attended the meeting.

• In advance of the meeting, each participant was assigned to two different MCAH essential services discussion groups (based as much as possible on her/his expertise). Each received the mCAST-5 instruments with instructions to review before the meeting.

• The meeting included an overview of the needs assessment and the capacity assessment, followed by two break-out sessions with separate discussions of 5 essential services during each time block.

• MCAH staff compiled notes from the sessions which the core planning group reviewed. Then notes from all 10 sessions were sent to all participants and key stakeholders who could not attend the meeting for their additional input.

• Core planning group identified key capacity needs, most of which were cross threaded through the input on most or all of the mCAST-5 instruments.

• All stakeholders were invited to prioritize the capacity needs and share additional ideas for potential strategies to address via an on-line survey.

• The core planning group reviewed and provided additional input on the compilation of stakeholder input summarized on Worksheet E.

IV. Community Health Profile

To address maternal and child health needs it is important to consider not only health indicators, but also the broader community context and the geographic, socioeconomic, and political factors that influence both the development and the solutions to health problems. While San Diego County faces some issues that are common throughout the state, others are unique.

MCAH program functioning within the local Public Health Department

San Diego's MCAH program is part of the Maternal, Child and Family Health Services (MCFHS) Branch, a subdivision of the Health and Human Services Agency's Public Health Services (PHS). PHS is headed by the County's Public Health Officer and includes the following other services: Border Health; Community Epidemiology; Emergency and Disaster Medical Services; HIV, STD and Hepatitis; Immunization; Public Health Laboratory; Public Health Nursing; TB Control and Refugee Health; and Vital Records.

The Public Health Officer reports to the office of the Agency Director as part of the Executive Team. The Executive Team also consists of the directors or managers of other operational divisions (Aging and Independence Services, Behavioral Health Services, Child Welfare Services, Public Administrator/Public Guardian, the Agency's six geographic regions), and support divisions (Contract Support, Human Resources, Information Technology, Strategic Planning and Operational Support, Compliance, Legislative Affairs, Media and Public Affairs).

Thus, MCFHS is functionally connected to other Public Health branches, as well as to all aspects of the Agency. The Agency was formed in 1998 by combining Health and Social Services with a philosophy of "no wrong door" for citizens to access services. While integration and collaboration among all divisions and

programs is a challenge in a large agency, the leadership philosophy and structure strongly support Agency-wide strategic planning, leading to integrated resources and services.

In addition to the MCAH program, MCFHS includes California Children's Services (effective February 2009), Child Health and Disability Prevention, Health Care Program for Children in Foster Care, Share the Care Dental Health Initiative, San Diego Kids Health Assurance Network, and Chronic Disease and Health Disparities. With the addition of CCS to MCFHS, the management structure was modified from a single coordinator to co-management by the Assistant Deputy Director of Public Health and the Deputy Public Health Officer. The MCAH Director and the MCH/BIH/FIMR Coordinator report to the Deputy Public Health Officer. Within MCFHS, the emphasis is on integration and collaboration among the programs because of the significant overlap in the populations and families the programs serve and the close relationship between maternal health, pregnancy outcomes, children's health, and family well-being.

Functional role of the MCAH program within the larger MCAH system

San Diego has a long history of public-private partnerships and collaboration. The MCAH Director and MCAH staff are involved with multiple formal and informal collaborative efforts with community agencies and programs that serve the MCAH population. The reach of the MCAH program into the local MCAH system is additionally strengthened by relationships established by the other programs in MCFHS. MCFHS program managers and professional staff play a leadership role on many community advisory boards. MCAH maintains close ties to other publicly funded programs administered outside of HHSA, including the Adolescent Family Life Program, WIC agencies, Regional Perinatal System, Sweet Success, and the California Border Healthy Start.

The MCAH program is seen as a "neutral party," and is thus in a position to pull together agencies or providers that might normally consider themselves to be competitors. Ongoing collaboratives convened by MCAH and other MCFHS programs bring together stakeholders for educational, networking, and planning opportunities on a regular basis. MCAH is also able to convene stakeholder groups for specific purposes such as addressing perinatal substance use or providing input for the needs assessment and planning process.

Many community programs and health care providers serving the MCAH population look to the County program as a source of up-to-date and reliable information, education, and resources. Support and information coming to the county from California MCAH, as well as national MCAH organizations, such as CityMatCH, strengthen our capacity to play this role. MCAH also calls on the expertise of professionals in the community, particularly from our local universities and the March of Dimes. Because of functional coordination within HHSA, the MCAH program is also in a position to help individuals or local programs link to other Agency programs.

Population Characteristics

Population Demographics- San Diego County continues to grow, with the total population in *2008* estimated at *3.15* million, an increase of *over 332,000* people *(12%)* over the 2000 Census. The population is evenly divided among genders, *50.14%* female *49.86%* male.

According to the U.S. Census Bureau *2005-2007* American Community Survey, the median age for county residents at *34.2* years is slightly younger than California *(34.5)* and nationwide *(36.4)*. Nearly 25% of the county's population is under 18 years of age. A little over 50% of San Diego County residents are white, 30% are Hispanic, 10% are Asian or Pacific Islander. African-Americans comprise a little over 5%, American Indians represent half of one percent, and almost 4% are categorized as other.[1]

Approximately *23%* of the county's total population is reported as foreign born in the American Community Survey as compared to 12.5% of the U.S. population. The majority of county residents reported English as the only language spoken at home, while *35%* reported that they spoke a different language at home.[1]

Population Trends - The county's population is projected to reach *3.6* million residents by 2020 and nearly 4 million residents by 2030.[2] San Diego County's population, like that in the rest of the state, is expected to become increasingly diverse. The total population in San Diego County is expected to grow by 32% with nearly 1 million new residents from 2004 to 2030. About two-thirds of the increase is the result of natural increase (births minus deaths) and the remaining one-third is the result of net migration, both domestic and international. The Hispanic population is expected to increase by *77%,* growing to *1.5* million residents, *equaling the number of whites in the county in 2030.* Population projections for 2030 show the number and proportion of the population that is white is declining, and other groups increasing over the projected decades. By 2010, San Diego County's white population will become a minority (under 50% of the population) representing 47% of the population. Thus, the county will have no majority racial or ethnic group. Statewide, that is true today. The 2000 Census found that only 47 percent of Californians classified themselves as non-Hispanic White.

During the 26-year forecast period, the *county's median age will increase by more than five years, from 33.7 to 39.0.* The juvenile population (under 18) will grow by *9 percent from 762,487 to 834,109* which is already much more diverse than older residents of the county. The increase in the size and diversity of the young population has immediate implications for meeting the public health needs of our children. There will be an increase in diversity of women giving birth as today's children move into their childbearing years over the next two decades.

Socio-economic Characteristics

Households and Families - San Diego County has over *1.1* million households according to the *2005-2007* American Community Survey, with an average household size of *2.73* and an average family size of *3.34*. Families make up nearly 66% of the households, with married-couple families representing 49% and single female head of household representing 11.6% of families. Non-family households (people living alone or people living in households where no one is related to the householder) make up 34% of all households in San Diego County.[1]

Income - In *2007*, family median income was *$71,139*, 7% higher than the state median of *$66,420*. For non-family households, the median income was *$41,566*, slightly higher than the state *($39,212)*. Median incomes differed by gender with males at *$47,021* and females at *$38,828* in the county. This is slightly higher compared to the state with incomes for males at *$46,068* and females at *$38,694*. Since *2000*, the growth rate for per capita income in San Diego County has outpaced state and national rates.

The *2005-2007* American Community Survey estimates that *11.3%* of county residents (323,757) were living below the poverty level, lower than the state rate of *13.0* and the U.S. rate of *13.3%.* It is estimated that *7.9%* of San Diego County families live in poverty as compared to *9.7%* of California families and *9.8%* in the U.S. Of San Diego families living below the poverty level, *22%* of the households had a female head of household with no husband present, *11.7%* included related children under 18 years of age, and *8.8%* included people 65 years old and over. In San Diego County 15.1% of children under 18 live in poverty, which is significantly lower than the statewide rate of 18%.[1]

Employment *– In April 2009, the rate of unemployment in San Diego County was 9.1%, higher than the national rate of 8.6%, but lower than the California rate of 10.9%, according to the State of California Employment Development Department. Compared to April 2008 unemployment rates, San Diego County jumped to 9.1% from 4.9%.*[3]

Housing *– The median price for a home in San Diego County in April 2009 was $290,000 compared to $400,000 in April 2008. These rates included resale homes, resale condominiums, and new homes and*

condominiums. The present economic downturn, including the rise in unemployment, has experts predicting more foreclosures in the future.[4]

Even with the drop in housing prices, many of our most vulnerable populations still lack of affordable housing. Health can be directly impacted due to lack of funds for medical care. Problems such as communicable diseases and stress related to overcrowding, or environmental health concerns, such as lead exposure or poor air quality in housing in older urban areas, can occur. In the worst cases, homelessness can result due to inability to afford even poor quality housing. The Regional Task Force on Homelessness estimates that San Diego's urban homeless population consists of about *2,472* families with children.[5]

Education - With *44* districts, *732* schools, and an estimated *495,689* students enrolled during the *2007-2008* school year, San Diego County is continually adapting its educational systems to meet the needs of the growing population.[6] In *2006-07*, the overall graduation rate from San Diego County public schools was *82.4%*, compared to *80.6%* for the state. The graduation rate in San Diego County was at its highest in the school years ending *2001 - 2003 at 89%* and has fluctuated to a low of *82.4%*.[7] Of San Diego County residents 25 years and over, *84.9%* had at least graduated from high school, and *33.2%* had bachelors or higher degree. Both rates exceed statewide and national rates.[1]

Health Status and Risk Factors

Birth Demographics - Women of childbearing age (15 to 44 years) comprise *21%* of the total county population. *The birth rate in San Diego County has remained relatively steady at 15.2 births per 1,000 population in 2006 compared to 15.1 in 2003.* There were *47,545* live births in *2007*;[8] Hispanics had the largest proportion of births with *44%*, followed by whites at *33%*, and Asian and Pacific Islander at 10%. According to *2005* data, *59.2%* of Hispanic women giving birth were born in Mexico.[9] In *2005*, 28% of all births in San Diego County were to unmarried women and *20.5%* were to mothers who had not completed high school.[10] The rate of adequate prenatal care in San Diego County, *74% for 2004-2006,* is significantly lower than the statewide rate of *78.5%* as well as the Healthy People 2010 goal of 90%.[9]

Health Coverage and Health Status - According to the 2007 California Health Interview Survey, *15.3%* of adults in San Diego County are uninsured, *5.4%* have Medi-Cal coverage, and *56.2%* have job-based health insurance. Adult health indicators for the County are not significantly different from statewide indicators, although the percent indicating their health status as "poor" *(2.2%)* was significantly lower than the statewide percentage *(4.9%)*.[11] The Department of Public Health County Health Status Profiles *2008* reports San Diego's indicators better than the state on *many* morbidity and mortality indicators for adults. However, San Diego's rates are worse than the Healthy People 2010 benchmarks for deaths due to suicide (*9.9* per 100,000 population) and *drug induced deaths (10.4 per 100,000)*, and for new cases of AIDS (*16.48* per 100,000 persons over age 13).[9]

Access to Health & Social Services

Lack of insurance is a significant barrier to access to care. Based on data from the *2007* California Health Interview Survey, approximately *38,000 (4.7%)* uninsured children (ages 0 to 17) and *334,000 (17.8%)* uninsured non-elderly (ages 18 to 64) adults reside in San Diego County.[11] *However, if the proposed changes to the eligibility requirements in the Healthy Families Program take place, close to 20,000 children in San Diego County will lose access to a medical home. If the Healthy Families Program is eliminated, close to 80,000 children in San Diego County will lose access to a medical home. The increasing unemployment rate is another factor impacting health insurance rates. As it climbs, more people are losing their employer based health insurance, and thus their medical home.*

V. Health Status Indicators

Attached as separate files, Workbook B and Workbook B Addendum.

VI. Local MCAH Problems/Needs

The data show that the top five problem areas for the 2004 assessment persist and remain San Diego County's top priority areas.

Priority 1. Children and Weight

The proportion of overweight children continues to increase and is alarming because of the long-term health consequences. Overweight children are more likely to develop type 2 diabetes and cardiovascular, orthopedic, and other health problems. Being overweight can affect children's social and psychological development. Overweight children are at higher risk for becoming overweight adults and developing chronic diseases associated with being overweight.[12] Some factors that may have contributed to the overweight rise in recent history are increased technology, corporate interests, and government policies.[13] For instance, food is now mass produced and cheaper, while at the same time, entertainment activities for children are more passive, so that less time is spent on physical activities.[14, 15]

One source of the percent of children who are overweight is the CDC Pediatric Nutrition Surveillance System (PedNSS). PedNSS monitors the status of low-income children in federally funded maternal and child health programs. In San Diego County, 13.3% of children under age 5 were overweight during the 2004-2006 period; this was slightly higher than the 12.6% in 1995-1997. Over the same period, the percent of children aged 5 – 19 overweight increased by 46%, going from 15.3% to 22.4%. This prevalence is more than four times the Healthy People 2010 goal of 5%.

The California Physical Fitness Test is required to be given to all public school children in fifth, seventh, and ninth grades and identifies overweight children.[16] It is more representative of the population than PedNSS. However, statistical significance testing was not available for any of the comparisons made. Overall, 28.7% of fifth graders, 29.9% of seventh graders and 30.6% of ninth graders were overweight in the 2007-2008 school year. Among fifth graders, males were more likely to be overweight, 37.5%, compared to 19.5% among females. In the ninth grade, however, the difference was not as great, with a lower proportion of males and a higher proportion of females being overweight, 32.4% of males versus 28.8% of females.

Differences between race/ethnic groups were large. In the fifth grade, four ethnic groups, Pacific-Islanders (41.1%), followed by Hispanics (36.8%), Native Americans (33.5%), and African-Americans (29.2%), had a higher percent of overweight children than the overall rate of 28.7%. In the ninth grade, Pacific-Islanders (44.8%) and Hispanics (39.1%) were still the highest ranked, but African-Americans were third with 35.3%, and Native Americans close with 34.9% overweight. Rates for the other groups were around half that of the highest groups, but still unacceptable. Asians had the lowest prevalence at 17.4%. However, prevalence among Filipinos, which was separate from the Asian category, was 23.3%, or nearly one out of four. Whites were intermediate with 21.3%.[17]

Priority 2. Low/Very Low Birth Weight and Prematurity

Being born too small or too soon puts an infant at risk for illness, developmental delays, and death. Some risks are the mother's demographics, health, behavior, and environmental factors. Birth weight is one indicator of the degree of maturity and extent of an infant's physical development[18], and trends in San Diego County and the State are discouraging. Data were available for 1995 through 2006 and revealed that both low

and very low birth weight and premature births continue to rise. San Diego's low birth weight prevalence increased 18%, from 5.6% in 1995 to 6.6% in 2006. However, the most recent 3-year average rate still compares favorably against the state's, as it did in the beginning of the period (1995-1997), but only because the state rate also rose.

The 2004-2006 average African-American rate, 11.24%, is 1.7 times higher than the overall County rate (6.58%). Much lower in comparison, but still not meeting the Healthy People 2010 goal of 5.0%, are the Asian (7.39%), White (6.72%) and Hispanic (5.71%) groups. All race/ethnic groups worsened during the time period analyzed except Asian, which remained about the same. In terms of absolute change, the White group increased the most, with a rise of 1.35 percentage points (5.37% to 6.72%).

Local analyses found that births to very young girls and women over age 35 were more likely to be low birth weight than the county overall. Averaging rates from 2005-2007, the rate for delivering a low birth weight baby for girls under age15 was 16.1%. The percent among women 35-39 was 7.8%, and got successively higher with each older age group. Over one out of four births (26.9%) was low birth weight among mothers 45 and over. Variations by geography also exist. The rate for Central region of the county, 7.3%, was significantly higher compared to the overall rate (6.7%). Factors contributing to this may be differential distribution of age, race/ethnic, and socio-economic populations.

Very low birth weight (under 1,500 grams) shows similarly discouraging trends. Both the county and state increased between 1995 and 2006. The County increased by 33%, from 0.9% to 1.2%, and the state by 9%, from 1.1% to 1.2%. This trend is particularly concerning since these very small infants are at even higher risk for death or long-term health and developmental consequences. The Healthy People goal is 0.9%.

Preterm births are those that occur before 37 weeks of gestation. Those babies born premature are not fully developed and may not survive outside the womb. The percent of San Diego babies born premature increased 9.1% from 1995 (9.9%) to 2006 (10.8%). California's preterm rate also increased, but less. So, while the local three-year average rate was lower initially, it is no longer significantly different from the state. Race/ethnic disparities were similar to those seen for low birth weight. During 2004-2006, 16.00% of African-American births were premature. Asians had the second highest percent, 11.94%, and there was no significant difference between White (10.74%) and Hispanic (10.69%). No group showed improvement and rates for White and Asian groups were actually increasing at period end. In evaluating geographic areas, Central region's preterm rate was 12.9%, significantly higher than the County's 11.0% in 2005-2007 (from local analyses). The Healthy People 2010 goal is 7.6%.

Underlying reasons for these worsening trends in preterm and low birth weight may be the rise in multiple births, use of infertility treatments, obstetric interventions earlier in pregnancy (e.g. induction of labor and cesarean delivery), older maternal age, and changes in maternal health (e.g. improper weight gain).[19]

Priority 3: Health and Dental Insurance for Children

The California Health Interview Survey (CHIS) is a random-dial telephone survey of a wide range of health topics, including health insurance. It has been conducted biennially beginning in 2001.[20] The percent of children under 20 currently with health insurance did not significantly change between 2001/2003 (87.6%) and 2005/2007 (92.0%). Additional statistics were also obtained independently from the AskCHIS website.[21] In 2005/2007, children under 12 and adolescents 12-17 were about equally likely to be insured (94.6% and 93.5%, respectively). But children 18-19 (72.8%) were much less likely to be insured. By race/ethnicity, a significantly lower percent of Latino children were insured (86.4%) compared to the county total (91.9%). The White group (95.0%) was not significantly different from the overall percent. Statistics were also available for African American, American Indian, Asian, Pacific Islander, and two or more races categories; however, estimates for these groups were statistically unreliable.

The rate of children age 2-11 with dental insurance did not significantly change between 2001/2003 (77.8%) and 2005/2007 (80.4%). Statistics obtained from AskCHIS for 2007 revealed that rates for Latino (73.5%), White (84.4%) and the county overall (82.8%) were not significantly different; rates for other race/ethnicities were statistically unreliable. CHIS statistics (from FHOP) showed the percent of children who had visited the dentist in the past year was 82.1% and had not significantly changed from 2001/2003 (76.1%).

Children with even short periods of uninsurance (1-4 months) are less likely to have a usual source of care and are more likely to experience delays in getting needed care than those with continuous insurance, public or private.[22] Although present uninsured statistics are not available, the percentage has likely increased with the economic downturn that began in 2008. Generally, employment-based coverage parallels the unemployment rate.[23] In April 2007, unemployment in the County was 4.1% and in April 2009, it was more than double, at 9.1%.[24] Government funded safety net programs have experienced jumps in enrollment as well. In April 2008, 171,545 children under 21 were in Medi-Cal and 71,506 children were in Healthy Families; a year later, the programs have a combined increase of over 13,000 children[25, 26]. Due to budget shortfalls, the State has also proposed cuts to these programs at the time they are most needed.

Priority 4: Prenatal Care Access and Utilization

Healthcare providers can provide behavioral and medical interventions at prenatal care visits that can reduce maternal and infant morbidity and mortality. At these visits, mothers may receive education about health risks, preventive measures can be taken, and medical conditions can be diagnosed and managed or treated.[18]

San Diego County falls short of the 90% Healthy People 2010 goal for births where the mother received first trimester prenatal care. Looking at 1995 through 2006, although early prenatal care rates are higher at the end of the period than the beginning, rates only increased until 2003 and remained unchanged thereafter. Statistics are also available for White, Hispanic, African-American and Asian race/ethnicities. Rates are worst among African-Americans (81.96%) and Hispanics (82.06%). Asian (89.10%) and White (88.64%) rates are highest. Examining trends over time, African-American and Asian groups have made continuous progress while the Hispanic and White groups progressed only initially. Improvement among Hispanics plateaued after 2003, and the White actually worsened after 2002.

Since 1995, the percent of births where the mother began prenatal care in the third trimester decreased through 2003; but, since then, the trend line has plateaued through 2006. Therefore, the 2004-2006 rate of 2.68% is still over 50% lower than the 1995-1997 one of 5.88%. Although rates for all four race/ethnic groups decreased from the early through mid part of the analyzed period, most recently, the rate for White births are increasing and that of Hispanic and African-Americans has stagnated; only the Asian rate is continuing to decrease.

The adequacy of prenatal care utilization index is a more comprehensive indicator that takes into account both the timing of prenatal care initiation and the number of visits. In San Diego, the measure worsened between 1995 (71.6%) and 2001 (68.3%), but increased to 72.7% in 2006. In comparing the four race/ethnic groups for which data are available, rates are lowest among African-Americans (69.62%) and Hispanics (70.82%), but not remarkably higher for Whites (73.85%) and Asians (73.89%). The Healthy People 2010 goal is 90%. Since 2000 and 2001, trends have been positive for Asians and Hispanics, respectively. However, through the entire period of analysis (1995-2006), rates went down for Whites and African-Americans. The change was larger for Whites. For the initial three-year period, their rate was 80.23% and in the final three-years, it was 73.85%.

Priority 5: Infant, Fetal and Perinatal Mortality

Infant mortality is the death of a live-born infant prior to one year of age. San Diego's rate remained about the same between 1995 and 2006, while the State's decreased by 26%. However, because the county rate was lower than the state's at the start of the analysis period, their most recent average rates (2004-2006) were not

significantly different (4.97 and 5.16 per 1,000 births, respectively). The Healthy People 2010 goal is 4.5 per 1,000 births. Rates for White, Hispanic, African-American and Asian race/ethnic groups are disparate. The end period (2004-2006) African-American rate, at 10.43 per 1,000 births, was highest and more than three times that of the lowest group, Asians, with 3.03. Hispanic and Whites were intermediate, with 5.25 and 4.52 deaths per 1,000 births. Trend lines for all groups were essentially flat. Among county geographic regions, there were no significant differences.

The risk of infant death is greatest immediately after birth.[18] In San Diego, the majority of infant deaths (72.6% in 2004-2006) were neonatal, that is, they occurred within the first 28 days of life. And the majority of these (83.4%) occurred at under 7 days of age. The causes of neonatal deaths usually originate in pregnancy (e.g. immaturity, delivery complications, congenital malformations).[18] Countywide, the rate of neonatal deaths did not change between 1995 and 2006, but the State's decreased. In the county's most recent three-year period (2004-2006), there were 3.61 deaths per 1,000 births; the Healthy People 2010 goal is 2.9. Race/ethnic disparities also exist, and again, African-Americans have the highest rate of 7.53; moreover, their rate increased in the first half of the analysis period, but plateaued through 2006. No group made any significant progress over time, but the Asian rate was below the Healthy People 2010 goal, with 2.41 deaths per 1,000 births at period end.

Post-neonatal deaths are those that occur between 28 days to less than one year of age. The majority of these deaths are attributable to congenital malformations, SIDS, infections, and injuries.[18] San Diego has made progress, with its rate decreasing by nearly a third from 1.9 to 1.3 per 1,000 births between 1995 and 2006. The Healthy People 2010 goal of 1.2 deaths per 1,000 births is getting closer. However, much of this decrease appears to have occurred in one race/ethnicity. The White group made significant gains, going from 1.73 to 1.06 (a decrease of 39%), but there was no improvement in the Hispanic and African-American groups. Statistics were not available for other groups.

Fetal deaths are deaths that occur before birth. California mandates reporting of all fetal deaths of at least 20 complete weeks of gestation, but reporting is known to be incomplete. Fetal deaths may be related to chromosomal or congenital anomalies, maternal factors, and environmental exposures.[18] Between 2004 and 2006, there was an average of 209 fetal deaths a year, only slightly fewer than infant deaths at 230 a year. Countywide, the fetal mortality rate decreased in the early through mid part of the analysis period, going from 5.7 in 1995 to 4.1 per 1,000 births and fetal deaths in 2002 (a 28.1% change). Since then, it has remained unchanged. San Diego's most recent three-year average (2004-2006), 4.51, did not meet the Healthy People 2010 goal of 4.1. Race/ethnic disparities in fetal mortality mirrored those observed for infant mortality. Rates were highest for African-Americans (7.48), followed by Hispanics (5.09). Those for Whites (3.77) and Asians (3.63) were lowest, but not significantly different from each other; further evaluation revealed that their rates decreased between 1995 and 2006. Meanwhile, trends for the groups with the highest rates, African-American and Hispanic, were essentially flat.

Perinatal deaths include late fetal deaths (at least 28 weeks of gestation) and infant deaths within 7 days of birth. One caveat related to this measure is that gestational age for fetal deaths (used in the calculation of the perinatal death rate), was missing or inaccurate for 10.6% of fetal deaths in the 2006 sample year. The County rate decreased throughout the 1995-2006 period, from 5.5 to 5.1 per 1,000 late fetal deaths and births. In the three-year end period (2004-2006), rates were highest for African-Americans (9.39). Hispanics (5.64) and Whites (5.04) had intermediate rates. Asians had the lowest (3.50) and were the only group that met the Healthy People 2010 goal of 4.5 deaths per 1,000 late fetal deaths and births. No group showed any significant changes over time except for African-Americans; their rate decreased nearly 50%, going from 14.8 in 1997 to 7.6 in 2006.

Infant mortality rates decreased tremendously in the last century. In the U.S., the rate dropped 86%, from 47.0 per 1,000 in 1940 to 6.7 in 2006.[27] This progress was largely attributable to advances in medicine and

technology. However, increases in low birthweight and preterm rates make continuing gains more difficult. [7] The problem is also complicated by large race/ethnic disparities. More research needs to be done to determine causes and solutions specific to the African-American group; otherwise progress as a whole will be difficult to achieve.

NOTE: State and County overall and race/ethnicity statistics were provided by FHOP unless noted otherwise. Accompanying confidence intervals and trend tests were also provided for determination of statistical significance where comparisons were made. Perinatal statistics by maternal age and County Health and Human Services Agency region were obtained from local analyses using data from the Birth and Death Statistical Master Files (State of California, Department of Public Health, Center for Health Statistics); therefore methods and definitions may differ from that used by FHOP.

Data quality was an issue in some areas; this should be kept in mind as they may affect results. Most notably, race/ethnicity was missing for 7.0% of all births (2006 sample year). According to the State's Department of Finance protocol, births and deaths of unknown race/ethnicity (along with multi-race ones) were re-assigned to the White race/ethnic group. Also, gestational age for fetal deaths (used in calculation of the perinatal death rate) was missing or inaccurate for 10.6% of fetal deaths (2006 sample year).

VII. MCAH Priorities

The priorities for San Diego County have not changed from the previous local needs assessment. The core planning group convened to review and discuss the previous priorities and the current data trends. The data confirmed that the previous priority areas remain as current problem areas.

MCAH Jurisdiction: San Diego County

Priority 1. Children and Weight: Reduce the number of children (under age 19) who are overweight.
Priority 2. Low/Very Low Birth Weight and Prematurity: Reduce the number of preterm births and live births that are of low or very low birth weight.
Priority 3. Health and Dental Insurance for Children: Increase the number of children (up to age 19) who have health insurance; and increase the number of children ages 2-11 who have dental insurance and who have visited a dentist in the past year.
Priority 4. Prenatal Care Access and Utilization: Increase the number of pregnant women who receive first trimester and adequate prenatal care.
Priority 5. Infant, Fetal and Perinatal Mortality: Reduce the number of perinatal, neonatal, post-neonatal and infant deaths.

VIII. Capacity Assessment

Assessment of Essential Service #1: Assess and monitor maternal and child health status to identify and address problems.

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 Key Ideas: — 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)		
1.1.1 Does the local MCAH system 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.)?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak…. 4=strong	**Strengths:** ▪ The local MCAH system does use public health data that is available on the San Diego County website under (Health and Human Services Agency (HHSA). Currently, there are about 4000 visits each month to the website. ▪ County does mapping and has regional and other subgroup analysis. ▪ Death data is available and by subgroup. ▪ Hospital discharge data is available. ▪ Local public use data for (Request for Proposals) RFPs. ▪ Community Health Statistics Unit (CHSU) of the County does workshops. Needs to be more publicized. ▪ CHSU, including website, is very helpful. ▪ MCAH community has a lot of access. **Recommendations/Challenges:** ▪ Have statistics/data, but need to publicize. Need more resources. ▪ If people need statistics, they call the County's CHSU. But, some people do not know who to call. They would have to search online or make a blind call. ▪ Many of the reports listed on the CHSU website are quite old, for example the current Core Public Health Indicator is dated 2004. ▪ Need an interactive website that you select report parameters similar to the CA DPH Vital Statistics Query System. ▪ County Welfare System (CWS) has had difficulty obtaining information from hospitals on the cause of death/date of death for children. There is a 2 to 3 year delay in obtaining information on hospital deaths for CWS records. There are efforts being made to address this time delay. ▪ Due to HIPAA regulations it is difficult to break information into some categories that would be useful to determine local needs, racial/ethnic identities, etc. At this time figures are not available on Outpatient Health visits. ▪ Need regularly reported data on enrollment and disenrollment in Medi-Cal, Healthy Families, and CMS. This data should also include the amount of time it takes to determine eligibility. County's Emergency Medical System (EMS) is working on Medi-Cal accessibility.

Essential Service #1: Assess and monitor maternal and child health status to identify and address problems.		
Process Indicator	**Level of Adequacy**	**Notes**
1.1.2 Does the local MCAH system conduct analyses of public health data sets that go beyond descriptive statistics?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak…...4=strong	**Strengths:** ▪ Access to the database and analyses is available to the community. ▪ Community Health Improvement Partners (CHIP) – access to care, lower enrollment reasons, statistics. ▪ Multiple agencies and community groups use the information to track trends, identify risk factors and outcomes. ▪ Data collected enables these groups to compare local measurements with the state's and/or HP2010. ▪ Data collected can also be displayed in a mapping format which can be used to identify areas that need more support services, e.g. PHN referrals, child abuse. **Recommendations/Challenges:** ▪ Yes, but more can be done. CHIP needs assessment, Access to Care for Children Team (ACT) project (including GIS), we track trends, look at Healthy People 2010, etc. through the needs assessment. ▪ People want more maps. Already exists: ACT (eligibility for enrollment), Childhood Obesity Initiative (COI), tobacco outlets, immunization, asthma, pedestrian accidents. Needs: violence, safe parks/recreation and walkability maps.
1.1.3 Does the local MCAH system generate and analyze primary data to address state- and local-specific knowledge base gaps?	☐ ☒ ☐ ☐ 1 2 3 4 1=weak……4=strong	**Strengths:** ▪ Community Health Improvement Partners (CHIP) does needs assessments. ▪ Many things are accessible online, like studies. ▪ Hospitals look at utilization, claim, expenditures and discharge data. ▪ Union of Pan Asian Communities (UPAC) has a Pacific Islander study on breast health. Enrolled 120 women. Need more funding. ▪ CHSU working more with behavioral health. ▪ We have service data. **Recommendations/Challenges:** ▪ Not all hospitals have provided data, clinics do not report for inclusion, leaving a large gap in obtaining outpatient care information. It is difficult to break down some information into regional areas of the county. ▪ At this time there are still gaps in the information being collected to incorporate in the data base. ▪ Not coordinated. Looking/filling gaps.

Essential Service #1: Assess and monitor maternal and child health status to identify and address problems.		
Process Indicator	**Level of Adequacy**	**Notes**

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

Process Indicator	Level of Adequacy	Notes
1.1.4 Does the local MCAH system report on primary and secondary data analysis for use in policy and program development?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak……4=strong	**Strengths:** ▪ Most agencies within the MCAH system (not just County) do a good job with this. ▪ The local MCAH system provides use of the California Health Interview Survey, Youth Risks Behavior Survey, California Alcohol and Tobacco Use Survey (CAT), and Emergency Department (ED) discharges. **Recommendations/Challenges:** ▪ County tries to do evidence based programming. ▪ Need outpatient data. Have ED and deaths.
1.2. Data-Related Technical Assistance Key Idea: — Enhance local data capacity		
1.2.1 Does the local MCAH system establish framework/standards about core data expectations for other agencies that contribute to the health and well-being of the local MCAH population?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak….4=strong	**Strengths:** ▪ Depends on funder, for example, First 5 does a good job of getting information/reports out on their programs and associated impact on indicators for MCAH population. ▪ Standards are out there. ▪ For CHIP, they share their data with work teams and board. ▪ Health plans make HEDIS measures public on state website (higher score = higher enrollment). ▪ Immunization program sets standards, e.g., need HPV vaccine and oral exams, cervical exams, other STDs. **Recommendations/Challenges:** ▪ There are very different expectations for agencies and contractors. With the data collected and available, progress towards the HP2010 goals is visible. Health Insurance Plans use HEDIS measurements (chart reviews) to determine quality of service. ▪ For contractors, it depends on the funder.

Essential Service #1: Assess and monitor maternal and child health status to identify and address problems.		
Process Indicator	**Level of Adequacy**	**Notes**
1.2.2 Does the local MCAH system provide training/expertise about the collection and use of MCAH data to other agencies that contribute to the health and well-being of the local MCAH population?	Provide training/expertise ☐ ☐ ☐ ☒ 1 2 3 4 1=weak….4=strong Use of MCAH data ☐ ☒ ☐ ☐ 1 2 3 4 1=weak….4=strong	**Strengths:** ▪ The local MCAH system provides adequate training/expertise about the collection and use of MCAH data, but the training opportunities are not always used effectively by other agencies/organizations. ▪ Training/expertise avenues available are Community Health Statistic, Pacific Public Health Training Center, CHIP (how to use statistics in needs assessments), San Diego Immunization registry reaches providers and schools, UCLA-CHPR provides data and demography training, Tobacco (reaching adolescents using media), University of San Diego, Nonprofit Management Solutions, SANDAG and Council of Community Clinics provide many trainings for the local MCAH agencies/organizations that contribute to the health and well-being of the local MCAH population. **Recommendations/Challenges:** ▪ How well are these publicized? Depends on what list you're on or field you're in or who you know by chance, e.g., rural mental health, small community groups may be left out.
1.2.3 Does the local MCAH system assist local health agencies in data system development and coordination across geographic areas so that MCAH data outputs can be compared?	☐ ☐ ☒ ☐ ☐ 1 2 2.5 3 4 1=weak…..4=strong	**Strengths:** ▪ Collaborative meetings in the County bring the local MCAH system together to develop and coordinate across geographic areas so MCAH data can be compared. ▪ Some effective collaborations have been ED Connect, East County Collaborative, Tool Kit for AB1433 Oral Health Assessment for kindergartner/first-time first graders, and the Diabetes/Council of Community Clinics and Coverage Initiative system that was just started. ▪ Community organizations get consultation from County MCAH and CHSU. ▪ Collaborative meetings where data people participate. ▪ Contractors help community organizations. ▪ County assists with First 5. ▪ County evaluation consultants work with County contractors – tobacco control program.

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)*

- EMS and Community Health Statistics Unit (CHSU) is very responsive to data requests and have a wealth of data that is shared
- Availability, web-based stats- CHSU
- Superior mapping capability of the data compared to other Counties

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

- Lack of data from outpatient hospitals and clinics
- Lack advertising for trainings on how to use the data base, not always able to determine immigrations status or obtain race/ethnicity information
- Lack of staff trained in biostatistics and epidemiology
- Lack of adequate resources for data collection and analysis
- Lack regular public reporting of Medi-Cal, Healthy Families, and CMS enrollment, disenrollment and length of time to determine eligibility (believe it's available, but have no idea how to access it.)

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

- Advertise trainings
- Develop technology (use of webinars for trainings)
- Stronger emphasis on data collecting to look at outcomes and priority setting
- CHIS data is geocoded
- Reach out to CBOs/agencies not aware of Community Health Statistics Unit

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

- Weak economy
- Decreased funding for programs and staff
- State and federal cuts
- Increase in people being uninsured
- Capturing health issues before end outcome (prevention)

Assessment of Essential Service #2: Diagnose and investigate health problems and health hazards affecting women, children, and youth.

Essential Service #2: Diagnose (analyzing the cause or nature of health problems/hazards) and investigate health problems and health hazards affecting women, children, and youth.		
Process Indicator	**Level of Adequacy**	**Notes**
2.1 Does the local MCAH system study factors that affect health and illness to respond to MCAH issues?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak…..4=strong	**Strengths:** ▪ Yes, but limited. ▪ Asthma data collected on ED visits. ▪ MCAH system does a good job of collecting and disseminating infant mortality rates. ▪ Organizations that collect data include: San Diego Association of Governments (SANDAG) and Sierra Club. ▪ Collecting and disseminating data from hospitals. **Recommendations/Challenges:** ▪ Funding determines where MCAH focus is. ▪ Laws dictate what is reported (funding source). ▪ Report Card doesn't address all issues. ▪ The system looks at same problems and doesn't address any new ones. ▪ Community Health Statistics Unit (CHSU) data in North Central Region is limited. Example: ICD-9 diagnosis reported to State, then turned around to the local level. If it were mandated, we would have more access to the information. Data is pulled from different resources. ▪ CHSU has the capability of doing more, but not there yet because of technology and current reporting systems (has limitations). Systems don't talk to each other. We can pull the data, but what about the rest, part of a puzzle, not the whole thing. ▪ EMS reports where the ambulance goes to, but do we know what cause it is for? ▪ Create a EPA sampling station. ▪ Home visits to post partum patients. How do we collect it into a system? ▪ CBOs collect data, but do not share because of proprietary reasons. ▪ Example: Oral Health project with 20 clinics that are First 5 funded, but data is not shared. ▪ We have a lot of data that isn't accessible. We get grants to study things, but we never know what they are doing. ▪ Need to look at environmental factors affecting health (Bay area has written a lot about this, need to look into it.) ▪ Need to look at post-partum depression. ▪ Need for data collected on environment exposures besides lead and baseline data, development for children, social, environment, emotional and post-partum.

Essential Service #2: Diagnose (analyzing the cause or nature of health problems/hazards) and investigate health problems and health hazards affecting women, children, and youth.		
Process Indicator	**Level of Adequacy**	**Notes**
2.2 Does the local MCAH system 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?	☒ 1 ☐ 2 ☐ 3 ☐ 4 1=weak…..4=strong	**Recommendations/Challenges:** ▪ MCAH system does not engage in environmental hazards. ▪ Environmental Health collects data (done on emergency situations). Where are the results? We need to communicate. ▪ New research has not filtered to MCAH; sensitive area. ▪ Need to have cluster study examining environmental factors. Use GIS to study these clusters. ▪ Environmental factors/concerns falls on CBO and the community. ▪ Need local (zip code) data to activate/motivate people to action. ▪ Check cashing places, but no bank. ▪ Healthy food choices availability in more impoverished neighborhoods. ▪ Children and Obesity - Safe environments for exercise, creating walkable communities. ▪ Heard that City of San Diego has a new lead policy, under age 7 required to get lead testing before entry into day care. ▪ Need to look at environment – place matters (safe, walkable communities). ▪ Requirement at Head Start to report lead exposure. They aren't looking at the bigger community for input. No needs assessment. ▪ Chronic low-level lead exposure is difficult to measure. Testing the environment is better for low-level exposure. Blood test is for acute level. ▪ Getting different government entities to speak to each other. ▪ Limited, where is it reported? ▪ Need to engage community residents to advocate for themselves and their community.

Essential Service #2: Diagnose (analyzing the cause or nature of health problems/hazards) and investigate health problems and health hazards affecting women, children, and youth.		
Process Indicator	**Level of Adequacy**	**Notes**
2.3 Does the local MCAH system develop and enhance ongoing surveillance systems/population risk surveys and disseminate the results at the state and local levels?	☐ ☒ ☐ ☐ 1 2 3 4 1=weak….4=strong If you take out the word *develop*, then it would be a 3.	**Strengths:** ▪ Ongoing surveillance is pretty good. ▪ Doing better in certain regions (e.g., South). ▪ Schools do surveillance (5th, 6th, & 7th grade – collect basic health information like height, weight, BMI, etc.) ▪ Community Health Improvement Partners (CHIP). ▪ Report Card. **Recommendations/Challenges:** ▪ We are responding to mandates. ▪ Surveillance system needs to be expanded. Areas for expansion include: environmental, post-partum, school failures, retention in school, information before drop-out, behavioral problems, learning disabilities, drug issues, and performance. ▪ Need local (zip code) data to activate/motivate people to action.
2.4 Does the local MCAH system serve as the local expert resource for interpretation of data related to MCAH issues?	☐ ☒ ☐ ☐ 1 2 3 4 1=weak…..4=strong	**Strengths:** ▪ Strong in certain areas: First 5 programs (maternal piece), infant mortality, SIDS, immunizations, infectious diseases, injury prevention, University of California, San Diego (UCSD), America Academy of Pediatrics (AAP), traditional public health. ▪ Local expert is the doctor, UCSD, March of Dimes, different resources. **Recommendations/Challenges:** ▪ Weak (expertise not well developed) in certain areas: new morbidity, learning development, environmental risks, alternative medicines, mental health. ▪ Lots of experts, but we do not have a clearinghouse. ▪ System is fragmented. Can get 10 different opinions about one issue. No cohesion among the specialties. ▪ Interpretation of data. (Who interprets the data?)

Essential Service #2: Diagnose (analyzing the cause or nature of health problems/hazards) and investigate health problems and health hazards affecting women, children, and youth.		
Process Indicator	**Level of Adequacy**	**Notes**
2.5 Does the local MCAH system 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?	☐ ☐ ☐ ☒ 1 2 3 4 1=weak…..4=strong	**Strengths:** ▪ Data and information is available. ▪ Fetal Infant Mortality Review (FIMR) adopted early, conducts case reviews, lead to perinatal grief group and also the Fair Chance initiative targeting African American women and families. ▪ FIMR is throughout the County, this is traditional public health. ▪ MCAH system knows how to look at traditional public health issues like FIMR. ▪ Fetal Infant Mortality Review (FIMR) has created materials. How do you get information to the frontline people? Will the frontline people have the time to educate? ▪ These are traditional areas that public health has looked at, rates are low, we already know about them. **Recommendations/Challenges:** ▪ Maternal death, is it a concern? Do not know what we do in that arena? What are the resources? ▪ Need to focus on the future emerging health issues, like obesity. ▪ Need for expansion. ▪ County is the only one that can access infant death records.
2.6 Does the local MCAH system study factors that affect health and illness to forecast emerging MCAH threats that must be addressed in strategic planning?	☒ ☐ ☐ ☐ 1 2 3 4 1=weak…..4=strong Group would have scored this question higher, but felt that the part about forecast emerging MCAH threats was weak and scored it lower.	**Recommendations/Challenges:** ▪ Study factors, doing some, but is MCAH system focusing on forecasting emerging threats and weaknesses? ▪ County is forecasting emerging issues with chronic diseases, but not other areas. ▪ Access to care: What are the barriers? (Transportation, insurance, cost to meet co-payments). ▪ Need to look at environment and eliminating causes. ▪ Chronic disease is becoming a bigger issue (increased cost) and it relates to our diet, environment, exercise and emotional environment. ▪ Looking at the same stats, why are they doing that? ▪ Concerning African American fetal/infant deaths, prenatal care is received, but there are environmental/social issues not addressed.

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)*

- County MCH Coordinator
- MCAH staff/system – small town community feel, committed, passionate, open-minded staff
- Collaborative county
- Information sharing amongy MCAH players – connections, community relationships
- Community Pediatrics Groups
- Community Clinic system – great as a medical home for prenatal care, good, holistic, in tune with needs of patients, cultural diversity
- Opportunity to get support from high level executives (public health)
- American Academy of Pediatrics at table for issues
- March of Dimes
- Council of Community Clinics
- Hospitals – good systems of care
- SART (Sexual Assual Reponse Team)
- First 5
- County bringing people together

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

- Conservative leadership/politicians (e.g., flouridated water)
- Grant dependent programs - narrow grant opportunities
- Funding constraints (complex funding streams)
- Revenues down
- Economic – high cost of living
- Budget cuts, Infrastructure going away, loss of people and agencies
- Medi-Cal reimbursement low, providers dropping out
- Nursing care limited due to Medi-Cal cuts
- Cultural shifts are slow to happen (development)
- Many cultures – do we have resources to meet these cultural needs
- Not enough capacity – limited number of people to serve (e.g. language barriers)
- Don't do as much coordination among agencies
- Community engagement
- Don't know how to solicit (we are all competing for funds)
- Children not valued, women too (pay lip service)
- Services are competing with each other
- Lack of sharing data
- Lack of a data clearinghouse
- Need to assess and address environmental factors as theyimpact health
- Do not use enough charitable foundations
- Do not know how to solicit funds without competing

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

- New presidential administration
- Need more coordination
- Lots of collaborative opportunities
- First Five to coordinate services
- Share successes
- Need to bring County programs into mix
- Services for developmental screenings
- Newborn visit model for universal care
- Faith-based community for funding collaborations
- Provide trainings for community members to advocate for themselves.
- Self/community surveys
- Technology to better reach partners and for partners to better reach data

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

- Funding constraints (complex funding streams)
- Revenues down
- Budget cuts, Infrastructure going away, loss of people and agencies
- Nursing care limited due to MC cuts
- Turf issues
- Do short term planning and not long term planning for goal setting
- Unfunded mandates
- Higher crime, domestic violence, alcohol, tobacco and other drugs, depression, higher morbidity factors increase due to economy

Assessment of Essential Service #3: Inform and educate the public and families about maternal and child health issues.

Essential Service #3: Inform and educate the public and families about maternal and child health issues.		
Process Indicator	**Level of Adequacy**	**Notes**
3.1 Individual-Based Health Education Key Idea: — Assure the provision and quality of personal health education services		
3.1.1 Does the local MCAH system identify existing and emerging health education needs and appropriate MCAH target audiences?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak……4=strong	**Strengths:** ▪ We all know our communities & know problems well. Grassroots based do well. ▪ Emerging. What does 10 look like? Hard to keep up with and grade. ▪ Existing is known. Lots of collaboration and great partnerships in San Diego. ▪ Black Infant Health (BIH-MCAH) has brought forth community partners (leaders and clients) to address problems. Both existing and emerging. **Recommendations/Challenges:** ▪ Technology needs to be increased to reach population. Connection is lost when people move around. ▪ We need to become more accountable. ▪ We need to better inform the public. ▪ Head Start goes into home and needs more networking so client will not fall through the cracks. ▪ Important issue to population – listen to client's input in regards to needs. ▪ March of Dimes reaches out to professionals, but they do not have the resources. Preconception resources lacking. ▪ March of Dimes had money and no one wanted it. Pamphlets do not work to move people to action, explore other technology. ▪ San Ysidro Health Center does not go for grants under $100,000.

Essential Service #3: Inform and educate the public and families about maternal and child health issues.		
Process Indicator	**Level of Adequacy**	**Notes**
3.1.2 Does the local MCAH system conduct and/or fund health education programs/services on MCAH topics directed to specific audiences to promote the health of MCAH populations?	☐ ☒ ☐ ☐ 1 2 3 4 1=weak….4=strong	**Strengths:** ▪ Call center model being worked on for Medi-Cal clients. ▪ Logan Heights can get resources. County has resources available to be picked up, but not ordered online. **Recommendations/Challenges:** ▪ San Ysidro has a Childhood Obesity Initiative funded by private industry; 186 kids on wait list. ▪ Need better computer resources, funding, computer resources not being met. ▪ County decided to decrease family planning. No money available due to budget cuts. Money is inconsistent. Political situation dictates funds. Outreach is cut. Clinics look at what is reimbursable. ▪ Need to have one place to go for everything. Some models exist, but are difficult. ▪ Need one application/centralized or regional eligibility list. ▪ County should play more of lead role in bringing players together for comprehensive proposals, programs, etc.
3.2 Population-Based Health Information Services Key Idea: — Provide health information to broad audiences		
3.2.1 Does the local MCAH system identify existing and emerging MCAH population-based health information needs?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak…..4=strong	**Strengths:** ▪ Health education is delivering information for population based health information needs. ▪ As a whole we are doing well and have a handle as to what is going on in population, but there is room for improvement. ▪ There are a lot of First 5 advertisements and many other agencies with strong messages.
3.2.2 Does the local MCAH system design and implement public awareness campaigns on specific MCAH issues to promote behavior change?	☐ ☒ ☐ ☐ 1 2 3 4 1=weak…..4=strong	**Recommendations/Challenges:** ▪ Develop awareness campaigns based on best practices (Louisiana model). ▪ Need more effective health promotion. (ex. Bus stop-yes, movies-no) March of Dimes – MCAH campaigns need to be better. ▪ Campaigns are run at wrong time. Advertising in middle of the night. ▪ Time and place needs to be changed to meet awareness. ▪ Obesity, sexual health, drug/alcohol out there but not award winning. Public television not being watched. ▪ Strategic plan needed to disseminate information better for public awareness to be effective. ▪ Need to re-evaluate campaigns.

Essential Service #3: Inform and educate the public and families about maternal and child health issues.		
Process Indicator	**Level of Adequacy**	**Notes**
3.2.3 Does the local MCAH system develop, fund, and/or otherwise support the dissemination of MCAH information and education resources?	☐ ☒ ☐ ☐ 1 2 3 4 1=weak….4=strong	**Strengths:** ▪ CPS does provide education, but fewer in the future. ▪ Support from the County is great. The missing link is policy makers and stakeholders. **Recommendations/Challenges:** ▪ Resources allocated in the future, in the process of transition. ▪ We are approaching the policy maker instead of the other way around. If it is in the media, they will approach you if you are "connected". ▪ Some community meetings have poor turnout, for example, South Bay policy meeting. ▪ Individual "connection" often leaves with individual. ▪ If MCAH cannot lobby, why are we answering this question?
3.2.4 Does the local MCAH system release evaluative reports on the effectiveness of public awareness campaigns and other population-based health information services?	☐ ☒ ☐ ☐ 1 2 3 4 1=weak….4=strong	**Strengths:** ▪ San Ysidro does extensive evaluation, and Logan does evaluation. ▪ March of Dimes (MOD) does evaluation **Recommendations/Challenges:** ▪ County does not look at this as a whole. Internally done and not shared with the group. Academic yes, but not everywhere.

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)*

- New County HHSA leadership
- Commitment to our people
- MCAH system brings together community leaders to address certain community needs then community members are asked to the table to see if the needs are really the needs of the community
- Informed systems/professionals

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

- Different agencies competing for limited funding – same pot of money although programs may have slight differences
- Significant competition among organizations for funding – limits ability to impact
- County should provide health education materials and resources to community clinic sites for desemination
- Provide information by taking information and resources to clinic sites as we tight schedules to pick up
- Stronger collaboration with organizations that provide health education services is needed
- Educate public
- Conservative county climate; cuts in services, programs and staff
- Lack a resource clearinghouse
- Too many “individual connections”; when person leaves so does the political connection

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

- Effective “health promotion” aka “marketing” in communities > PSAs (Radio, TV) billboards
- New federal administration! New policies
- Activate those individuals and groups who can lobby for change
- Technology – putting information out to where people get their health messages
- Develop a “Centralized Eligibility Database” CEO (clients) for local MCAH organizations and partners for outreach and recruitment.
- Have a “CEO” in each service region – South, Central, North Central, etc.
- Coordination of services – Regional level
- Collaboration and sharing among organizations

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

- Funding and budget
- Budget/economy
- Information/media saturation
- Live in conservative communit

Assessment of 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.

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**
4.1 Does the local MCAH system respond to community MCAH concerns as they arise?	☐ ☐ ☒ ☐ ☐ 1 2 2.5 3 4 1=weak……4=strong	**Strengths:** ▪ There are a lot of community organizations that do not have extensive knowledge of available resources or the structure of the local MCAH programs (community versus county versus hospitals, etc.). ▪ There are existing networks in the community (Mental Health Council meetings, Healthy Start Consortium, Perinatal Care Network (PCN Quarterly meeting, etc.). However, there are many community groups that are unaware of these resources. ▪ Workplace Breast Feeding policy for County in development. ▪ Childhood Obesity Initiative. ▪ Regional Perinatal System. ▪ Breastfeeding Coalition. **Recommendations/Challenges:** ▪ There is little communication between community organizations and the local MCAH program. ▪ Sometimes it takes several attempts (3 calls, 2 emails, etc.) to get the right person. If you are fortunate to find the right person within an organization to assist with your needs the person is usually helpful and knowledgeable. ▪ There is a need to increase awareness of existing MCAH resources among community agencies, hospitals, and other organizations. ▪ Strategies to increase communication – create a MCAH web page for community to access and have links to partner organizations. ▪ Need to know more about existing resources so that connections and collaborations can be made. ▪ Need to increase awareness of existing MCAH resources among community agencies, hospitals, and other organizations. ▪ Barriers: Not enough money to adequately meet all unmet needs that can be identified.

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**
4.2 Does the local MCAH system identify community geographic boundaries and/or stakeholders for use in targeting interventions and services?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak……4=strong	**The following processes and programs are strong in identifying community boundaries and stakeholders for use in targeting interventions and services:** ▪ MCAH strategic planning process. ▪ Regional Perinatal Systems strategic planning and technical assistance (have been asked to be involved). ▪ Childhood Obesity Initiative. ▪ Healthy Eating Active Community (HEAC). ▪ Tobacco Control Resource Program (TCRP). ▪ CX3 process. **Recommendations/Challenges:** ▪ The local MCAH does identify community geographic boundaries for targeting interventions and services. However, this at times can cause fragmentation and duplication of efforts (recreating the wheel). There may be lessons learned or best practices developed in one region that could be duplicated in another, but at times there is lack of communication between the various geographic regions. Less decentralization may be better. On the other hand each geographic region is unique and interventions that work in one region may not work in another due to population, environment or other issues. ▪ There is no data for specific locations within the regions – example Southeast San Diego. ▪ Some fragmentation of services within regions.

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**
4.3 Does the local MCAH system provide trend information to targeted community audiences on local MCAH status and needs?	Trend information gathered ☐ ☐ ☒ ☐ 1 2 3 4 1=weak……4=strong Trend information disseminated ☐ ☒ ☐ ☐ 1 2 3 4 1=weak……4=strong	**Strengths:** ▪ Trend information gathered: Yes, the local MCAH does collect information about public health trends (e.g., Statistics Unit, Biostatistician, GIS mapping). ▪ Childhood Obesity Initiative reports outcomes. ▪ Fetal Infant Mortality Review (FIMR). ▪ Regional Perinatal Systems. ▪ CHIP needs assessments. ▪ Data: birth data, infant mortality, low birth weight, teen birth, fertility rates, premature care, etc. ▪ TCRP Report Card reports selling to minors. ▪ Children's Initiative – A Health Report Card (breastfeeding, low birth weight, prenatal care). **Recommendations/Challenges:** ▪ More could be done with GIS mapping. ▪ Trend information disseminated: Additional information needs to be put out in the community of the resources available for public health data (who to contact, what information is collected, etc.). The current dissemination is not adequate. ▪ MCAH and breastfeeding stats not publicized by MCAH.
4.4 Does the local MCAH system actively solicit and use community input about MCAH needs?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak……4=strong	**Strengths:** ▪ The local MCAH does solicit input about MCAH needs. Examples include, CHIP Access to Care forums, Perinatal Care Network (PCN) Quarterly meetings, Obesity coalition meetings, County MCAH forum, Regional Perinatal System, etc. ▪ Support in the community to address oral health needs of the clients: increased number of access points (new dental clinics), education in the community. ▪ Oral health recognized by MCAH state level as a strength. **Recommendations/Challenges:** ▪ There needs to be more of a systematic approach to get other organizations involved to provide input. Some suggested strategies are shared network, blog, website, etc. ▪ Need to be more aggressive in outreach.

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**
4.5 Does the local MCAH system provide resources for community generated initiatives and partnerships among public and/or private community stakeholders (e.g., CBOs, hospital associations, parent groups)?	☐ ☐ ☐ ☒ ☐ 1 2 3 3.75 4 1=weak……4=strong	**Strengths:** ▪ The local MCAH does provide resources (funding, assistance) for community initiatives and partnerships among public and/or private community stakeholders. ▪ Staff support California Diabetes, March of Dimes, Sweet Success, Share the care Dental, Childhood Obesity Initiatives, County Maternal Child and Family Health Services, Regional Perinatal Systems. ▪ Mental Health Services conducted community forums and provided funding opportunities. ▪ Public Health Nursing assist community organizations by providing information, staff support, etc. (Central Region). **Recommendations/Challenges:** ▪ CA regulation – must have local Breastfeeding Coordinator. No time or money to support breastfeeding.
4.6 Does the local MCAH system collaborate with coalitions and/or professional organizations to develop strategic plans to address health status and health systems issues?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak……4=strong	**Strengths:** ▪ The local MCAH does collaborate with coalitions and/or professional organizations to develop plans to address health issues, provide assistance, and obtain funding from grants, but more can be done. Examples of collaborative partners are Obesity Coalition, Outreach, Enrollment, Retention and Utilization. ▪ FIMR outcomes and recommendations are used to improve health systems. **Recommendations/Challenges:** ▪ Medical professionals are not at the table. There is a gap between medical professionals and community coalitions. ▪ There are many organizations and programs, but we need one agency to be responsible for collecting and sharing programmatic information to avoid duplication of efforts.

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)*

- Needs assessment available
- History of collaboration
- Existing networks, coalitions
- Human resources (passion)
- Multicultural population
- Existing system of care in Children's Mental Health
- Data
- Strong network of public/private partnerships

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

- Existing networks, coalition – need to link more
- More strategic collaboration
- Lack of centralization (look at both decentralization and centralization)
- Size of the County and diverse needs
- Need better coordination and communication to disseminate trend data
- Bureaucracy
- Limited diverse workforce
- Multicultural population
- Budgetary restrictions and fiscal resources
- Funding (state/federal)

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

- Enhanced technological systems
- CHIP (policy/advocacy comm.) – presents information on MCAH
- New mental health funding, collaborate with MCAH, fit in existing structure of mental health; potential funding of Public Health internet which can coordinate between both programs, SanDiego.networkofcare.org
- 2-1-1 and MCAH collaboration is threaded through 2-1-1
- Create a central communication center to link partner organizations (website or resource clearinghouse)

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

- Financial threat, funding cuts, impact on public health issues
- Loss of staff
- Salaries, difficult recruiting physicians, healthcare professionals
- Succession planning, limited number of graduates are going into Public Health
- Patients not going into clinics to seek services
- Conservative, political environment

Assessment of 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 #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**
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		
5.1.1 Does the local MCAH system actively promote the use of the scientific knowledge base in the development, evaluation, and allocation of resources for MCAH policies, services, and programs?	☐ ☒ ☐ ☐ 1 2 3 4 1=weak……4=strong	**Strengths:** ▪ 2-1-1 gathers data and feeds it back. ▪ Data is gathered. Need analysis and scientific knowledge to compile. ▪ Doing some data analysis but it is crude. Ability to pool like organizations to do the data analysis. ▪ Dental Share the Care identifies gaps in services. ▪ Immunization. ▪ County contracts are performance based and there are opportunities for MCAH. **Recommendations/Challenges:** ▪ Data collection is a large task and need to weigh resources. ▪ Data collecting in different ways by different organizations. ▪ Scientific knowledge is not driving allocation of resources. ▪ Funding constraints. Funding drives outcomes. ▪ Have county contracts required to be listed in 2-1-1 to get additional info (data). ▪ Be able to use and have access to existing local data and community stakeholders input for Request for Proposals (RFPs) and Source Selection Committees. ▪ More collaboration is needed.

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**
5.1.2 Does the local MCAH system support the production and dissemination of an annual local report on MCAH status, objectives, and programs?	☐ ☒ ☐ ☐ 1 2 3 4 1=weak……..4=strong	**Strengths:** ▪ MCAH system is good at sharing data with its partners, but not so good sharing with others outside the system. ▪ County moved to CalWin system and data extraction is more difficult. ▪ Immunization good at data collection. ▪ Report Card. **Recommendations/Challenges:** ▪ Lots of reports, but hard to find. ▪ Data repository or system not existing through CHIP's website. ▪ Disseminate data. ▪ Needs to be requested. ▪ Create MCAH listserve and provide links to data.
5.1.3 Does the local MCAH system establish and routinely use formal mechanisms to gather stakeholders' guidance on MCAH concerns?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak……..4=strong	**Strengths:** ▪ Lots of collaboration, advisory boards, parent groups. ▪ Best practices shared. ▪ Sharing of information is happening in this county which is not happening in other counties. ▪ Strength collaboration, ▪ Using faith based entities more, ▪ San Diego Kids Health Assurance Network (SD-KHAN) Community Collaborative Meetings. ▪ Perinatal Care Network meetings share information about MCAH concerns. ▪ Strong stakeholders meetings (Healthy San Diego meetings), quality care, best practices need to be shared. **Recommendations/Challenges:** ▪ Funding limits the collaboration. ▪ Budget constraints limit mileage and meetings. ▪ Collaboration, advisory boards, parent groups do not provide what is really needed and ties in with the community. Does not make the connections, not coordinated. Coordination is needed. ▪ System as a whole needs to come together to collect community input because it is not connected. Individual organizations may do it. ▪ Lots of little pods with information, but not connected. Need to funnel it up. Who should the information go to? Someone at the County? ▪ Focus on vitality of regular meetings so it is a project and action oriented group. Meetings with a purpose, balance and continued interest.

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**
5.1.4 Does the local MCAH system use diverse data and perspectives for data-driven planning and priority-setting?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak……..4=strong	**Strengths:** ▪ MCAH uses data well. From reports seen we use diverse data systems and different perspectives.
5.2.1 Does the local MCAH system participate in and provide consultation to ongoing state initiatives to address MCAH issues and coordination needs?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak……..4=strong	**Strengths:** ▪ AB1433, dissemination of materials, dental screening, obesity, OB initiatives statewide not existing, Family PACT – limited to Medi-Cal funding. Need mechanism to get information to OBs. ▪ Wellness policy. ▪ Good job at connecting with the state, need planning in our topic areas to find opportunities to identify and work with other groups (OBs). ▪ RFP and Source Selection Committee expertise available upon request is great. ▪ Advisory Boards. ▪ Coalitions. ▪ MOA/MOU's. ▪ State and National organizations. **Recommendations/Challenges:** ▪ Resources to attend State meetings limited. ▪ Mid-Year status report for Medi-Cal children (state mandate from law). Need to have advocates and MCAH staff involved in state mandates. ▪ Funding streams separates us. ▪ Develop more efficient ways to share information. ▪ Introductory class on different services for agencies not involved in health. ▪ Updated organization charts. ▪ Use webinars to increase participation among stakeholders. ▪ Webinars are useful to service providers and even family members, and are cost effective. ▪ More online trainings for every agency involved in MCAH. ▪ The needs are there, the resources are there, the leadership ties it together. ▪ How do we coordinate on a regional level? Team collaboration on a larger scale is needed. Need to prioritize and work on strategic plan for the region. ▪ What key health issues need to be addressed in our region? Go after funding as a collaborative group. ▪ Need data from across agencies to examine needs. ▪ Working with cross programs (ATOD and MCAH)

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**
5.2.2 Does the local MCAH system develop, review, and routinely update formal interagency agreements for collaborative roles in established public programs (e.g., WIC, family planning, Medi-Cal, First Five)?	☐ ☐ ☐ ☐ 1 2 3 4 1=weak……..4=strong	The group did not address this question nor the following question as the strengths and recommendations/challenges are very similar to other questions previously addressed.
5.2.3 Does the local MCAH system serve as a consultant to and cultivate collaborative roles in new local or state initiatives through either informal mechanisms or formal interagency agreements?	☐ ☐ ☐ ☐ 1 2 3 4 1=weak……..4=strong	Not addressed by group.

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)*

- Expertise available for contract development and advocates for women and children
- Collaboration
- Research facilities
- Inclusive development of policies and procedures
- First 5
- Staff knowledge/quality

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

- Internally focus
- Leadership structure
- We need another public health champion
- County website is large, confusing, too many links
- Funding
- Changing demographics
- Cultural diversity
- Geography
- Unification across silos
- No consistency in how data is collected
- No organized way of sharing all MCAH data and reports
- Lack a data clearninghouse
- Lack a coordinated system to collect community input

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

- Group excited about the “potential”
- “Place matters” over-arching concept that all can embrace
- Looking at what we have in common
- Collaborate better on outcomes of meetings – one day meeting
- Create a listserve to disseminate information
- Technology
- Collaborate and go after funding collaboratively
- Webinars
- Strength in numbers
- Request contractors to list 2-1-1 to list data

- Some questions on CHIS, links to reporting
- New partnerships
- Government relationship based on incentives
- Best practices revisit cross connect
- Advocacy
- Wealthy County
- Business community
- Collaborate efforts
- Annual sharing meetings

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

- Limited financial resources
- Hiring freeze
- Economy
- Nature of relationship between physicians and government

Assessment of 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.

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**
6.1 Legislative and Regulatory Advocacy Key idea: — Assure legislative and regulatory adequacy		
6.1.1 Does the local MCAH system periodically review *existing* federal, state and local laws, regulations, and ordinances relevant to public health in the MCAH population?	Community overall ☐ ☒ ☐ ☐ 1 2 3 4 1=weak…....4=strong County ☐ ☐ ☒ ☐ 1 2 3 4 1=weak…....4=strong	**Strengths:** ▪ Examples of existing Federal, State and local laws, regulations, and ordinances (**LRO**) were discussed, i.e. curfews for minors, age limit for tobacco and alcohol sales, and requirements for finger-printing of individuals that work with minors. ▪ Certain agencies/programs have designated staff assigned to monitor existing legislation. ▪ A number of County Agencies promote compliance with existing regulations through education, mailings and being available to answer questions from the public. ▪ Office of Violence and Prevention conducts legislative review of mandates, funding for contracts, especially as budgets are being cut. ▪ CHDP reviews all proposed legislation, not existing. ▪ Education Branch teaches existing laws to providers. **Recommendations/Challenges:** ▪ Include review of LROs as standing agenda items for meetings. ▪ Some County agencies do not routinely reviewing existing laws/regulations/ordinances, most review as needed to make sure their department/agency is in compliance.

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**
6.1.2 Does the local MCAH system monitor *proposed* legislation, regulations, and local ordinances that might impact MCAH and participate in discussions about its appropriateness and effects?	Community overall ☐ ☐ ☒ ☐ 1 2 3 4 1=weak…....4=strong County ☐ ☐ ☐ ☒ 1 2 3 4 1=weak…....4=strong	**Strengths:** ▪ Many agencies, programs and professional associations have employee(s) designated to constantly monitor proposed LROs. ▪ Groups other than County Agencies hire lobbyists to represent their interests regarding proposed changes to existing LROs and to new LROs. ▪ Non-profit organizations support grass root efforts to support or defeat proposed LROs depending on their impact on the mission and goals of the groups. ▪ Groups specifically mentioned include: American Academy of Pediatricians, California District for Child Health Legislation, San Diego County Dental Society with the California Dental Association, San Diego County Dental Hygienists' Society with the California Dental Hygienists' Association, Children's Initiative Advocacy, Health Services Advisory Board, California Conference Local Health Department Agencies, Child Welfare Office of Violence Prevention, Commission on Children, Youth and Families, Domestic Violence Council, Policy Institute at USD, ACOG – American Council of Obstetricians and Gynecologists.
6.1.3 Does the local MCAH system devise and promote a strategy for informing elected officials about legislative/regulatory needs for MCAH?	Community overall ☐ ☐ ☒ ☐ ☐ 1 2 2.5 3 4 1=weak…….4=strong	**Strengths:** ▪ As individuals on personal time, participants have provided letters of support or opposition for legislative/regulatory issues for MCAH. ▪ Group discussed varying degrees of legislative activities for other programs such as professional associations and non-profit (501-c3) community based organizations in San Diego County. **Recommendations/Challenges:** ▪ This is not an area in which County Agencies and staff participate.

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**
6.2 Certification and Standards Key idea: — Provide leadership in promoting standards-based care		
6.2.1 Does the local MCAH system disseminate information about MCAH related legislation and local ordinances to the individuals and organizations who are required to comply with them?	Community overall ☐ ☒ ☐ ☐ 1 2 3 4 1=weak……..4=strong County ☐ ☐ ☒ ☐ 1 2 3 4 1=weak……..4=strong	**Strengths:** ▪ Group mentioned the various professional organizations within the County, State and on a National level that MCAH related legislation and local ordinances to and how these organizations disseminate the information to the individuals and other organizations required to comply with them. ▪ Some methods involve websites, newsletters and mailings. ▪ There are multiple collaborations established in the community that bring together professional associations, non-profit groups (501-c3), city and county groups, etc. to address issues of concern on a more regional basis. Examples of collaboratives mentioned were: Linda Vista Collaborative, COMPACT of Escondido, San Diego County Dental Society with the California Dental Association, Council of Community Clinics, North County Community Collaborative, North County Dental Taskforce, Fluoridation Coalition, 0-5 Initiative in the South Bay
6.2.2 Does the local MCAH system 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?	Community overall ☐ ☒ ☐ ☐ 1 2 3 4 1=weak……..4=strong County ☐ ☐ ☒ ☐ 1 2 3 4 1=weak……..4=strong	**Strengths:** ▪ Group agreed that local MCAH system has an effective role of providing leadership in collaboration with professional organizations and other agencies to publicize the standards and promote quality of care for women, infants and children. ▪ Among community groups/agencies mentioned was the Safe for Babies information located on websites and available in brochures working with Child Welfare Services. The efforts of collaborations like the San Diego Diabetes Coalition, East Bay Collaborative Network, CHIP, Local Chapter of AAP, American Lung Association, United Way, and Coalition on Children and Weight to Work with representatives from multiple organizations, schools, hospitals, clinics and county agencies show how effective these groups are in educating the public and addressing the quality of care available in the MCAH system.

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**
6.2.3 Does the local MCAH system integrate standards of quality care into MCAH-funded activities and other publicly or privately funded services?	Community overall ☐ ☐ ☒ ☐ 1 2 3 4 1=weak……..4=strong County ☐ ☐ ☐ ☒ 1 2 3 4 1=weak……..4=strong	**Strengths:** ▪ Group agreed that there is an excellent level of integrating standards of quality care into MCAH-funded activities and other publicly or privately funded services. **Recommendations/Challenges:** ▪ Group identified potential for increased interaction with the Navy, Border Health Council, and the Native American population on MCAH issues.
6.2.4 Does the local MCAH system develop, enhance, and promote protocols, instruments, and methodologies for use by local agencies that promote MCAH quality assurance?	Community overall ☐ ☐ ☒ ☐ 1 2 3 4 1=weak……..4=strong County ☐ ☐ ☒ ☐ 1 2 3 4 1=weak……..4=strong	**Strengths:** ▪ The use of the Edinburgh Postnatal Depression Scale as a screening tool, use of evidence based practices by Public Health Nursing, the Welcome Baby program used by First 5, Share the Care supporting the Tool Kit for AB1433 implementation and Epidemiology working with the County Office of Education on MERSA, are just a few examples showing the development, enhancement and promotion of protocols, instruments and methodologies that promote MCAH quality assurance.
6.2.5 Does the local MCAH system participate in or provide oversight for quality assurance efforts among local health agencies and systems and contribute resources for correcting identified problems?	Community overall ☐ ☒ ☐ ☐ 1 2 3 4 1=weak……..4=strong County ☐ ☐ ☒ ☐ 1 2 3 4 1=weak……..4=strong	**Recommendations/Challenges:** ▪ We have many resources and data that are available to help correct identified problems, but there is limited access to these resources and data. Data is available on Fetal Infant Mortality rates, Domestic Violence deaths, CHDP has an oversight on quality assurance, CPSP uses a comprehensive perinatal systems program and under Title 15, Public Health Nurses evaluate facilities in juvenile halls and at Los Colinas Women's facility. All of this programmatic data needs to be shared.

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)*

- Public Safety
- Emergency Services
- Current community relationships
- Health and Development Services (First 5)
- Family Services (home visits)
- Conservative fiscal stewardship
- LRO compliance promoted through education, mailings and being available to answer questions from the public
- Local, State and Nation support
- Collaboration between various agencies
- Non-County agencies support in monitoring LROs

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

- Coordination between providers (not always on the same page)
- Access to care issues (locations of services may act as barriers-gang territories)
- Public transportation (inconvenient or unknown)
- Diversity of community (does county staff reflect/represent diversity of the San Diego County residents)
- Conservative view (interpretation of policies and situation)
- Some County agencies do not routinely review existing LROs, most review as needed to make sure their department/agency is in compliance

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

- New HHSA Director who values community relationships
- Increase and work more closely with the Foster Care/Kinship Care population
- New administration at the federal level may bring health care reform
- Technology (portable medical records)
- College-training force with emphasis on giving back to the community
- Increase oversight of quality assurance efforts
- Include review of LROs as standing agenda item for meetings
- Increase interaction with Navy, Border Health Council and the Native American population on MCAH issues

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

- Budget crisis (locally, state and federal levels)
- Unfriendly/unsafe neighborhoods
- Increased needs for public services (higher unemployment rates)
- Staff retiring/staff reductions lead to workforce shortage
- Increased public/parental concern on the safety of vaccines and Family PACT-federal level reductions.

Note issue outside the scope of our discussion: Undocumented Immigrants

Assessment of 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.

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**
7.1 Assure access to services Key ideas: — Provide oversight and technical assistance — Ensure access to comprehensive and culturally appropriate services		
7.1.1 Does the local MCAH system develop, publicize, and routinely update a toll-free line and other resources for public access to information about health services availability?	☐ ☒ ☐ ☐ 1 2 3 4 1=weak…....4=strong	**Strengths:** Group mentioned the following as resources: ▪ 211 Referral Line, Domestic Violence Hotline, Perinatal Care Network 800 Line, Consumer Center for Health Education and Advocacy, CTIS Pregnancy Risk Information Line, Birthline, Immunizations. AIM, Parent Connection. ▪ First 5 projects have included: Welcome Home Baby Program, Plaza Bonita Billboard, TV ads, toll free line – 8/11 new 1-888 line will roll into 211. ▪ Health fairs, public health nurses promote County Public Health programs. ▪ School packets sent out with resources. ▪ Calendar to promote Smoke-Out Day activities (Smokers' Helpline). ▪ Welcome Baby Program – Kit for New Parents trains parents on how to use the kit and it goes out to everyone, not just low-income populations. ▪ Border Program reaches audiences at swap meets and laundry rooms. ▪ Concern is that paper materials are thrown away. Another concern is TV advertisements need to be chosen carefully for time of day and channel used. Average person will not see it. ▪ San Ysidro Health Center links with Scripps Mercy Chula Vista Emergency department to link clients with a medical home. ▪ Public Health Centers contract with SAY San Diego to assist with access to health care and other resources. ▪ CHDP Gateway programs in place at community health clinics. ▪ Media campaigns - bus sides, billboards and promotional items. ▪ In-service trainings to share various resources in the community. ▪ Notice of eligibility/consumer report services. ▪ Other non traditional community-based organizations.

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**
7.1.1 Does the local MCAH system develop, publicize, and routinely update a toll-free line and other resources for public access to information about health services availability? (continued)		**Recommendations/Challenges:** ▪ Give information to patients in outpatient setting. Give information at discharge. ▪ School nurses are a great resource for connecting to service/medical home upon discharge from hospital. ▪ Explore billboard campaign for 211. It has been available for years, yet the average citizen is unaware of its existence. Should be in the white and yellow pages along with 911. Posters should be displayed in mobile phone store and kiosks – people would program it in right there. ▪ Written/printed materials go in trash. ▪ Collaborate with hospitals better. ▪ We don't use Public Health Centers enough. Change language/approach on how we market community clinics.
7.1.2 Does the local MCAH system provide resources and technical assistance for outreach, improved enrollment procedures, and service delivery methods for unserved and underserved populations?	Overall rating ☐ ☐ ☒ ☐ 1 2 3 4 1=weak…….4=strong Clinics rate this as: ☐ ☒ ☐ ☐ ☐ 1 1.5 2 3 4 1=weak…….4=strong 2-1-1 staff rate this as: ☐ ☐ ☐ ☒ ☐ 1 2 3 3.5 4 1=weak…….4=strong	**Strengths:** ▪ Group felt the answers from other questions from Essential Service #7 reflected their opinions. See 7.1.1 and 7.1.6. Group also mentioned the following as providing resources and technical assistance: ▪ First 5 Healthcare Access Initiative. ▪ Gift of Health program. ▪ SD-KHAN collaborative disseminates information on best practice to a large audience. ▪ Access to Care for Children Team (ACT) report that was developed by CHIP in collaboration with EMS and HHSA. This report is a resource for providing information on Medi-Cal and Healthy Families Outreach and Enrollment. **Recommendations/Challenges:** See 7.1.1 and 7.1.6

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**
7.1.3 Does the local MCAH system assist unserved and underserved MCAH populations in accessing health care services?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak….4=strong	**Strengths:** Group felt the answers from other questions from Essential Service #7 reflected their opinions. See 7.1.1 and 7.1.6. ▪ Outreach efforts of community clinics (e.g. CAAs, Promotores). **Recommendations/Challenges:** ▪ Better connection between clinic and resources. ▪ Increase in employment turnover of clinic staff. ▪ Resources are out there, people do not always know how to find it. ▪ More outreach. ▪ We have high numbers of income eligible, but why don't they enroll? ▪ The system is difficult to navigate.
7.1.4 Does the local MCAH system provide resources to strengthen the cultural and linguistic appropriateness of providers and services to enhance their accessibility and effectiveness?	Non-Hispanic ☒ ☐ ☐ ☐ 1 2 3 4 Hispanic ☐ ☐ ☒ ☐ 1 2 3 4 BIH ☐ ☒ ☐ ☐ 1 2 3 4 1=weak……..4=strong	**Strengths:** Group felt the answers from other questions from Essential Service #7 reflected their opinions. See 7.1.1 and 7.1.6. ▪ A lot of resources for Hispanics. ▪ CHIP and San Diego Council on Literacy have already collaboratively developed a report on health literacy in San Diego County (published in 2008 and available on the CHIP website). Title of the report is "When Words Get in the Way: A Collaborative Approach to Addressing Health Literacy in San Diego County". We are currently in the process of implementing three report recommendations. ▪ Many of the health plans have interpreters available as well as language lines patients can call for assistance. **Recommendations/Challenges:** ▪ Limited resources for non-Hispanic (e.g. Somali). ▪ Health literacy needs to be part of the conversation. ▪ Depends upon the specific population. Populations such as recent refugees may not be served as well as other populations that have been here for some time.

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**
7.1.5 Does the local MCAH system 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?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak…....4=strong	**Strengths:** ▪ Group felt the answers from other questions from Essential Service #7 reflected their opinions. See 7.1.1 and 7.1.6. Group mentioned other collaborative efforts: ▪ CHDP Gateway program. ▪ Healthy Families and CAAs. ▪ Collaborate on writing grants. ▪ Works with churches and other non-traditional programs to gain better access to services. **Recommendations/Challenges:** ▪ Resources for low income clients are going down. ▪ Link to funding streams to meet needs. No sharing of funding opportunities. ▪ More physicians saying "no" to Medi-Cal. ▪ Opportunity for outreach in libraries, doctor waiting rooms, restrooms/lobbies, grocery stores, PTAs/school, Penny Savers, and local newspapers. ▪ Need more County collaboration/communication between own departments. ▪ Collaborate more closely with Head Start programs to maximize MCAH service coordination to families served.
7.1.6 Does the local MCAH system actively participate in appropriate provider enrollment procedures and provision of services for new enrollees?	☐ ☒ ☐ ☐ 1 2 3 4 1=weak…....4=strong	**Strengths:** ▪ "Safety Net Connect" to start in North Region. CHIP is the recipient of the grant and partners include HASDIC and Council of Community Clinics. Project looks to link community health centers to hospitals. ▪ BIH links with Family Health Center to give referral. ▪ SANDAPP provides counseling for teens, referral to Medi-Cal. ▪ PCN Quarterly meetings are an excellent to stay informed. ▪ EPSDT. ▪ San Diego City Schools (100+ school nurses) to go to with questions. ▪ MCAH work with hospitals on discharge to create a medical home. ▪ MCAH collaboration within local communities- Differs from region to region. Create strong, unique partnerships based on region. ▪ Healthy Mom Equals Healthy Baby linking health outcomes to community issues. ▪ PCN works closely with County Family Resource Center staff in ensuring compliance with procedures and protocols to assist pregnant women into Medi-Cal. ▪ County ensures compliance with CPSP program requirements.

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**
7.1.6 Does the local MCAH system actively participate in appropriate provider enrollment procedures and provision of services for new enrollees? (continued)		**Strengths:** ▪ "Safety Net Connect" to start in North Region. CHIP is the recipient of the grant and partners include HASDIC and Council of Community Clinics. Project looks to link community health centers to hospitals. ▪ BIH links with Family Health Center to give referral. ▪ SANDAPP provides counseling for teens, referral to Medi-Cal. ▪ PCN Quarterly meetings are an excellent to stay informed. ▪ EPSDT. ▪ San Diego City Schools (100+ school nurses) to go to with questions. ▪ MCAH work with hospitals on discharge to create a medical home. ▪ MCAH collaboration within local communities- Differs from region to region. Create strong, unique partnerships based on region. ▪ Healthy Mom Equals Healthy Baby linking health outcomes to community issues. ▪ PCN works closely with County Family Resource Center staff in ensuring compliance with procedures and protocols to assist pregnant women into Medi-Cal. ▪ County ensures compliance with CPSP program requirements.
7.2 Coordinate a system of comprehensive care Key Idea: — Provide leadership and oversight		
7.2.1 Does the local MCAH system provide leadership and resources for a system of case management and coordination of services?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak……...4=strong	**Strengths:** The following programs and organizations provide strong leadership and resources creating a system of case management and coordination of services. ▪ Perinatal Care Network. ▪ Black Infant Health Program. ▪ Perinatal Street Outreach Program. ▪ San Diego SART project. ▪ Public Health Nurses. ▪ Social service organizations. ▪ Community Clinics. ▪ California Border Healthy Start. ▪ SANDAPP. ▪ SAY San Diego. ▪ First 5 Welcome Home Baby Program. ▪ California Early Start. ▪ Military organizations.

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**
7.2.2 Does the local MCAH system provide leadership and oversight for systems of risk-appropriate perinatal and children's care?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak……..4=strong	**Strengths:** ▪ SD Fetal and Infant Mortality Review (FIMR). ▪ Perinatal Care Network (PCN). ▪ Child Health Disability Prevention (CHDP) Program. ▪ Foster Care Program. ▪ March of Dimes. ▪ Regional Perinatal Systems (i.e. Sweet Success, Welcome Baby Program). ▪ SANDAPP. ▪ SAY San Diego. ▪ California Border Healthy Start. ▪ Community Clinics. ▪ CTIS Pregnancy Risk Information Line ▪ California Early Start. ▪ Social service organizations. ▪ Military organizations.

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)*

- Collaborative nature of San Diego
- Existing resources: First 5, Welcome Baby Program - Kit for New Parents; SD-KHAN; 2-1-1, Community Health Centers, Domestic Violence, PCN, CPSP, etc.
- Existing reports/data to guide efforts so a lot of initial work has been done
- 2-1-1 and domestic violence hotlines
- Caring and resourceful staff
- MCAH brought all these providers together to look at our community
- MCAH recognizes that there are weakness and are willing to address the issues
- Local collaboratives efforts
- Perinatal Care Network is a strong and consistant collaborative
- A lot of resources for Hispanic population
- Outreach efforts of community clinics

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

- Difficult to reach out to families who traditionally (mid/high income levels) are not the target population of our efforts
- Advertisements should be on mainstream stations as most people do not watch public TV
- Access to internet not reaching certain populations
- Resources are out there, people don't always know how to find it
- High number of income eligible, why don't they enroll
- Not enough outreach/resources for fathers/males
- Low-income clients cannot access websites
- Ethnically/linguistically diverse information not available (e.g. Somali)
- System is difficult to navigate through
- Low health literacy information not available
- High staff turnover at county and clinic; need better systems for providing information for use of frontline staff and consumers about resources
- Access to services not publicized enough (new uninsured may not be aware of programs if they have never used the system before)
- Lack of adult and mental health services
- Case management /care coordination is not a billable service for community clinics; need appropriate funding streams to support these positions and activities
- Not enough sharing of funding opportunities
- Low County collaboration/communication between own departments
- More providers saying "No" to Medi-Cal

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

- Reach out to school nurses at various school districts
- Discharge planning – Hospital Association of San Diego and Imperial Counties

- Safety Net Connect CHIP/HASDIC/Council of Community Clinics – linking community health center to hospitals
- "One Stop" enrollment for all programs: Medi-Cal, Healthy Families, Food Stamps, CalWorks
- Improve linkage between food stamps and Medi-Cal. Increase access through food stamps and food bank (inter-connectedness)
- Need more collaboration between Medi-Cal type programs and clinics
- Place messages on fast food bags that go home with customers
- Inter-agency coordination built into county contracts or MOA/MOUs (ie. ADS, CWS, MCFHS, PHN)
- Evaluate kids needing extensive care who are in Healthy Families, are also eligible for share of cost Medi-Cal
- Have County Public Health Nurses get training on EPSDT - how to access it and how to expand services
- County departments need to communicate several initiatives in collaboration with County. MCAH can link into existing pilot projects – no need to create new partnerships
- Expand Emergency clinic models to link up patients with medical home -once you get to a clinic, staff can give you info on insurance, MCAH services, etc.
- 2-1-1 posters in fast food restaurants, grocery stores, mini-marts
- Outreach in libraries, doctor waiting rooms, restrooms/lobbies, grocery stores, PTA/school, Penny Savers, local newspapers, on milk cartons or grocery store bags.
- Linking MCAH services to the EDD offices throughout the County of San Diego
- Cultural care outreach - improve understanding of US healthcare system
- Coordinate with food bank to promote outreach of services
- Increase outreach efforts to non-Hispanic populations
- Need better access to DV, drug, mental health, eating disorders, drunk driver resources
- Utilize Public Health Nursing for outreach activities

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

- State budget cuts
- Territory wars – agencies need to survive
- Loss of insurance due to economy
- Fewer funding opportunities available
- Transient population - moves frequently

Changes to rules for kids coverage; reduction to mid-year status report, new interpretation of deemed eligibility

Assessment of 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.

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

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**
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)		

8.1.1 Does the local MCAH system 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?	☐ ☐ ☒ ☐
	1 2 3 4
	
	1=weak……..4=strong
		Strengths:
		▪ Group felt that development and enhancement of formal and informal relationships with outside analysts to build local public health analytic capacity was occurring within the MCAH system.
		
		Recommendations/Challenges:
		▪ It was noted that while these relationships were being established by individual institutions and organizations, more could be done to improve sharing of information across the MCAH system. Groups mentioned included:
		  ▪ Community Health Outreach Program working with City College.
		  ▪ Children's Hospital in Quality Improvement could be doing more with larger organizations to help capacity.
		  ▪ Some community clinics use outside evaluators such as Harder and Co. to get data analysis needs met.
		  ▪ SDSU, TPAC, AAP.
		▪ Need more uniform data collection.
		▪ Need to make it available to smaller coalitions.

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**

8.1.2 Does the local MCAH system monitor the numbers, types, and skills of the MCAH labor force available at the local level?	☒ ☐ ☐ ☐
	1 2 3 4
	
	1=weak……..4=strong
		Recommendations/Challenges:
		▪ Group agreed that there is no coordination at the MCAH system level to monitor numbers, types and skills of the MCAH labor force available at the local level. Group mentioned:
		  ▪ Neighborhood Health Center has no notification process, experiences a high turn-over rate and has no system for monitoring public health nursing.
		  ▪ Magna Journey at the hospital level could possibly be offered to the County, but competition for health care labor may make sharing information difficult.
		  ▪ Coalition on Children, Youth and Families is beginning to look at workforce issues.
		  ▪ Area Health Education Center (AHEC) – associated with Scripps – is a potential source for collaboration.
		▪ Although monitoring numbers of the healthcare workforce system-wide was an unknown, the skills/competencies needed for each type of position were understood.
		▪ On a micro/institution level only – not macro.

8.1.3 Does the local MCAH system monitor provider and program distribution throughout the LHJ?	☐ ☒ ☐ ☐ 1 2 3 4 1=weak……..4=strong	**Strengths:** Group mentioned: ▪ Level 1-3 nurseries are monitored throughout the County. ▪ Preschools. ▪ Perinatal Network Resource Guide. ▪ 2-1-1. ▪ Sources for mapping distribution: OSHPD, LA County's Healthy Cities, San Diego County Community Health Statistics – GIS service. ▪ Available by issue/program. **Recommendations/Challenges:** ▪ No "dashboard" county-wide. ▪ Monitoring may depend on the issue. ▪ No overall system.

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**
8.1.4 Does the local MCAH system integrate information on workforce and program distribution with ongoing health status needs assessment in order to address identified gaps and areas of concerns?	☒ ☐ ☐ ☐ 1 2 3 4 1=weak……..4=strong	**Recommendations/Challenges:** ▪ Group felt that there was no systematic review of specific workforce numbers/skills needed which makes addressing gaps and areas of concern difficult. ▪ There are shortages of labor in every aspect of meeting needs of families. ▪ Some institutions are addressing gaps but not systematically. ▪ Addressing gaps is money driven, similar to grants, and dependent on FTE. ▪ For individual institutions/programs only.
8.1.5 Does the local MCAH system create financial and/or other incentives and program strategies to address identified clinical professional and/or public health workforce shortages?	☐ ☒ ☐ ☐ ☐ 1 1.5 2 3 4 1=weak……..4=strong	**Strengths:** • Great place to work for someone fresh out of MPH programs. • Some institutions are working with local universities. • School of Nursing is expanding at SDSU. • National University is starting an MPH program. • Alliant University mental health program looked into workforce recruitment/training. • UCSD gives access to people/students from community resulting in an increase in applications to UCSD. **Recommendations/Challenges:** • Qualifications do not match titles compared to other regions. • High cost of living in San Diego makes it difficult to attract specialty providers. • Regulatory environment horrendous; it would be nice to cut so that less time is devoted to monitoring. • MCH program does not exist at SDSU. • Recruitment is occurring, but dealing with fewer resources to do so. • Aging population in healthcare workforce.

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**
8.2 Competency Key Ideas: — Provide and support continuing professional education — Participate in pre-service and in-service training		

8.2.1 Does the local MCAH system 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)?	☐ ☐ ☒ ☐
	1 2 3 4
	
	1=weak……..4=strong
		Strengths:
		▪ Each coalition/group does its own education. Examples:
		  ▪ CHDP provides training.
		  ▪ California Border Healthy Start has monthly Educational Quality Circle workshops.
		  ▪ Perinatal Care Network has quarterly meetings that pertain to MCAH populations.
		  ▪ Dental health professionals, both pre- and licensed, receive training on various issues that impact the targeted population. Students actually participate in hands on opportunities to provide access to care.
		
		Recommendations/Challenges:
		▪ Decrease in trainings within HHSA.
		▪ Consider using the County Learning Management System (LMS) to provide and support training needs.
		▪ Gaps in training for coordination of services.

8.2.2 Does the local MCAH system play a leadership role in establishing professional competencies for MCAH programs?	☐ ☒ ☐ ☐ 1 2 3 4 1=weak……..4=strong	**Recommendations/Challenges:** ▪ Group felt that no institution played a true leadership role establishing professional competencies for MCAH programs. ▪ County is very descriptive/prescriptive in County contracts. ▪ San Diego City College has a Promotora program which has a set curriculum to establish competencies to train and certify community outreach workers. ▪ Care management competencies exist. ▪ Individual programs have own competencies.

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)*

- Collaborative environment
- Good academic insititutions
- Great town
- Work ethic of County staff – diversity and commitment
- First 5 prop money
- Share the Care
- SD-KHAN
- Great place to work for someone fresh out of MPH programs
- School of Nursing is expanding at SDSU
- National University is starting an MPH program
- San Diego County Community Health Statistics Unit

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

- Cost of living
- Insuffcient number of ethnic, diverse workforce
- Job retention
- Decrease in housing prices
- Local university doesn't train students who will stay
- Limited resources for clinical opportunities
- Foster child transition weak regarding health
- Qualifications do not match titles compare to other regions
- No coordination to monitor numbers, types and skills of MCAH workforce at the local level
- No systematic review of specific workforce numbers/skills needed, which makes addressing gaps and areas of concern difficult
- Not enough sharing of information across the MCAH system
- Only monitors numbers at the micro/institutional level, not at the macro level
- No overall system of monitoring provider and program distibution through LHJs
- Lack uniform data collection

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

- Federal and State mandates for Electronic Medical Records by 2014 – opportunity for interoperability money?
- GIS technology
- Streamline education pathway for workforce
- Mental Health Act
- Linking monitoring of program and provider distribution
- New political environment
- Need more uniform data collection

- Improve sharing of information across the MCAH system
- Make data available for smaller coalitions

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

- Border issues (insurance issues)
- Financial crisis
- Conservative political environment (County)
- High cost of living in San Diego makes it difficult to attract specialty providers
- Aging population in healthcare workforce
- Falling housing prices

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

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 Does the local MCAH system support and/or assure routine monitoring and structured evaluations of MCAH services and programs?	☐ ☐ ☒ ☐ ☐ 1 2 2.5 3 4 1=weak……..4=strong	**Strengths:** ▪ Evaluation becoming more and more common because of funding requirements. - Most programs evaluate processes. - More funders require at least some level of outcomes. ▪ First 5 has been a leader in expecting evaluation and establishing criteria. ▪ Many hospitals are involved in measuring outcomes and conducting MCH quality improvement projects. (Some part of CMQCC and/or other health system or consortia measures.) ▪ Some local programs (SANDAPP, BIH) are part of statewide or national (Border Healthy Start project, Nurse Family Partnership) data collection and evaluation plans. ▪ Resources to help are available, such as private consultants, Institute for Public Health (SDSU School of Public Health), universities faculty and students. ▪ Technology is making it easier to collect, track and report evaluation data; electronic medical records will increase the ability to evaluate healthcare outcomes. ▪ Grant funded programs usually have some evaluation requirements. ▪ We have access to good data to track population. ▪ Programs that provide data collection and evaluation include: Perinatal Care Network, BIH, Perinatal Street Outreach, Regional PHNS, CPSP providers, CHDP providers, Share the Care and Foster Care Passport Program. ▪ A lot of the County's services are contracted out; we looking at outcomes. **Recommendations/Challenges:** ▪ Some programs/efforts are harder to evaluate, for example, policy changes. ▪ Best to involve evaluators at onset of project planning to help set up measurable outcomes and data collection systems. ▪ Programs often do not have resources to pay for evaluators (expensive). ▪ Programs do not use standardized measures; County MCAH tracks standard indicators. ▪ Proximal measures are important, but not always valued. Evaluation tools are limited. Resources do not exist to capture outcomes. ▪ Grants do not evaluate effectiveness.

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**
9.2 Does the local MCAH system 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?	☐ ☐ ☒ ☐ ☐ 1 2 2.5 3 4 1=weak……..4=strong	**Strengths:** ▪ County contracts generally require consumer satisfaction survey requirements twice a year. ▪ Recent Access to Care Team community forums and Community Health Improvement Partners needs assessments included consumer input on access and satisfaction with system of care. ▪ Hospitals and health plans gather satisfaction data. Some hospital inpatient (L & D, nursery, pediatrics) units are using that information to change practice. ▪ ACT Program – Community forums on qualitative and quantitative data for needs and access. ▪ CA Border Healthy Start Consortium did broad community level surveys. ▪ UCSD is a baby-friendly hospital and has breastfeeding program for low birth weight babies. Data is shared. Client satisfaction is very specific to their clients. ▪ Perinatal Care Network provides phone calls to follow-up with postpartum clients. ▪ Black Infant Health Program does evaluation of outreach and connecting to care. ▪ CPSP – quality of care with additional education. ▪ MCFHS – perinatal data request for reports and grant applications. ▪ Breastfeeding Coalition Advisory Group. ▪ Welcome Baby Kit. ▪ CA Diabetes Pregnancy Program – Sweet Success. ▪ Childhood Obesity Initiative. ▪ REHDI Coalition. ▪ March of Dimes. ▪ CalLearn – Always meeting to look at access and client satisfaction. **Recommendations/Challenges:** ▪ We collaborate, but can coordinate better. We can share data.

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**
9.3 Does the local MCAH system perform comparative analyses of programs and services?	☐ ☒ ☐ ☐ ☐ 1 1.5 2 3 4 1=weak……..4=strong	**Strengths:** ▪ County MCAH program compares among regions for some programs, but not across programs. ▪ First 5 programs have some comparison of outcomes to county programs; also compare different contractors under the large developmental services initiative (but similar services and populations, just in different areas) ▪ CHIP does health needs assessments (needs to look at it more in-depth). ▪ Some MCFHS local outcomes are compared to state outcome, national, and HP 2010, if requested. **Recommendations/Challenges:** ▪ Little comparative information available. ▪ Evaluations usually focus on outcomes, not effectiveness. ▪ People are reluctant to share evaluation outcomes, especially for comparison because of fear of losing funding. ▪ Do not think this is being done. Hard to collect same data from each program level for comparative analysis. ▪ Not many similar programs to compare back and forth. ▪ Need to have better coordination. ▪ Real need for more in-depth evaluation to determine program effectiveness related to health concerns. ▪ Do we have a measure to look at comparison groups? o BIH statewide data (potential to compare within counties). o Nurse Family Partnerships. o Perinatal Street Outreach (deliveries at each hospital). o Welcome Home Baby (make some comparisons).

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**
9.4 Does the local MCAH system disseminate information about the effectiveness, accessibility, and quality of personal health and population-based MCAH services?	Evaluation results in general ☐ ☒ ☐ ☐ 1 2 3 4 1=weak……..4=strong Sharing about best practices ☐ ☐ ☒ ☐ 1 2 3 4 1=weak……..4=strong	**Strengths:** ▪ Dissemination is mandated for health plans and clinics. ▪ Regional Perinatal System disseminates Perinatal Profile information to hospitals so they can compare own data to countywide, but hospital-specific information is not disseminated. ▪ Some of our programs are recognized as best practices and those tend to be shared with other jurisdictions, presented at conferences, etc. ▪ Some local programs that disseminate information include: - Children's Initiative Health Report Card on families and children. - CHIP Needs Assessment regarding perinatal issues. - FIMR. - Childhood Obesity Coalition. - Health Passport Program for Foster Care Children. - Emergency Dental Care stats and Sealant Clinic outcomes (Share the Care). - REHDI. **Recommendations/Challenges:** ▪ Dissemination efforts are made but are uncoordinated ▪ Need to find ways to get information out to consumers
9.5 Does the local MCAH system use data for quality improvement at the state and local levels?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak……..4=strong	**Strengths:** ▪ County and other agencies (CHIP, Children's Initiative) make population based data available on the internet and via request to assist other organizations in planning; has not been framed in terms of quality improvement data, but it does provide the benchmarks and consistent tracking to help assess improvements. ▪ County MCAH programs use evaluation data from own programs to improve. ▪ Inpatient continuous quality improvement projects are based on data. ▪ Some networks such as First 5 and San Diego Kids' Health Assurance Networks have had panel discussions or other forums to discuss translating evaluation information into programs and polices. ▪ Programs that use data for quality improvement include: - March of Dimes. - FIMR. - Regional Perinatal System. - Foster Care Passport Program. ▪ Hospitals do continuous quality improvement.

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**
9.6 Does the local MCAH system assume a leadership role in disseminating information on private sector MCAH outcomes?	☒ ☐ ☐ ☐ 1 2 3 4 1=weak……..4=strong	**Strengths:** ▪ FIMR program includes private sector outcomes, but organizations/practitioners are not identified publicly. ▪ Childhood Obesity Initiative working with private sector physicians on issues like tracking children's Body Mass Index. ▪ MCFHS has raw birth and infant mortality information and provides analysis to others, as requested. ▪ Regional Perinatal System provides strategic planning. ▪ First 5 working with AAP to bring doctors into discussions, not sure if they are taking a leadership role. ▪ Active AAP Chapter in our County. **Recommendations/Challenges:** ▪ Just starting to do this; little incentive for private practitioners to share information. ▪ County has educational information, but does not know how to get the information into hospitals. ▪ Hospitals – educational information can be given out during stay at hospital, a missed opportunity. ▪ We give parents/doctors what we "think" they need without asking. ▪ Disconnect with private and Medi-Cal sector.

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)*

- Passionate people
- Access to good data to track population outcomes (for certain things)
- Norm (becoming more)
- Leadership of First 5 (money that comes with)
- ACT, community forums, California Border Healthy Start, Breastfeeding Coalition, Nurse Family Partnerships
- Diversity
- Good collaboration
- Ties with universities (research)
- Sharing best practices
- Strategic planning
- Good community input into MCAH needs assessment
- Efforts are made to share information with families
- Have some resources available, such as private consultants, Institute for Public Health (SDSU School of Public Health), univerisity faculty, and students.
- Some programs are part of statewide data collection and evaluation
- Hospitals and health plans gather satisfaction data and using that information to change practice

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

- Technology (hospital has it, community doesn't)
- Lack of standardized measures (for some things)
- Expensive to evaluate
- Diversity of population and diversity of people working in population
- Lack of coordination and communication among inpatient/outpatient providers in MCAH
- Conservative political environment community (makes it difficult to get action to change)
- IRB
- HIPAA (maybe)
- Not very much comparative analysis among programs
- Collaborate well, but we do not coordinate
- Focus on outcomes, not effectiveness
- Lack of coordinated disemination efforts

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

- Technology (hospital has it, community doesn't)
- Lack of coordination and community among inpatient/outpatient providers in MCAH
- County is in a position to help (GIS mapping)
- Social political change to focus more on outcome programs

- Quality vs. quantity
- Advances in technology
- Better coordination through collaboratives
- Collaborative with universities (SDSU – intern program)
- Need to find ways to get information out to consumers
- Inpatient hospital opportunity to provide education and resource information

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

- Economic times (high cost of living)
- Reduced funding
- Territory war (driven by funding)
- Immigration status
- Sharing of personal information
- Idea of evaluation itself
- Limited funds for outcome evaluations

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

*This refers to systematic information gathering and analyses.

Essential Service #10: Support research* and demonstrations to gain new insights and innovative solutions to maternal child and adolescent health-related problems.		
Process Indicator	**Level of Adequacy**	**Notes**
10.1 Does the local MCAH system encourage staff to develop new solutions to MCAH-related problems in San Diego County?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak…..……..4=strong	**Strengths:** ▪ The County was the first in the State to put money into MCAH efforts and to put a lot of emphasis on it. We have innovative strategies and have even won a national award. The County fundamentally focuses on kids, cops and trees and kids first. These successes should be celebrated and publicized more on a larger scale. ▪ In terms of encouraging staff to develop new solutions, EMS developed, with the help of hospitals, the new Emergency Discharge Database. They are building new data measures and compiling a report describing visits by types of childhood injuries and illnesses. This is just one of their data sources that can be used to obtain new findings and trends over time. ▪ The mCAST sheet indicates that "research" refers to "systematic information gathering and analysis". The County does that - looks at surveillance data and provides constant ongoing statistical trends and community comparisons. The information is also used to direct programs. They do not have the research staff to determine anything other than gross trends, but work with researchers and students who do have the time and capability to look more deeply. They also try to get as much online as possible - the website gets 4,000 hits a month. People who know about the Health Statistics Unit website use it. Otherwise it's hard to find, e.g. by Googling. We have to let other people know it is there. ▪ The Chronic Disease and Health Disparities unit does small scale demonstration projects. An element that might be helpful is a more formal link with universities at a higher level in terms of research project opportunities and students and faculty. For example, a collection site of opportunities so we can we synergize and complement each other.

Essential Service #10: Support research* and demonstrations to gain new insights and innovative solutions to maternal child and adolescent health-related problems.		
Process Indicator	**Level of Adequacy**	**Notes**
10.1 Does the local MCAH system encourage staff to develop new solutions to MCAH-related problems in San Diego County? (continued)		**Recommendations/Challenges:** ▪ It is hard to judge how effective the MCAH system is. The problem is if the system is defined as everyone because MCAH and children are not a big priority in the big scheme/system of health and health research. There is also no group in the county that sets priorities for research in MCAH. Everyone has legal mandates and academic interests and gets grants, but there is no national priority for children. We have a fractured, scattered, uncoordinated system for addressing research needs of population in general. ▪ Maybe the County or the County collaboratively with major community players could coordinate the system. The problem with this is the County is prohibited by the Board of Supervisors from doing academic research. They are frugal with tax dollars and maintain they do not go to support research when there are academic institutions responsible for it. The County does surveillance, not research, and tends not to do more than descriptive analyses. We are supposed to assess and implement more than conduct new research; cull the new research out there and transform it into programs. For the County to set a research agenda might be problematic and a role that would be better served by the medical or nursing school or the MCH program at SDSU. ▪ The County can link with researchers as part of their team and articulate the public-private partnership more. We understand the importance of research and should integrate it into programming and demonstration projects. For example, if we want to have an obesity intervention, what are things we should try based on research and then evaluate. There is no group calling the shots. Evaluation can show projects are successful, but are often tacked on after-the-fact, retrospective things. MCFHS has a lot of partners in academic research like C-BEACH and also uses students to do some of the work. They are not steering or setting a research agenda, but making an attempt to use valid methods and take measurements to determine what are legitimate outcomes. ▪ In the healthcare field, there is no presence of a broader structure that wants ideas for the average pediatrician, obstetrician or nurse that they want to participate in. There is no one person that will speak out on this issue to everyone in the San Diego County and be a focal point. EMS has a good relationship with Emergency Departments, but it took a long time to establish through CHIP and HASDIC.

Essential Service #10: Support research* and demonstrations to gain new insights and innovative solutions to maternal child and adolescent health-related problems.		
Process Indicator	**Level of Adequacy**	**Notes**
10.1 Does the local MCAH system encourage staff to develop new solutions to MCAH-related problems in San Diego County? (continued)		▪ The MCAH system is not connected or coordinated. We have individuals in silos that work with the County, but there is no infrastructure for MCAH issues. The County can take the initiative to coordinate between the community and health department like they did with obesity. However, there are administrative barriers and staffing limitations also. There is great potential, but we need to take another step to bridge things together. This is also a health promotion issue - promoting MCAH and keeping it in the forefront. Keeping the community aware and abreast of activities and innovative strategies, broadcasting successes and branding MCAH.
10.2 Does the local MCAH system serve as a source for expert consultations to MCAH research endeavors in San Diego County?	☐ ☐ ☒ ☐ 1 2 3 4 1=weak……..4=strong	**Strengths:** ▪ EMS teaches and has students. They work with outside groups like CHIP, SafeKids, Children's Hospital and HASDIC and serve as data experts. They provide a constant source of information and do presentations, not necessarily program or evaluation related, but more on surveillance information - e.g. What is happening in the County? They also help private partners do program implementation. ▪ Group has expertise in infant mortality and low birthweight. They help programs with implementation and work to get high risk women into prenatal care. Emphasis is on what will change the race/ethnic disparities. ▪ The County's Chronic Disease program has established some innovative best practices and has served as a resource nationally for universities. They have impacted state agendas and national information sharing. They also work with graduate students locally. **Recommendations/Challenges:** ▪ A group member has worked on intraoperative safety and only found out that another hospital was working on it as well, independently, when he saw their paper in a national publication. There is no forum to communicate locally what we are all working on. Again, bridging is the issue - we have to go out on our own and find out who's doing what. There needs to be a resource that can connect us. We have 16 birthing facilities in the County, a medical school and school of public health - top research and resources. Why silos? Maybe we are losing commonality because everyone has their own narrow issue and everyone is too busy. Information on best practices needs to get into hands of physicians and nurses that work in community. Can MCFHS put up a website for researchers and evaluators and show data pertaining to the issues? They could also involve academia and hospitals. We need more coordination of the current fragmented infrastructure.

Essential Service #10: Support research* and demonstrations to gain new insights and innovative solutions to maternal child and adolescent health-related problems.		
Process Indicator	**Level of Adequacy**	**Notes**
10.3 Does the local MCAH system conduct and/or provide resources for state and local studies of MCAH issues/priorities?	☐ 1 ☐ 2 ☐ 3 ☒ 3.5 ☐ 4 1=weak……..4=strong	**Strengths:** ▪ There are a lot of resources here for state and national levels. Group has presented on Black Infant Health and Healthy Start program activities and best practices nationally, e.g. at CityMatCH. ▪ EMS has also presented at state and national organization meetings. They were the first in many areas, like the trauma system and electronic pre-hospital system. **Recommendations/Challenges:** ▪ The local MCAH system serves as experts nationally more than locally. Again, this is indicative of an infrastructure problem. There is a gap between people doing cutting edge research and implementers in the field. Professors and hospital directors and other community leaders know students and need to know where they can place students to work on projects. The Childhood Obesity Initiative asked a group of researchers from different universities to serve on an advisory group and sounding board to the evaluation effort. There was good attendance and good input. That could be a model and part of the infrastructure plan.

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)*

- Dedicated and skilled personnel (highly important)
- Innovative programming, recognized best practices (highly important)
- Past successes and reputation of county
- National experts residing locally
- We have many (16-18) birthing facilities in concentrated area - we have a large population to work with and assist
- The new public health officer and HHSA directors are very public health oriented; they are interested in moving forward and doing things most effectively and evaluating it, not just the way they have been done; this administrative leadership emphasizes evaluation and change, e.g. new technologies

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

- Silos, lack of coordination, particularly with researchers
- Current economic conditions
- Research, information/data gathering in County MCAH is very staff limited; lack of staff and personnel; need more staff who are trained; we are looking more at measurable outcomes and analyzing complex systems; need liaison with research institutions and data, someone dedicated
- Lack data clearninghouse

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

- County MCAH can link with other entities, and encourage them to do research and demonstration projects
- San Diego is ahead of rest of country; biotech, IT, residents open to new ideas; OB climate for contraception is forward thinking; there are opportunities to do innovative things that would not exist elsewhere in the country
- Universities, talented pool of people
- Diverse population
- Border community
- New private-public collaborations – (highly important)
  -between Public Health Services (PHS) and public health researchers
  -admin leadership of PHS and HHSA are very interested in evaluation
  -need more work through CHIP and HASDIC to coordinate with hospital administrators; hospital administrators only listen to money, not good practice, in terms of implementation and costs of implementation; they are under economic pressure and only adopt recommended (e.g. ACOG, AAP) practices when they are tied to money; Scripps, Sharp and UCSD are fighting each other economically; how do we get them to adopt high standards of care on a benevolent basis? - need an economic tie-in; prevention does not pay for hospitals when their services are required less; hospitals are being built where the reimbursement is located, not needed; the County can provide carrots and sticks for implementation of research-based interventions and tie it to reimbursement; just getting OB's to chart BMI is hard
- Universal medical record as surveillance tool
- Diversity in researchers is needed (highly important)
- Universal health coverage/single payer system
- Best practice/establishment of guidelines and setting new standard for inclusion of research in demonstration projects

- More health promotion
- Identification of a neutral entity or central location where different organizations can come and discuss these issues, instead of in silos or at organizational levels
- Philanthropy and bridging with businesses and industry is untapped wealth, e.g. biotech or IT industry could help us; the County spokesperson would probably be the new HHSA director, who has built public private partnerships as a regional director
- The regional director has a health background

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

- County MCAH prohibited from doing research
- Health insurance industry
- Budget cuts, fiscal (highly important)

IX. MCAH Capacity Needs

Stakeholder Input

The core planning group decided to invite a broad number of community stakeholders to provide input on the ten essential public health services. During a one day meeting held in November 2008, 62 stakeholders received an overview of the needs and capacity assessments and participated in two of the ten essential service discussions. Stakeholders received the mCAST-5 instruments prior to the meeting and were assigned to discussion groups based on their expertise. Those who could not attend the meeting provided input separately.

Capacity Needs

Stakeholders rated the local MCAH system's current level of adequacy and identified strengths, weaknesses, opportunities, and threats (SWOT) to the 10 essential public health services. Numerous capacity needs were identified during the meeting. MCAH staff collapsed the identified needs into four broad areas of capacity needs.

It was clear upon completion of the SWOT analysis that there are many great people and programs serving the MCAH population in San Diego County. It was equally clear that there needs to be an improved capacity for systematic coordination and collaboration on MCAH efforts. There is also a need for a resource sharing system. There was much desire to share resources such as program best practices, relevant population data, training opportunities, health education materials, and evaluation tools and expertise. Another capacity that needs improvement is monitoring the availability and competency of the local workforce to address MCAH needs especially among diverse populations. A fourth capacity identified as needing improvement is coordination on outreach and media campaigns targeting diverse MCAH populations.

Ranking of Capacity Needs

All capacity assessment stakeholders had an opportunity to rate the four capacity needs based on their judgment of the importance and feasibility of addressing each need. Thirty-five individuals completed the electronic survey. MCAH staff developed an initial plan to address the priority capacity needs with input from the core planning group. The plan reflects the fact that improving the top priority need (systematic coordination and collaboration across sectors) was judged substantially less feasible than the other needs. Directing most short term efforts toward developing the infrastructure for improving the need that ranked second (share, coordinate and publicize resources) is the most realistic way to begin. Once that infrastructure is established, it will serve as the basis to make improvements for the higher ranked need, as well as for needs three and four.

Worksheet E
(Part A is optional; Part B is required)

MCAH Capacity Needs Worksheet

Part A (Optional). The intent of this step is to identify from the list of Capacity Needs identified through the mCAST-5 a set of priority areas to address in the near term. Given the local context (e.g., funding cuts, hiring freezes, political will…) how realistic is it to focus on this capacity need? See Section 9 of the guidelines for instructions on completing this worksheet.

MCAH Jurisdiction: San Diego County

Capacity Need	Importance 5=high 3=moderate 1=low	Feasibility 5=high 3=moderate 1=low	Total Points	Priority Ranking
1. Systematically coordinate and collaborate to prioritize, fund, plan and deliver services for the MCAH population, including hospitals and medical professionals, as well as public health and community based organizations.	180	114	294	1
2. Share, coordinate and publicize resources* among all sectors that serve the MCAH population, capitalizing on technology when possible to enhance information sharing and communication. *Examples of resources: program best practices, reports, program and population level data, health education materials, training opportunities, quality improvement and evaluation results, information on regulations and legislation, and expertise for program evaluation and research.	151	137	288	2
3. Monitor and improve the availability and competence of the local public health and health care workforce to address MCAH needs, particularly for our diverse populations.	151	123	274	3
4. Support coordinated outreach and multimedia health education/promotion campaigns, including information about available services to reach diverse populations.	149	125	274	4

** 35 stakeholders completed the survey*

Part B (Required). Copy the top 5 to 10 capacity needs (e.g., as ranked in Part A above) and provide your analysis below. Bulleted points are preferred over narrative descriptions.

MCAH Jurisdiction: San Diego County

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
1. Systematically coordinate and collaborate to prioritize, fund, plan and deliver services for the MCAH population, including hospitals and medical professionals, as well as public health and community based organizations.	**Short Term:** ♦County MCAH can use established collaborative meetings (Perinatal Care Network, San Diego Kids Health Assurance Network) to begin the process of reaching out to community partners for preliminary planning for systematic coordination and collaboration on MCAH programs and issues. **Long Term:** ♦ See strategies for capacity need # 2 below. ♦Develop infrastructure to support coordination and collaboration across the communitywide MCAH system.	♦ Difficulty getting shared responsibility, ownership and leadership for MCAH priorities. ♦ Plan must be broken down into realistic and manageable steps.	♦State MCAH and other local jurisdictions can share best practices. ♦ Local organizations can commit to participate as an active collaborator with County MCAH.

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
2. Share, coordinate and publicize resources* among all sectors that serve the MCAH population, capitalizing on technology when possible to enhance information sharing and communication. *Examples of resources: program best practices, reports, program and population level data, health education materials, training opportunities, quality improvement and evaluation results, information on regulations and legislation, and expertise for program evaluation and research.	**Short term:** ♦ Concurrently assess: • Stakeholder commitment to contribute to and use a resource sharing system. • Existing and potential electronic systems. ♦Develop administrative structure (staff, funding) to create, implement, maintain, and evaluate the resource sharing system. **Long term:** ♦ Utilize the resource sharing system to coordinate planning needed to address capacity need # 1.	♦ Cost. ♦ Staff resources to research, implement, and maintain an electronic system. ♦ Commitment on part of stakeholders to update and utilize an electronic communication system.	♦ Share learning experiences around creating an electronic communication system. ♦ Advertise the electronic communication system with colleagues.

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
3. Monitor and improve the availability and competence of the local public health and health care workforce to address MCAH needs, particularly for our diverse populations.	**<u>Short term</u>:** ♦Integrate information about workforce development, trainings, and serving diverse populations into system for sharing resources (See strategies for capacity need # 2 above.) **<u>Long term</u>:** ♦ Integrate planning/funding proposals for monitoring and improving the local workforce into communitywide collaboration structure. (See strategies for capacity need # 1 above.)	♦ Unclear who will lead this effort. ♦ Unsure who has the technology or resources, both financial and human, to commit to this effort.	♦ Share best practices on partnerships between MCAH organizations and local schools of public health, nursing, medicine, and other related fields.

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
4. Support coordinated outreach and multimedia health education/promotion campaigns, including information about available services to reach diverse populations.	**Short term:** ♦Integrate information about campaigns and services into system for sharing resources. (See strategies for capacity need # 2 above.) **Long term:** ♦ Integrate planning/funding proposals for campaigns and public information about services into communitywide collaboration structure. (See strategies for capacity need # 1 above.)	♦ Unclear who will lead this effort. ♦ Unsure who has the technology or resources, both financial and human, to commit to this effort.	♦ Share opportunities and best practices on MCAH educational and media campaigns.

References

1. United States Census Bureau. American Community Survey, 2005-2007. <http://www.census.gov/acs>

2. San Diego Association of Governments (SANDAG). 2030 Regional Growth Forecast Update, July 2008, No.2.

3. State of California Employment Development Department, Labor Market Information Division. <http://www.sandiegoatwork.com/pdf/lmi/unemployment_stats/apr09_12mos_sdcaus.pdf>

4. San Diego Union Tribune. <http://www.signonsandiego.com/sdhomes/area_homesales/index.php>

5. Regional Task Force on the Homeless. San Diego County's Homeless Profile. San Diego, CA, 2006. <http://www.rtfhsd.org/docs_profile/executive_summary.doc>

6. San Diego County Office of Education. Countywide Profile, 2007-2008. <http://www.ed-data.k12.ca.us/welcome.asp>

7. California Department of Education. Educational Demographics Unit. <http://dq.cde.ca.gov/dataquest/>

8. State of California, Department of Health Services, Center for Health Statistics, Birth Statistical Master File.

9. California Department of Public Health; California County Profile Report, San Diego County, 2008. <http://www.cdph.ca.gov/pubsforms/Pubs/OHIRProfiles2008.pdf>

10. California Department of Public Health, Improved Perinatal Outcome Data Reports, 2007. <http://ipodr.org/073/vs/socioeconomics.html>

11. California Health Interview Survey, 2007. <http://www.chis.ucla.edu/>

12. "Overweight Children and Youth." Child Trends DataBank. June 2009. <http://www.childtrendsdatabank.org/indicators/15OverweightChildrenYouth.cfm>

13. Koplan J, Liverman CT, Kraak VI. "Preventing Childhood Obesity: Health in the Balance." The National Academies Press. 2005.

14. Variyam JN. "The Price is Right: Economics and the Rise in Obesity." Amber Waves, Vol. 3, No. 1. Economic Research Service/ USDA. February 2005.

15. "A Nation at Risk: Obesity in the United States." The Robert Wood Johnson Foundation. May 2005.

16. Program Overview, Overview of the California Physical Fitness Test (PFT). California Department of Education. May 27, 2009. <http://www.cde.ca.gov/ta/tg/pf/pftprogram.asp>

17. 2007-08 California Physical Fitness Report. DataQuest, California Department of Education. Retrieved 5/27/2009. <http://data1.cde.ca.gov/dataquest/>

18. Adams MM, Alexander GR, Kirby RS, Wingate MS. Perinatal Epidemiology for Public Health Practice. Spring Science+Business Media, LLC. 2009.

19. Martin JA, Hamilton BE, Sutton PD, Ventura SJ, et al. "Births: Final Data for 2006." National Vital Statistics Reports; Vol 57 No 7. Hyattsville, MD: National Center for Health Statistics 2009.

20. California Health Interview Survey, About CHIS. UCLA Center for Health Policy Research. Retrieved 5/2009. <http://www.chis.ucla.edu/about.html>.

21. California Health Interview Survey, AskCHIS. UCLA Center for Health Policy Research. Retrieved 5/2009. <http://www.chis.ucla.edu/main/default.asp>.

22. Cummings JR, Lavarreda SA, Rice T, and Brown ER. "The Effects of Varying Periods of Uninsurance on Children's Access to Health Care." *Pediatrics* 2009; 123; e 411 - e 418.

23. Brown ER, Lavarreda SA, Peckham E and Chia YJ. "Nearly 6.4 Million Californians Lacked Health Insurance in 2007 – Recession Likely to Reverse Small Gains in Coverage." Los Angeles, CA: UCLA Center for Health Policy Research, 2008.

24. Historical Civilian Labor Force. State of California, Employment Development Department, Labor Market Information Division. Retrieved May 22, 2009. <http://www.calmis.ca.gov/file/lfhist/sand$hlf.xls>

25. Report MRH003R, Children on Medi-Cal Report by Age Groups. County of San Diego, Health and Human Services Agency, Strategic Planning and Operational Support. May 2008.

26. Healthy Families Program Current Subscribers Enrollment by County. State of California, Managed Risk Medical Insurance Board (MRMIB). Retrieved May 2009. <http://www.mrmib.ca.gov/MRMIB/HFPReports1.shtml>

27. Heron MP, Hoyert DL, Murphy SL, Xu JQ, Kochanek KD, Tejada-Vera B. "Deaths: Final Data for 2006." National Vital Statistics Reports 2009; 57 (14).
<http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_14.pdf>

Appendix A

Worksheet A: MCAH Stakeholder Input Worksheet

MCAH Jurisdiction: San Diego County

Stakeholder Participant's Initials	Organizational Affiliation	Sector Repre-sented	Section Provided Input On					
			Mission Statement & Goals	Community Health Profile	Health Status Indicators	Local MCAH Problems/Needs	MCAH Priorities	Capacity Assessment
AA	Neighborhood House Association	E						X
ADA	County of San Diego, HHSA, MCFHS, Share the Care Dental Program	A						X
KA	County of San Diego, HHSA, MCFHS, Access to Care (SD-KHAN)	A	X	X	X	X	X	X
VA	Family Health Centers of San Diego	C						X
CB	County of San Diego, HHSA, Office of Violence Prevention	A						X
HB	Council of Community Clinics	E						X
IB	County of San Diego, HHSA, North Coastal Public Health Center	A						X
MB	County of San Diego, HHSA, North Central Public Health Center	A						X
PB	UCSD Women's Center	B						X
AC	County of San Diego, HHSA, MCFHS	A	X	X	X	X	X	X
BC	County of San Diego, HHSA, Central Region Public Health Center	A						X
TD	County of San Diego, HHSA, MCFHS, Chronic Disease and Health Disparities	A						X
PE	County of San Diego, HHSA, MCFHS	A	X	X	X	X	X	X
BF	Consumer Center for Health Education and Advocacy	E						X
JF	United Way of San Diego County	F						X
RF	County of San Diego, HHSA, MCFHS, Access to Care (SD-KHAN)	A	X	X	X	X	X	X
MF	County of San Diego, HHSA, Child Welfare Services	B						X
MF	211 San Diego	E						X
BG	Black Infant Health Program	E						X
CG	San Diego Adolescent Pregnancy	E	X	X	X	X	X	X

Stakeholder Participant's Initials	Organizational Affiliation	Sector Repre-sented	Section Provided Input On					
			Mission Statement & Goals	Community Health Profile	Health Status Indicators	Local MCAH Problems/Needs	MCAH Priorities	Capacity Assessment
	and Parenting Program							
NG	University of California, San Diego	B						X
KH	County of San Diego, HHSA, MCFHS, Access to Care (SD-KHAN)	A						X
PH	County of San Diego, HHSA, MCFHS	A						X
PH	County of San Diego, HHSA, Mental Health Services	A						X
PH	Sharp Grossmont Women's Center	C						X
PI	Children's Initiative	E						X
SJ	County of San Diego, HHSA, MCFHS	A	X	X	X	X	X	X
KK	San Ysidro Health Center, Center for Latino Research & Health Promotion	C						X
LL	County of San Diego, HHSA, Public Health Nursing Administration	C						X
RL	Health Net of California, Inc.	J						X
ELT	County of San Diego, HHSA, Alcohol and Drug Services	A						X
ILP	County of San Diego, HHSA, MCFHS, Chronic Disease and Health Disparities	A						X
RM	County of San Diego, HHSA, First 5 Commission	A						X
CM	Childhood Obesity Initiative	E						X
CM	County of San Diego, HHSA, MCFHS, Share the Care Dental Program	A						X
DM	Project New Village	E						X
JM	Scripps Mercy	C						X
PN	University of California, San Diego	B						X
GN	Health and Developmental Services, AAP, Chapter 3	H						X
AP	Migrant Education Program – Region IX	E						X
WP	County of San Diego, HHSA,	A	X	X	X	X	X	X

Stakeholder Participant's Initials	Organizational Affiliation	Sector Repre-sented	Section Provided Input On					
			Mission Statement & Goals	Community Health Profile	Health Status Indicators	Local MCAH Problems/Needs	MCAH Priorities	Capacity Assessment
	MCFHS, CPSP							
KR	County of San Diego, HHSA, North Inland Public Health Center	A						X
LR	County of San Diego, HHSA, Community Health Statistics Unit	A						X
MR	California Border Healthy Start Project Concern International	E	X	X	X	X	X	X
TR	Regional Perinatal System	B	X	X	X	X	X	X
DS	County of San Diego, HHSA, Public Health Administration	A	X	X	X	X	X	X
HS	County of San Diego, HHSA, Community Health Statistics Unit	A						X
LS	Family Health Centers of San Diego	C						X
MS	County of San Diego, HHSA, MCFHS	A						X
NS	March of Dimes, San Diego and Imperial Division	F	X	X	X	X	X	X
SS	Community Health Improvement Partners	E						X
SS	County of San Diego, HHSA, MCFHS, Chronic Disease and Health Disparities	A	X	X	X	X	X	X
CT	County of San Diego, HHSA, MCHFS, Maternal and Child Health	A	X	X	X	X	X	X
GT	County of San Diego, HHSA, MCFHS, Maternal and Child Health	A						X
HT	University of California, San Diego	B						X
ST	County of San Diego, HHSA, South Region Public Health Center	A						X
DW	County of San Diego, HHSA, MCFHS, Access to Care (SD-KHAN)	A						X
GW	County of San Diego, HHSA, MCFHS, Maternal and Child Health	A	X	X	X	X	X	X
JW	County of San Diego, HHSA, MCFHS, CHDP	A						X
NW	San Diego County Breastfeeding Coalition	E						X
RW	Family Health Centers of San	C						X

Stakeholder Participant's Initials	Organizational Affiliation	Sector Repre-sented	Section Provided Input On					
			Mission Statement & Goals	Community Health Profile	Health Status Indicators	Local MCAH Problems/Needs	MCAH Priorities	Capacity Assessment
	Diego							
PY	County of San Diego, HHSA, MCFHS, Share the Care Dental Program	A						X