



**Tulare County
Health & Human Services Agency**

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MCAH 5-Year Needs Assessment 2010 to 2014

Department of Health Services

Maternal Child Adolescent Health (MCAH) Division

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Acknowledgment

Tulare County MCAH Needs Assessment could not have been accomplished this report without the many hours of time contributed by staff of the Tulare County Department of Health Services, Tulare County Children Services Network and especially to our community partners who gave their time and attention in helping us map out a successful course for our next five years. Special thanks to the Family Health Outcomes Project for the data and guidance.

Sincerely,
Cathy Volpa, RN, BSN, PHN
 Maternal Child Health Division Manager
 Tulare County Health & Human Services Agency

Executive Summary

The Tulare County Maternal Child Adolescent Health (MCAH) 5-Year Needs Assessment is a core public health function required of each local Title V funded Maternal Child Adolescent Health agency, such as the Tulare County MCAH Division. It is required as part of the application process for Title V MCAH federal Block Grant funds.

The primary focus of this local assessment is on assessing the capacity of the local MCAH system to carry out the Ten Essential Public Health Services (worksheet D attached), which define the elements of health systems and services necessary to address the needs of women, children, and youth. The purpose of examining capacity is to determine where strengths and weaknesses lie, to improve and better coordinate MCAH activities, and to provide a detailed basis for policy and funding decisions. The scope of this assessment and the five components of the community health assessment applied to identifying the needs of the maternal and child health population are to:

1. Develop a community health profile
2. Assess capacity to address health issues
3. Select MCAH indicators
4. Collect, analyze, and present the data
5. Identify problems and set priorities

In July 2008, Tulare County MCAH began the planning process for this needs assessment. A Stakeholder Group (worksheet A) was organized to provide valuable insight and knowledge in the following areas and activities related to this assessment:

- Review the Ten MCAH Essential Services with team members to ensure that everyone shares a common understanding of them.
- For each Essential Service, discuss each Process Indicator and determine a response category. Discuss and record strengths, weaknesses, opportunities, and threats (SWOT) related to performance of each Essential Service.
- Review and identify the status of listed Capacity Needs.

Stakeholders included county staff from MCAH, as well as representatives from juvenile justice, education, child welfare, community and faith-based organizations, health, and mental health.

Tulare County MCAH saw improvements in many of the priority areas set forth in the previous MCAH 5-Year Needs Assessment:

Table 1. Prior Year Needs Assessment Priority Areas

	Priority Areas	1995-1997 Start	2004-2006 End	Trend
1	Prenatal Care in First Trimester	72.7%	80.6%	Positive increase
2	Teen Pregnancy (17 years or younger)	64.7	35.3	Positive decrease

3	Decrease the use of alcohol, tobacco and other drugs during pregnancy	Tulare County implemented the Drug-Exposed Infant Program in 2007		
4	Neonatal Death Risk (<28 days)	3.2	3.2	Static
	Infant Death Rate (0 to 1 year of age)	6.0	5.0	Positive decrease
5	Childhood Preventable Injury (0 to 14 years of age)	20.6	22.9	Negative increase
6	Chlamydia	23.6	22.7	Positive decrease
7	Childhood Obesity (5 to 19 years of age)	15.1%	23.5%	Negative increase

From the results of the needs assessment, the following areas were identified as areas for focusing our efforts on improving in the next five-year cycle, 2010 to 2014:

1. Decrease the incidence of child deaths age 15 to 19 years
2. Decrease the incidence of childhood obesity less than age 5 and age 5 to 19 years
3. Increase the number of women exclusively breastfeeding at the time of hospital discharge
4. Increase the number of women accessing early and adequate prenatal care
5. Decrease short inter-pregnancy interval for women age 12 to 19 and 15 to 44
6. Decrease the rate of preterm births < 37 Wks Gestation
7. Decrease the rate of low birth weight babies (weighing less than 2,500 grams at birth)
8. Decrease the use of alcohol, tobacco and other drugs during pregnancy
9. Increase collaboration between existing community groups and through technology
10. Increase social marketing and service access

Mission Statement and Goals

MISSION:

The mission of the Tulare County MCAH Division is to protect, improve, and optimize the health and well-being of women, infants, and children in Tulare County. The mission of the Tulare County MCAH Division is developed to reflect and align with the mission statement of the Tulare County Public Health Department which is to protect, improve, and optimize the health and well-being of the people in Tulare County

GOALS:

- Goal 1- Improve the health and well-being of women, infants, children, and families
- Goal 2- Promote equity by reducing health status disparities among racial/ethnic groups, socioeconomic classes, or geographic areas
- Goal 3- Enhance preconception care to improve infant and maternal morbidity and mortality

Goal 4- Promote healthy lifestyle practices among MCAH populations and reduce the rate of overweight children and adolescents.

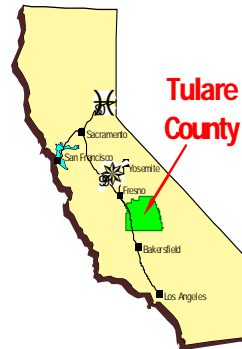
The first goal addresses issues identified by the U.S. Department of Health and Human Services (HHS) Healthy People 2010 Objectives. The second goal addresses issues that our local department of public health has identified for the county. The last two goals have been preliminarily identified by MCAH management.

Based on the 2010-2014 needs assessment as well as other Tulare County Public Health Department profiles relevant to MCAH populations, the advisory board will be reviewing the new priority areas in September 2009 to guide new goals for the Tulare County MCAH. Once these goals are identified they will also develop relevant performance measures. These performance measures help refine and focus the goals by identifying a measurable activity that determines progress in attaining the goal. The advisory board will identify targets (numerical expectations) and deadlines for achieving those targets. In sum, each performance measure, combined with its target and its deadline, will become an objective.

Community Health Profile

Source: Unless otherwise noted, the following Tulare County Demographic Information was obtained from the Tulare County Fiscal Year 2008/2009 Recommended Budget, <http://co.tulare.ca.us/pdfs/200809RecBudget.pdf>

Tulare County is situated on the east side of the San Joaquin Valley, which is part of California's Central Valley. The county is roughly equidistant from Los Angeles and San Francisco metro areas and is bordered by Fresno County in the north, Kings County in the west, Kern County in the south and Inyo County in the east. Tulare County encompasses an area of approximately 4,836 square miles, making it the seventh largest county (in terms of area) in California. The western third of the county is comprised of level lowlands, characteristic of the Central Valley. Elevations range from 500 to 3,000 feet with a varied topography of gently rolling hills on the western side facing the valley, to a rougher terrain of hills and mountains on the eastern side. The eastern third of Tulare County is comprised of the rugged Sierra Nevada Mountain range. Elevations rise quickly from 3,000 feet and peak at over 14,000 feet.



The California Department of Finance's January 1, 2008, estimate of the population of Tulare County is 436,839, an increase of approximately 2.4% over the prior year's estimate and 18.7% over the 2000 Census. Of California's 58 counties, Tulare County ranks 18th in terms of population size and 12th in terms of population growth when compared to the 2000 Census.

Despite Tulare County being the number two agricultural producer in the State with a 2007 estimated value of \$4,874,960,000, a disproportionate number of residents live in grinding poverty. Many are farm workers who make a day-wage and don't have health insurance. In short, Tulare County is poor. It has been known as "The Appalachia of the West."¹ Tulare County is second highest in the estimated number of people of all ages living in poverty in California at 23.7%, compared with the State average of 13.1%, and a U.S. average of 13.3%.² The median annual household income in Tulare County is \$41,933 compared to \$56,645 statewide.³ The percentage of children under age 18 living below the poverty level in Tulare County is 29.0%, for the State of California this number is 18.1% and for the United States as a whole it is 18.3%.⁴ The U.S. Census Bureau's statistics on poverty provide an important measure of the country's economic well-being and are sometimes used to assess the need or eligibility for various types of public assistance. The County's high poverty level puts a great strain on the County's public assistance resources.

Findings from the 2001 California Health Interview Survey conducted by UCLA Center for Health Policy Research indicate that approximately 70,000 Tulare County residents are uninsured (children and adults). Of this amount, 13,000 who are 65 years of age and under are eligible for either Medi-Cal or Healthy families.⁵ Tulare County residents are disproportionately uninsured at 16.7% when compared with California's uninsured rate of 13.2%.⁶ Tulare County's high unemployment rate and predominant agricultural industry are two leading factors in the inaccessibility of health insurance for residents.

The Tulare County MCAH programs as part of the Health Services Branch of HHS provide the following services to Tulare County:

- Women, Infants, & Children (WIC): The Women, Infants and Children Program (WIC) is a federal assistance program for women who are pregnant, breast-feeding or have recently had a baby and their children under 5 years of age. To be eligible for the WIC Program, applicants must meet income guidelines, be determined at medical risk by a health professional and receive regular medical check ups. The WIC Program provides participants with nutrition education, supplemental foods, breast-feeding encouragement and support and referral to health care and other social services.
- Nutrition Network: This program provides promotion of fruit and vegetable consumption, daily physical activity and participation in federally funded nutrition programs. Federal funding is provided through the Department of Agriculture's Food Stamp Nutrition Education Program.
- Perinatal Care Guidance: Case management to medically high risk pregnant women and promotes awareness of early prenatal care.

¹ Central San Joaquin Valley Delinquents and the California Youth Authority, *Out of Sight Out of Mind*, Nancy Richardson, Fresno, CA.

² U.S. Census Bureau, American Community Survey, 2006.

³ Ibid.

⁴ Ibid.

⁵ UCLA Center for Health Policy Research, California Health Interview Survey, 2007.

⁶ Ibid

- Comprehensive Perinatal Services: Comprehensive, culturally sensitive prenatal services through certification of area obstetrical providers.
- High Risk Infant Program: Multi-disciplinary coordination of activities to infants and families to assure children receive essential services to achieve maximum potential.
- Medically Vulnerable Infant Program: Intense specialized case management and expansion of services to infants born at-risk due to medical complications through the High Risk Infant Program.
- Perinatal Outreach and Education: Outreach and education to pregnant women to assure early and continuous prenatal care and to reduce tobacco and drug use for the purpose of preventing serious medical problems in infants.
- Sudden Infant Death Syndrome (SIDS) Program: Reduces the number of sudden infant deaths through child care education and helps families deal with the tragedy of SIDS loss.
- Information and Referral Line: An Agency service that provides a toll-free health information line for women and children.
- Drug Exposed Infant (DEI) Program: Planning grant to address the public health issues related to alcohol and other drug exposure during pregnancy. DEI committee was organized to develop a strategic plan and implement a coordinated system of care to provide from the needs of drug exposed infants and children from conception through three years of age.
- Cal-Learn: Cal-Learn is a state mandated program for the administration and case management of teens who are receiving “cash” public assistance, are pregnant and parenting, under age 19 and are not high school graduates or have not acquired a GED. Case management is provided with an emphasis on the teen graduating from high school or obtaining a GED.
- Adolescent Family Life Program (AFLP): AFLP, through intensive case management, reduces poor perinatal outcomes among pregnant teens and prevents subsequent pregnancies. Clients are assisted with their educational and economic potential in order to become self-sufficient adults. Males who are active in the parenting of their child are eligible to participate in this program.

The MCAH Division, because of its size, structure, and scope of services has ties to many community organizations and structures. It currently sponsors the following active collaboratives:

- Children Services Network: A multi-disciplinary network made up of representatives and experts from juvenile justice, education, child welfare, community and faith-based organizations, health, and mental health, focused on improving the well-being of children and families throughout Tulare County. The CSN actively promotes information exchange and service integration between health and human service providers from both governmental and community-based systems.
- High Risk Infant Team: Reviews high-risk infants born within Tulare County and makes referrals for early intervention services. The High-Risk Infant

Program within the local MCAH includes specialty programs such as the Medically Vulnerable Infant Program (funded by a grant from First 5 Tulare County) and the Drug-Exposed Infant Program (start-up funded by a planning grant from First 5 Tulare County).

- Child Death Review Team: reviews all records pertinent to the deaths of children ages 17 and younger, in order to recommend to the legislature and the public initiatives and changes that will reduce or prevent such deaths in the future.
- Domestic Violence Task Force: Raising awareness around the area of domestic violence. Law enforcement officials have been successful in applying and receiving funding for several innovative projects that have improved response and monitoring of perpetrators.
- Healthy Start Collaborative: MCH staff participates regularly in advisory boards and planning groups.
- San Joaquin Sierra Regional Perinatal Program: The MCH Director participates as a member of the Executive Committee and has actively participated in meetings, providing feedback to projects proposed.
- Tulare County Youth Coalition: A collaboration of Tulare County community based youth organizations, service providers, and individuals. Its mission is to encourage and support the development of knowledge, resources, and activities that promote a safe and positive environment for youth and their families.

Because the agency is comprised of other Divisions and Branches who also provide services to the MCAH population, MCAH staff are actively involved and collaborate with many interagency programs such as, but not limited to:

- Childhood Lead Poisoning Prevention Program: Educate parents and facilitates lead screening services for children at risk of lead exposure.
- Immunization Access Program: improves immunization compliance rates among young children, especially the age group of 0-2 years of age through the use of a mobile van to reach the rural communities.
- Suicide Prevention Task Force: The Tulare County Suicide Prevention Task Force is a collaboration between multiple government agencies, non profit organizations, private entities, and suicide survivors with a common mission to prevent suicide through collaborative efforts by engaging the community, decreasing the stigma associated with suicide and mental health services, enhancing surveillance systems and implementing effective programs and practices.
- Tobacco Control Program: A full time Tobacco Control Coordinator works within the community to educate and disseminate information on the dangers of smoking and smokeless tobacco.
- Alcohol and Drug Community Services: Promotes community awareness and local grass-roots activities that include Red Ribbon Month and drug free community and youth projects.

- Alcohol and Drug Treatment Services: The agency subcontracts with several substance abuse treatment facilities including four facilities targeting pregnant and postpartum women.
- ACT – Female Leadership Academy: The mission of ACT is to engage women of all ages in leadership opportunities that will promote social and personal change. The purpose of the Female Leadership Academy is to fulfill ACT’s mission.
- California Children’s Services (CCS): The California Children’s Services (CCS) Program provides specialized diagnostic service, medical treatment and rehabilitation for physically disabled children whose families are partially or wholly unable to provide such services. The CCS program has evolved into a joint State and County program that provides diagnostic and treatment services, medical case management and therapy services. The program is for medically eligible children from birth until their 21st birthday.
- Child Health & Disability Prevention (CHDP): CHDP provides complete health assessments for the early detection and prevention of disease and disabilities in children and youth. Children eligible for this program are those who are Medi-Cal eligible and those with family incomes at or below 200 percent of the federal poverty level. CHDP provides enrollment in health coverage for qualified children through Gateway to Medi-Cal and Healthy Families and educates providers about pre-enrolling children and youth into Gateway to Medi-Cal and Healthy Families. CHDP oversees the screening and follow-up components of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.
- CHDP Foster Care: Provides health care information coordination and documentation of health care services for children who have been detained. The program provides a Health Education Passport available to Foster Parents, CASA advocates and other health care providers, as appropriate. This provides the child with continuity and consistency in their medical care and treatment.
- Outreach to Pregnant Women: This program began in July 2004 and will provide outreach services to pregnant women to educate and advise on the importance of prenatal care, nutrition, smoking cessation, and the effects of drugs and alcohol on a developing fetus.
- Step Up: a countywide coalition comprised of the public, media, local businesses, school districts, faith-based organizations, community-based organizations, local government and law enforcement agencies. The goal was to create and implement plans to combat gang activity. Two tactics emerged: The need for an aggressive gang awareness campaign and more opportunities for at-risk youth to make positive contributions to their communities.

Local MCAH Problems/Needs *(use worksheet B attached as reference)*

Source: *Unless otherwise noted, the following statistical information was obtained from the University of California, San Francisco, Family Health Outcome Project (FHOP), California*

County MCAH Data Tulare County as required by the state MCAH 5-Year Needs Assessment Guidelines.

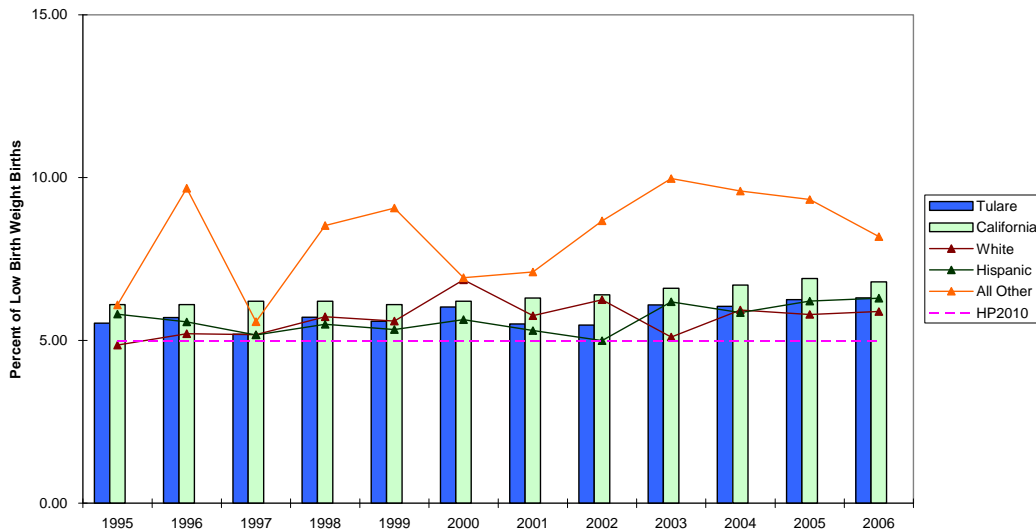
Race/Ethnicity: We have presented the following graphs to include local Race/Ethnic Groups, however due to small numbers, Asian, African-Americans, and American Indians have been combined into their own “All Other category.” The rates remain unstable for the latter and we have refrained from including details on race/ethnicity in this section. In developing policies to advance health equity, our Public Health Department along with our MCAH advisory committee will be examining MCAH related race and ethnic disparities as well as geographic disparities to help identify the appropriate goals and actions.

Based on the quantitative information from 27 health indicators (Worksheet B attached), below are the problems areas identified using the following criteria:

- Indicators that are significantly worse than State rates and/or Healthy People 2010 objectives
- Indicators that have become worse over time
- Priorities from 2005-2009 needs assessment that have shown no improvement or have become worse

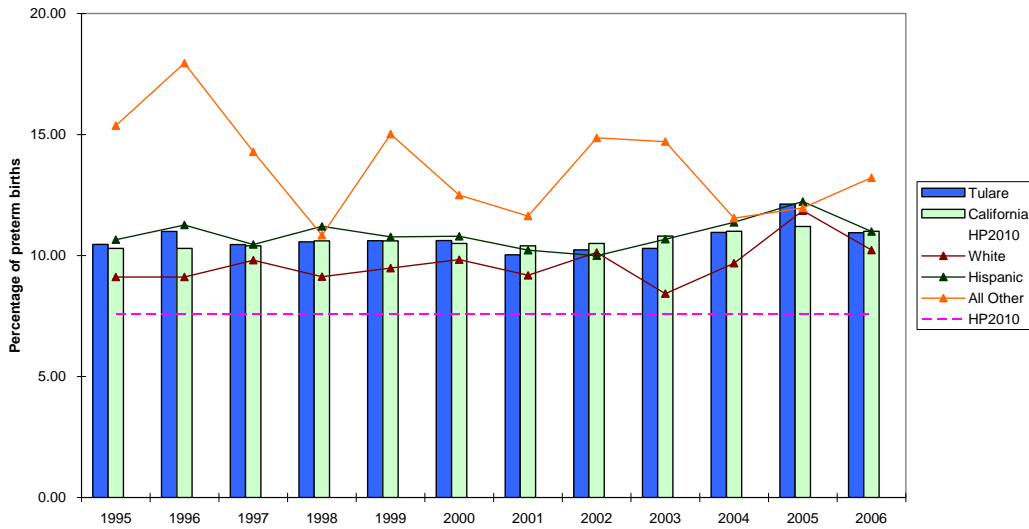
PROBLEM AREAS:

Figure 1 Low Birth Weights, 1996-2005



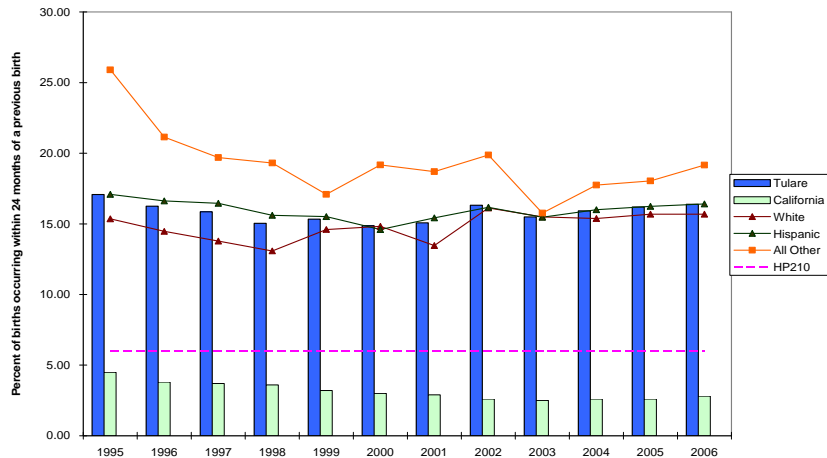
- Indicator 3 – Low Birth Weight (weighing less than 2,500 grams at birth): The local percentage of low birth weight infants has made small, but statistically significant increase from 5.5% (start period, 1995-1997) to the 6.2% (end period, 2004 -2006). The local percentage of low birth weight infants remains below the state finding of 6.8%, but are moving away from the Healthy People 2010 objective of 5%.

Figure 2 Preterm Births, 1995-2006



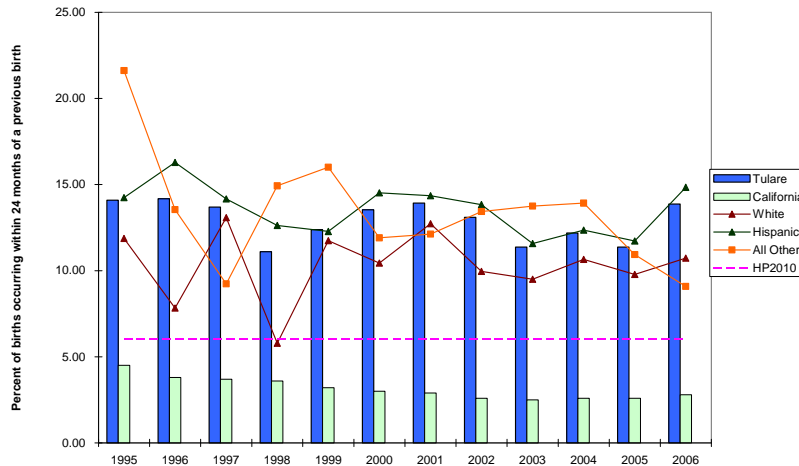
- Indicator 5 – Preterm Births** (less than 37 weeks gestation): Compared to the local start period (10.6% in 1995 -1997), the percentage of preterm births have made a small increase to 11.1% (2004-2006), but this has not been a statistically significant increase. Local percentages of preterm births are higher than the state (11.1% in 2004-2006) and the Healthy People 2010 objective of 7.6%.

Figure 3 Short Inter-Pregnancy Interval for Women Age 15-44, 1995-2006



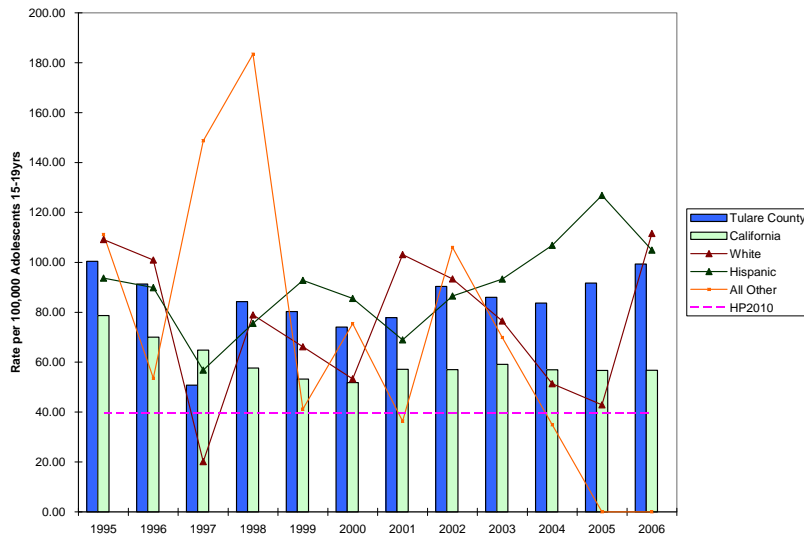
Indicator 6A – Short Inter-Pregnancy Interval for Women Age 15 to 44 (Births within 24 months of a previous birth): The local percentage of short inter-pregnancy intervals was 16.4% in 1995 -1997, and has made a small statistically significant decrease to 16.2% end period rate (2004-2006). These percentages are higher than the state end period (13.0% in 2004-2006) and the Healthy People 2010 objective of 6%.

Figure 4 Short Inter-Pregnancy Interval for Women Age 12-19, 1995-2006



- Indicator 6B – Short Inter-Pregnancy Interval for Women Age 12 to 19** (Births within 24 months of a previous birth): Compared to the local start period (14.0% in 1995 -1997), short inter- pregnancy intervals have decreased to 12.5%, but this has not been a statistically significant decrease. Local short inter-pregnancy interval for women age 12 to 19 remains higher than the state end period (9.7% in 2004-2006) and the Healthy People 2010 objective of 6%.

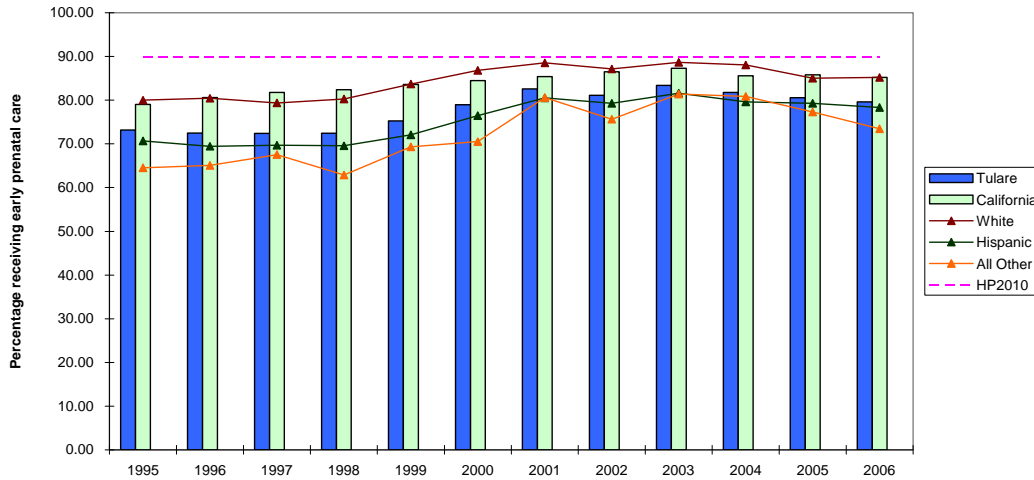
Figure 5 Adolescent Death Rate 15-19yrs, 1995-2006



- Indicator 12B – Child Death Rate Age 15 to 19 per 100,000:** Indicator 12B - Child Death Rate Age 15 to 19 per 100,000: The local rate has increased from the local 1995 to 1997 start period rate of 80.3 per 100,000 to the local 2004 to 2006 end period rate of 91.7 per 100,000. The local end period is higher

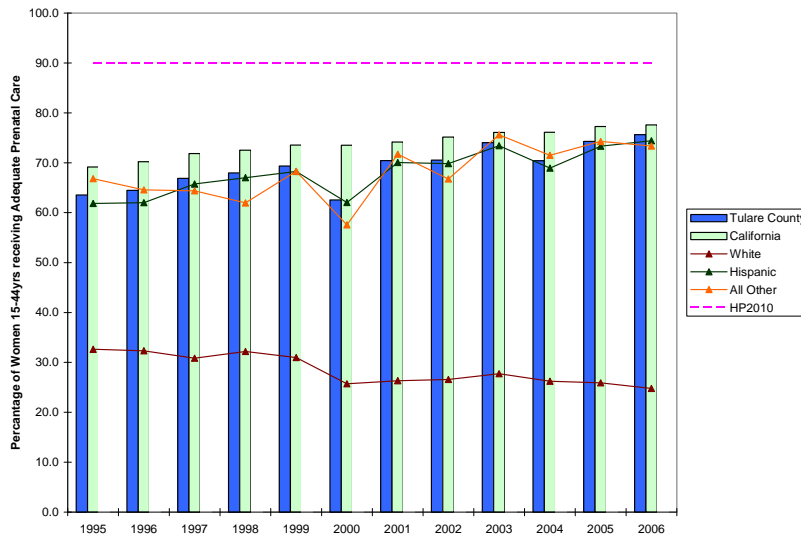
than the 2004 to 2006 state rate of 56.8 per 100,000 and the Healthy People 2010 objective of 39.8.

Figure 6 First Trimester Prenatal Care, 1995-2006



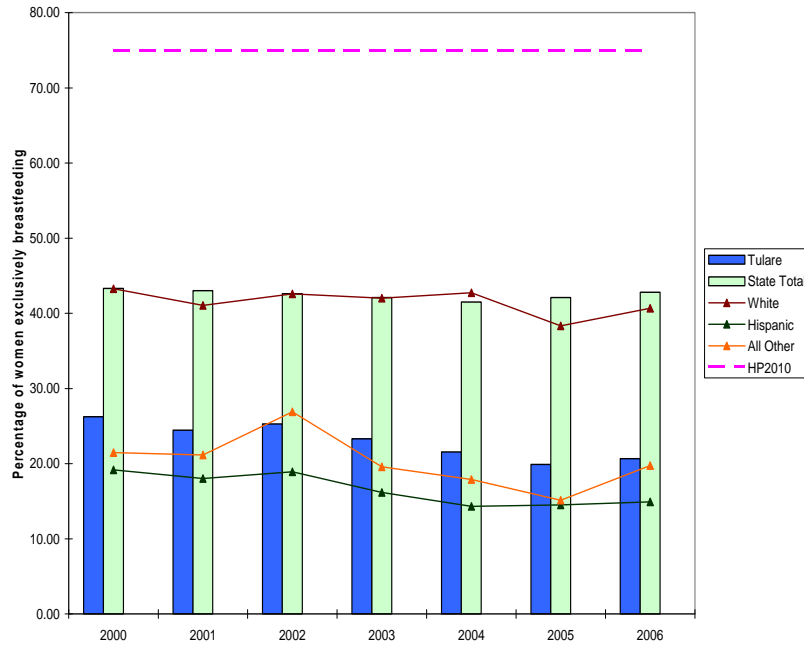
- Indicator 13 – First Trimester Prenatal Care for Live Births:** Even though the local rate has increased from the local 1995 to 1997 start period rate of 72.7% to the local 2004 to 2006 end period rate of 80.6%, it is lower than the 2004 to 2006 state rate of 85.6% and the Healthy People 2010 objective of 90%.

Figure 7 Adequate Prenatal Care, Women ages 15-44yrs, 1996-2006



- Indicator 14 – Adequate Prenatal Care (Kotelchuck Index) for Women Age 15 to 44:** The percentage of women ages 15-44 who obtained adequate prenatal care made a statistically significant increase from the initial period (64.9% in 1995- 1997) to 73.5% during 2004- 2006. These values remain lower than the state estimates of 77.0% for the same period and the Healthy People 2010 objective of 90%.

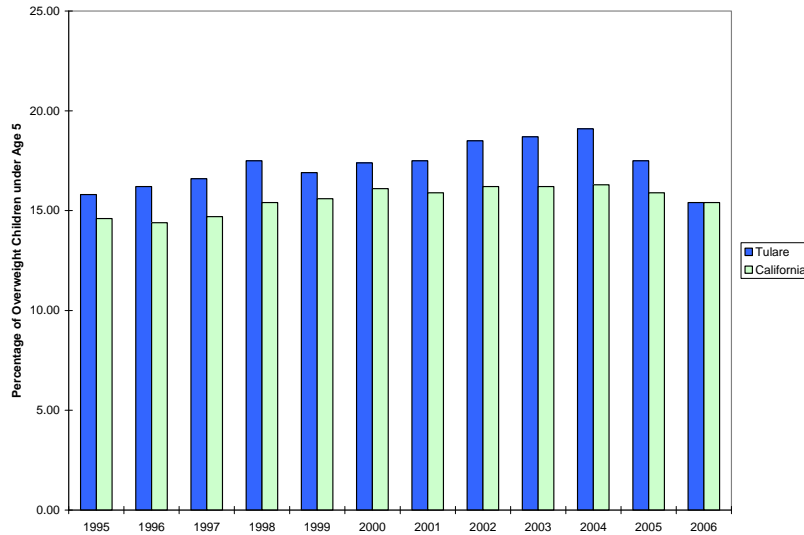
Figure 8 Women Exclusively Breastfeeding, 2000-2006



- Indicator 15 – Women Exclusively Breastfeeding at the Time of Hospital Discharge:** Collection on this indicator is new to the California Department of Public Health so the interval periods are short. The percentage of women exclusively breastfeeding at the time of discharge has made a statistically significant decrease from 25.3% during 2000-2002 to 21.3% from 2004-2006.⁷ This local indicator is lower than the state 42.5% (average for 2004-2006) and the Healthy People 2010 objective of 75%.

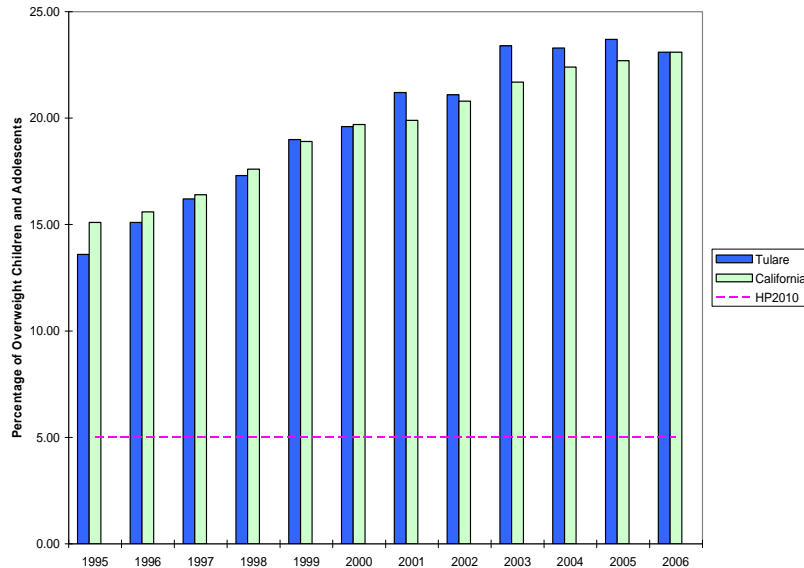
⁷California Department of Public Health, Genetic Disease Branch, Newborn Screening Test Form. <http://www.cdph.ca.gov/data/statistics/Pages/BreastfeedingStatistics.aspx>

Figure 9 Overweight Children under 5yrs, 1995-2006



- Indicator 19A – Children Less Than Age 5 who are Overweight:** The percentage of overweight children under age 5 has increased to 17.7% in 2004-2006 from an initial 16.2% in 1995-1997. While there is no Healthy People 2010 objective, the percentage of overweight children under age 5 is higher than the state percentage of 15.8% during 2004-2006.⁸

Figure 10 Overweight Children and Adolescents, 1995-2006



- Indicator 19B – Children Age 5 to 19 who are Overweight:** The percentage of overweight children and adolescents ages 5-19 has increased to 23.5% during 2004-2006 from an initial 15.1% in 1995-1997. These local percentages are

⁸ California Department of Health Care Services, Pediatric Nutrition Surveillance System (PedNSS) 2002, Table 16B
<http://www.dhcs.ca.gov/services/chdp/Pages/PedNSS2002Table16B.aspx>

higher than the Health People 2010 objectives (5%) and higher than the state percentage of 22.7% for the same period.

Worksheet C3: MCAH Priorities Worksheet

List the top ranked priorities from Part A that the Local MCAH Program will allocate time and resources to work on in the next five years.

MCAH Jurisdiction: Tulare County

Priority 1. Indicator 12B – Child Death Rate Age 15 to 19 per 100,000
Priority 2. Indicator 19 (A&B) – Children Less Than Age 5 and Children Age 5 to 19 who are Overweight:
Priority 3. Indicator 15 – Women Exclusively Breastfeeding at the Time of Hospital Discharge
Priority 4. Indicator 13 & 14 – Women Accessing and Receiving Early and Adequate Prenatal Care
Priority 5. Indicator 6 (A&B) – Short Inter-Pregnancy Interval for Women Age 12 to 19 & 15 to 44 (Births within 24 months of a previous birth)
Priority 6. Indicator 5 – Preterm Births (less than 37 weeks gestation)
Priority 7. Indicator 3 – Low Birth Weight (weighing less than 2,500 grams at birth)
Priority 8. Decrease the use of alcohol, tobacco and other drugs during pregnancy
Priority 9. Increase collaboration between existing community groups and through technology
Priority 10. Increase social marketing and service access

In the previous MCAH 5-Year Needs Assessment (2005-2009), it was commented in the needs assessment review from the region/state that they felt MCAH had too many priorities for being rural. Typically, we would whole-heartedly agree. However, in developing this needs assessments priorities and our (our=MCAH and stakeholders) ability to focus on the priorities we had several considerations that already give us a head start in focusing on these priorities thus allowing us to take on this number of priorities. Considerations are as follows: 1) As of fiscal year 2009/2010 the MCAH will implement the Nurse-Family Partnership Program which is an evidence-based program which assists in addressing short inter-pregnancy intervals, prenatal care, preterm births, low birth weight, breastfeeding, and substance abuse while pregnant; 2) In 2010, the 2-1-1 Resource and Referral System is scheduled to potentially be implemented in Tulare County which will give MCAH a heightened ability to increase services access; and 3) The Tulare County MHSA department has incorporated social marketing, a mental health educator, a maternal mental health education component which if implemented should have a positive affect in increased social marketing, collaboration, and community mental health education. In addition, several of the indicators chosen reflect a positive trend locally, but stay on the priority list because they remain below state rates and Healthy People objectives. Therefore, focusing on sustaining and enhancing the local positive trend moves MCAH closer to meeting the Health People objectives.

Worksheet E: MCAH Capacity Needs Worksheet

Major themes from the Capacity Assessment S.W.O.T. Analysis.

MCAH Jurisdiction: Tulare 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
<p>Increase collaboration between existing community groups and through technology</p>	<p>The Tulare County MCAH Division was just awarded a grant from First 5 Tulare County to implement the Nurse-Family Partnership (NFP) Program, and has subsequently been approved by the NFP National Service Office, who holds proprietary rights to the NFP, to use their evidence-based program. This program requires extensive collaboration with community groups to gain referrals, and connect clients with appropriate services within the community.</p> <p>The Tulare County MCAH Division has been working with the Tulare County Information Technology (IT) Division to develop a database which will house all the client information electronically for improved standard and ad-hoc reports. In addition, many of these reports will be released to the community and/or accessible to the community online.</p>	<p>With any new program come many challenges of learning a new system of care, and building necessary relationships and credibility within the community.</p> <p>With the database, MCAH and IT are working diligently on ensuring the utmost confidentiality vs. sharing of information.</p>	<p>The state MCAH can assist in advocacy for sustainability and funding of the evidence-based Nurse-Family Partnership state-wide.</p> <p>The Tulare County MCAH has been collaborating with many, if not all, the organizations and agencies within the community that provide services to children and families in Tulare County regarding the pending Nurse-Family Partnership Program. We will need these organizations and agencies to ensure referrals and resources.</p>
<p>Increase social marketing and service access</p>	<p>The Tulare County Mental Health Services Act Prevention and Early Intervention (PEI) Plan provides for a Social</p>	<p>The challenge we see is our dependence on two other programs that are not yet implemented.</p>	<p>Through a partnership with the Tulare County Mental Health Services Act who is funding and overseeing both the social marketing</p>

	<p>Marketing component that will enhance the communities' knowledge about "what is mental health" and "how do I access services to improve my mental health." We know that many of our programs affect the mental health of a family and therefore hope to partner efforts. In addition, there is a 2-1-1 Resource and Referral Hotline which is also in the PEI plan which will house the resources available to the community of Tulare. We will ensure comprehensive and up-to-date information is given to this access hotline to ensure we increase access to our programs.</p>		<p>component and the 2-1-1 component. Through an ongoing communication with or through United Way of Tulare County who will facilitate the development of the 2-1-1 component.</p>
<p>Increase staffing and funding for programs, services, and statistical work within the community</p>	<p>In such a difficult economic time, Tulare County MCAH is looking at all possibilities for increasing staffing, funding, and statistical work; however, it is more likely to get even more limited.</p>	<p>Challenges include funding cuts from the State and the Feds.</p>	<p>Find innovative approaches to bridge the challenge through all the assistance and/or partnerships listed in the first two rows above.</p>
<p>Defining a more cohesive approach to community awareness regarding programs and statistics</p>	<p>During the capacity assessment stakeholders were able to list off a tremendous amount of collaboratives in existence and utilized programs available to fully cover almost all issues related to the MCAH population, and a stockpile of available reports and data. However, all of these are not clearly defined, marketed, or cohesive causing lack of knowledge or frustration when searching for services of navigating through "the system."</p>	<p>Challenges include staff and technology to assist with defining, marketing and developing a cohesive model.</p>	<p>To accomplish this opportunity for cohesion, it would involve all the collaboratives and programs defined through worksheet D of this needs assessment.</p>