

**Mendocino County
Maternal, Child and Adolescent Health (MCAH)
5-Year Needs Assessment for 2010-2014**

Reported June 2009

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Acknowledgments and Next Steps

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If you would like to be involved in developing and implementing a plan to address any of the MCAH Priorities or Capacity Needs identified in this Assessment or have questions or comments, please contact:

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1. Executive Summary

The Maternal, Child and Adolescent Health (MCAH) Program of Mendocino County receives an annual Allocation of state and federal funding through the California Department of Public Health to carry out the core public health functions of community assessment, policy development, and assurance to improve the health of maternal, child and adolescent populations throughout Mendocino County.

Purpose

The purpose of the Mendocino County MCAH Needs Assessment is to, every five years, review and assess the health status of the maternal, child and adolescent populations, community health profile, and local capacity to meet the *Ten Essential Public Health Services to Promote Maternal and Child Health* and to prioritize the MCAH needs and capacity to address them in Mendocino County.

Needs Assessment Process

The MCAH Needs Assessment process occurred from August 2008 through June 2009 under the coordination of a Planning Group which consisted of the MCAH Director and Senior Public Health Analyst of Mendocino County Health and Human Services Agency (HHS), Community Health Services (formerly Public Health Branch).

- The Senior Public Health Analyst collected and compiled the Health Indicator data, prepared the data analysis, updated the community health profile and provided a summary of the health indicator data.
- The MCAH Director and PH Analyst provided a series of five Stakeholder Workshops that were held from January to May 2010 with assistance from FIRST 5 Mendocino. One Stakeholder Workshop provided review and input on the MCAH Mission Statement, Goals, Community Health Profile, Health Indicator Data, and determination of MCAH Priorities for 2010-2014. For the Capacity Assessment component, four Stakeholder workshops were held as well as interviews with several individuals. A final Internal Stakeholder meeting of the HHS Public Health Nursing Leadership Team was held to prioritize the Capacity Needs. Overall, twenty internal stakeholders and twenty-six external stakeholders participated in the process.

Highlights of Health Status Indicators

- Adolescent Tobacco, Alcohol and Other Drug Use: Data from the California Healthy Kids Survey shows a high use of tobacco, alcohol and marijuana use among students in the county.
- Breastfeeding: Although the county has a significantly higher percentage of women who plan to exclusively breastfeed their infants compared to the state, local data from the Loving Support Breastfeeding Program showed that only 34% continued exclusive breastfeeding for at least three months.
- Children Living in Foster Care as an indicator of Child Abuse and Neglect: Although the county's rate of children in foster care has significantly decreased, it is still significantly higher than the state's rate.
- Domestic Violence: The County's rate of domestic violence-related calls for assistance has decreased over time but is still higher than the state's rate.
- Health Insurance for Children and Adolescents: According to California Health Interview Survey data, the county's percent of children and adolescents with health insurance does not show a change over time from 2001 to 2007 or as compared to the state, and is still less than the Healthy People (HP) 2010 Objective.
- Low Birth Weight: The county's percent of low birth weight births shows an increase over time through 2006 but is not significantly different from the State's rate. Although the rate has decreased in 2007 and 2008, it still remains higher than the HP 2010 Objective.
- Oral Health and Access to Dental Insurance: CHIS data from 2001 to 2007 shows the county's increase in children's access to dental insurance and in the rate of children who have seen a dentist within the past year.

- Overweight Children and Youth: The county's percent of children less than 5 years who are overweight increased significantly over time but is still significantly lower than the state's rate. The county's percent of children 5-19 years who are overweight has increased over time and is higher than the HP 2010 Objective, but is not significantly different from the state's rate.
- Perinatal Tobacco, Alcohol and Other Drug Use: Data from the *4 P's Plus@ Screen for Substance Abuse* shows a higher rate of use by pregnant women in the county of alcohol, tobacco and marijuana compared to available data for California.
- Prenatal Care: For both Adequate Prenatal Care and First Trimester Entry into Prenatal Care, the county's rate has significantly increased over time but is still significantly lower than the state's rate or the HP 2010 Objective.
- Preterm Births: The county's rate of Preterm Births does not show a significant change over time or a difference from the state's rate, but still remains higher than the HP 2010 Objective.
- Sexually Transmitted Infections: The county's rate of reported Chlamydia infections in adolescent females has shown a significant decrease over time through 2006, although rising in 2007, and is significantly lower than the state's rate.
- Teen Births: The county's rate of births to teens ages 15-17 years has shown a significant decrease over time through 2006, although it rose again in 2007. The county's rate is not significantly different than the state's rate but has met the HP 2010 Objective.

Top ranked MCAH Priorities

1. Reduce the rate of Overweight Children and Youth
2. Reduce Perinatal Tobacco, Alcohol and Other Drug Use
- 3 A. Reduce Child Abuse and Neglect
- 3 B. Increase the number of Children and Adolescents who have Health Insurance
4. Reduce the Teen Birth rate
- 5 A. Increase the Breastfeeding rate
- 5 B. Reduce Adolescent Tobacco, Alcohol and Other Drug Use
- 6 A. Reduce Domestic Violence and Intimate Partner Violence
- 6 B. Improve Children's Oral Health and increase Children's Access to Dental Insurance
7. Reduce the rate of Sexually Transmitted Infections in Adolescents

Highlights of Capacity Assessment findings: The following Priority Capacity Needs were identified:

1. Work with stakeholders to identify what is needed to build sustainability into collaborations.
2. Build capacity within the county Health and Human Services Agency to collect and analyze data on consumer satisfaction on a regular basis.
- 3 A. Build capacity for data analysis and epidemiology.
- 3 B. Partner with countywide medical services and stakeholder organizations to broaden MCAH system.
4. Train existing staff to assess and respond to emerging MCAH issues with health education and public awareness campaigns.
5. Develop other sources of funding, i.e. grants, ARRA, etc.
6. Partner with local stakeholder groups to develop and expand services for families.
- 7 A. Build relationships with elected representatives to communicate MCAH priorities and funding needs.
- 7 B. Build capacity to develop primary data sources and to analyze primary and secondary data for biannual Community Health Status Report and other MCAH data needs.
- 7 C. Build collaboration between community resources and the Health and Human Services Agency (HHSA) to more adequately use outcome measures in program development and evaluation of effectiveness.

Emerging public health issues

Major public health issues of concern in Mendocino County continue to be access to health care, obesity and substance abuse. With state and local budget cuts looming, addressing these and other identified health priorities and capacity needs will continue to be challenging.

2. Mission Statement and Goals

At the Stakeholder Workshop on March 6, 2009, participants reviewed and recommended keeping the Mission Statement and Goals from the previous Five-Year MCAH Needs Assessment.

Mission Statement:

In partnership with the community, our mission is to safeguard and promote the health and wellness of the people of Mendocino County. For MCAH we do this by developing, preserving, promoting and improving services for women, children, adolescents and their families.

Goals:

1. All children born healthy to healthy mothers.
2. Equity of health status among racial/ethnic, age, gender, economic and regional groups.
3. A safe and healthy environment for women, children, adolescents and their families.
4. Equal access for all women, children, adolescents and their families to appropriate and needed care within an integrated and seamless system.

3. Planning Group and Process

The MCAH Director and Senior Public Health Analyst comprised the Planning Group, as they had done in the previous MCAH Five-Year Needs Assessment. The Planning Group met at least at least monthly from August 2008-June 2009 to plan and oversee the Needs Assessment process. The Senior Public Health Analyst collected and compiled the Health Indicator data and met with the MCAH Director to review the data analysis.

The Planning Group determined the process for gathering community input through Stakeholder Workshops in partnership with FIRST 5 Mendocino. At the beginning of the year, the MCAH Director made announcements or brief presentations at meetings of advisory boards, councils, and committees to notify community stakeholders regarding the MCAH Five-Year Needs Assessment process. Invitations and registration forms to attend the Stakeholder Workshops were emailed to over one hundred and forty community stakeholders representing a broad range of policy makers, community partners, health care providers, agencies and organizations.

One Stakeholder Workshop, with internal and external stakeholders, provided review and input on the MCAH Mission Statement, Goals, Community Health Profile, Health Indicator Data, and determination of MCAH Priorities for 2010-2014. Mendocino County Office of Education provided a conference room for this workshop.

The Capacity Assessment was done through one Internal Stakeholder Workshop and three External Stakeholder Workshops, as well as through several individual interviews with key stakeholders who were unable to attend the workshops. An outside stakeholder joined the Planning Group to assist in reviewing the SWOT and identifying Emerging Themes and Capacity Needs. A final Internal Stakeholder meeting of the Public Health Nursing Leadership Team was held to prioritize the Capacity Needs.

Overall, twenty internal (agency) stakeholders and twenty-six external stakeholders participated in the Needs Assessment. However, the lack of staff or time severely limited the ability to reach out to those who were unable to attend the Stakeholder Workshops, especially health care providers, Latinos and Native American representatives.

4. Community Health Profile

A. **The local MCAH Program** functions within the Nursing Services Division of Community Health Services (formerly Public Health Branch) of the Mendocino County Health and Human Services Agency (HHS). The MCAH Director serves as a Senior Program Manager and, in addition to the MCAH Program, oversees the Adolescent Family Life Program, Field Nursing, and Communicable Diseases and Immunizations.

B. **Within the larger MCAH “system”** in Mendocino County, the local MCAH Program functions as a community partner, collaborator and supporter through councils, coalitions and committees to identify and address MCAH needs, priorities and barriers. These include:

- **CalSAFE Interagency Partners**, a collaboration of agencies, consumers, providers and educators serving pregnant and parenting teens (including CalSAFE, AFLP and Cal-Learn) in order to assess needs, identify barriers, determine priorities, and develop strategies to address gaps in services and meet priorities.
- **Child Death Review Team (CDRT)**, a multi-agency group that reviews all deaths to children less than 18 years of age and provides a summary report annually.
- **Children’s Action Committee (CAC)**, a committee of the Mendocino County Policy Council on Children and Youth/Child Abuse Prevention Commission (PCCY/CAPC) that assists in providing leadership to prevent and respond to child abuse and neglect.
- **Children’s Health Committee**, a committee of PCCY/CAPC that addresses issues that impact the health of children and youth in Mendocino County.
- **Council on Domestic Violence**, with the mission to coordinate an effective response to domestic violence by the courts, criminal justice system, community service agencies, health care providers, and the community and to promote community awareness of the dynamics of domestic violence for the purpose of reducing the incidence in Mendocino County.
- **FIRST 5 Mendocino**, with nine members appointed by the County Board of Supervisors, provides Proposition 10 funding to local groups, organizations and agencies to address the needs of pregnant women and children 0-5 as identified in the Commission’s Strategic Plan.
- **Head Start (HS) Health Services Advisory Committee**, a collaborative of public agencies, HS staff, parents, and health professionals with the goal to help Head Start/Early Head Start programs set policies and procedures and identify resources within the community to meet the medical, dental, nutrition and mental health needs of children in these programs.
- **Healthy Kids Mendocino (HKM)** is a collaborative of the Health and Human Services Agency, FIRST 5 Mendocino, United Way, schools and other community partners whose goal is to achieve universal health insurance coverage for all children in Mendocino County.
- **Immunization Network of Northern California (INNC)**, a web-based regional immunization registry that is part of the California Statewide Immunization Information System (SIIS) plan to provide access to the statewide registry system throughout California. Mendocino County is an active participant in the network.
- **Mendocino County Breastfeeding Coalition** began in 2001 with the goal to promote and support breastfeeding in Mendocino County through education and outreach.
- **Mendocino County Child Care Planning Council** members are appointed by the County Board of Supervisors and County Superintendent of Schools to provide leadership in identifying child care and development needs, priorities and resources; promote accessible, affordable, quality child care services; collaborate and advocate for policy change and local capacity-building; and educate the community about child care and development issues.
- **The Family Resource Center Network** of Mendocino County includes Family Resource Center (FRC) organizations serving seven regions throughout the county: Action Network of Gualala, Anderson Valley FRC, Laytonville Healthy Start, Nuestra Alianza de Willits, Nuestra Casa FRC in Ukiah, Potter Valley Youth and Community Center, Safe Passage FRC (Fort Bragg), and The Arbor on Main (Ukiah, for 15-24 year olds)

- **Mendocino County Policy Council on Children and Youth/Child Abuse Prevention Commission (PCCY/CAPC)**, with members appointed by the County Board of Supervisors, serves as an interagency coordinating council to improve the quality of services to children, youth and their families and provides leadership, advocacy and coordination of community efforts related to the prevention of child abuse and neglect.
- **Partnership for Healthy Babies (PHB)**, a collaboration of public agencies, community-based organizations, health care providers, and interested public whose purpose is to address perinatal substance abuse and its effect on children. PHB's vision is "Mendocino County will be a community where every child is born free of the effects of alcohol, tobacco and other drugs and lives in a family that promotes healthy growth and development."
- **Raise&Shine**, a collaborative initiative of the Health and Human Services Agency, FIRST 5 Mendocino, mental health and pediatric health care providers, schools and community-based organizations that promotes early behavioral health education, intervention, screening, assessment and treatment for families of young children.
- **Ukiah Unified School District Health Advisory Council**, a collaborative of educators, school personnel, parents, community agencies and health professionals to advise the Ukiah Unified School district (UUSD), Board of Education, school administration and the community in the areas of school health policy, curriculum and services.

C. Sociodemographic Status

Population Demographics: The California Department of Finance estimated that Mendocino County had with a population of 90,509 in January 2007. The number of persons per square mile in Mendocino County was 24.6 compared to 217.2 statewide. The population of Mendocino County increased by 7% from 1990 to 2000, while California grew by 14%. Mendocino County's population is projected to be 93,166 in 2010, an increase of almost 8% from 2000 to 2010.

Age and race breakdowns for 2007 are shown in the following table:

AGE		RACE/ETHNICITY	
Age Group	Number (%)	Race	Number (%)
0-4 years	6,006 (6.5%)	White	65,275 (70.8%)
5-9 years	5,334 (5.8%)	Hispanic	18,255 (19.8%)
10-14 years	5,770 (6.3%)	Native American	5,347 (5.8%)
15-19 years	6,842 (7.4%)	Asian/Pacific Isl.	1,199 (1.3%)
20-44 years	28,568 (31%)	African-American	5,53 (0.06%)
45 + years	39,677 (43%)	Multi-race	2,028 (2.2%)

The Department of Finance age estimates for 2007 reveal that in Mendocino County

- 71% of the population is White/non-Hispanic, a decrease from 75% in 2000,
- 20% of the population is Hispanic, an increase from 16% in 2000,
- Spanish is the second most commonly spoken language in the county.
- Almost 6% of the population is Native American, an increase from 4% in 2000.

The Native American population is primarily from the indigenous Pomo tribes, with Mendocino County being home to 10 federally recognized Pomo tribes.

Socio-Economic Status: Mendocino County had an estimated \$39,705 median household income in 2006 compared to \$56,645 statewide. The Census 2006 estimated that in Mendocino County 19.3% of families with children below 18 years old were living below poverty level, and that 24.5% of children 0-17 were living in poverty compared with 18.1% statewide. The unemployment rates increased in 2007 to 6.4% for the County and 5.9% for the State. In 2008 they reached 8.7% for the County and 9.1% for the State. The majority of jobs in the County were found within the trade industry-wholesale and retail (19%), service industry (38%) and government (24%).

Education: From the 2005-2007 3-year estimate from the Department of Finance:

- 26% of Mendocino County residents 25 years and over reported high school graduation as their highest educational attainment,
- 18% had less than a 12th grade education compared to 20% statewide,
- 82% of residents reported having attained high school graduation or higher education compared to 80% statewide.

The four-year derived high school drop-out rates for Mendocino County was reported as 14.5% for school year 2006-07 compared to the State rate of 16.8%. This rate is an estimate of the percent of students who will drop out during a four-year period and is based on the drop-out rates of grades 9, 10, 11 and 12 in a school year.

D. Health Status

Births: The total number of births to Mendocino County residents varied from 1,125 in 2004 to 1,160 in 2008. The fertility rate, births per 1,000 women 15-44 years of age, was 66.7 in 2006 for Mendocino County, compared to the State rate of 71.3. For Mendocino County, the number of births to White women remained steady from 53.3% of all births in 2003 to 53% in 2008. The number of births to women of Hispanic ethnicity remained steady from 37.5% of all births in 2003 to 37.7% in 2008. Births to Native American women varied from 6.4% in 2003 to 7.8% in 2005 and 6.8% in 2008.

Child Deaths: Child deaths in Mendocino County are investigated by the Child Death Review Team. A report is produced each year on the summary of cause of death, location of death and other details of deaths to children 0-17 years old.

Child Deaths by Cause of Death & Age Group in Mendocino County

	2003	2004	2005	2006	2007	Total
Total #	23	14	12	18	5	72
# Natural	11	7	6	9	7	40
# Accidental	11	5	6	8	1	31
# Homicides	0	0	0	1	1	2
#Suicides	1	2	0	0	0	3
	2003	2004	2005	2006	2007	Total
Under 1 yr	9	8	7	10	2	36
1-4 years	2	0	3	3	0	8
5-9 years	0	1	0	0	0	1
10-14 years	6	2	1	2	0	11
15-17 years	6	3	1	3	3	16

The following summary can be seen from the above table:

- The number of deaths to children and youth between 0 and 17 years of age ranged from 23 in 2003 to 5 in 2007
- natural deaths account for 56% and accidental deaths for 43% of all child deaths between 2003 and 2007
- 3 suicides occurred to youth between 2003 and 2007
- 50% of all child deaths were to infants under 1 year of age

Infant Mortality

For the 3-year period 2004-2006, the infant death rates in Mendocino County were statistically higher than the State rate. However, the wide variation in county rates is due to the low actual numbers of infant deaths, from 7 deaths in 2002 to a high of 13 in 2008. Mendocino County had 19 infant deaths for the 2-year period 2007-2008.

E. Health Risk Factors

Homelessness

According to the 2007 Mendocino County Homeless Census and Survey, at any one point-in-time an estimated 1,422 homeless people are on the streets and in emergency shelters, transitional housing, permanent supportive housing, domestic violence shelters, voucher motels, hospitals, jails and rehabilitation facilities. Based on a comparison of survey results of homeless people interviewed in the 2005 and 2007 Census and Surveys, the following changes were noted:

- **Age** - About 23% of the people surveyed in 2007 were under 30 years of age compared to 33% in 2005.
- **Domestic Violence** - The percent of persons currently experiencing domestic violence or abuse increased from 3.3% to 11.9%.
- **Alcohol & Drug Abuse** - The percent of persons currently experiencing alcohol abuse increased from 19.9% to 34.6% and drug abuse from 22.4% to 28.6%.
- **Reason Turned Away** - The percent of persons turned away from shelter due to no available beds increased from 13.5% to 41.7%; those turned away due to drug/alcohol problems increased from 13.5% to 28.3%.

Hunger

Results in the 2007 California Health Interview Survey revealed that an estimated 38% of Mendocino County residents experienced food insecurity (cannot afford adequate food for their families on a consistent basis) compared to 35% statewide.

F. Access to Health and Social Services

Health Care Providers: In 2007, the approximate population-to-physician ratio in Mendocino County was 639 persons per physician and the population-to-dentist ratio was 1,462 persons per dentist. There is no Medi-Cal managed care in the county.

- The majority of health care providers practice in the inland Ukiah Valley where almost two-thirds of the population is located. Other pockets of health care providers are located in Fort Bragg /Mendocino on the north coast and Willits in the north county. Health care providers are also located in the smaller communities of Laytonville and Covelo in the north, Boonville in Anderson Valley, Redwood Valley and Potter Valley inland, and Gualala and Point Arena on the south coast. In Mendocino County in 2007, there were 142 licensed physicians including 32 in family practice, 20 in internal medicine, 13 in obstetrics/gynecology, and 10 in pediatrics.
- Besides private medical offices, primary health care services for women, children and adolescents are provided through 8 Federally Qualified Health Centers (FQHCs) and "look-alikes" and 10 Rural Health Clinics that are designated by the Federal Government to provide core primary care services to Medi-Cal and low income populations.
- Mendocino County HHS, Community Health Services provides birth control services and testing as well as treatment for sexually transmitted infections, including HIV testing in Ukiah and Willits. The agency also provides childhood and adult immunizations at its Ukiah, Willits and Fort Bragg offices.
- As of February 2009, there were 22 private provider offices or clinics throughout Mendocino County that provide Child Health and Disability Prevention (CHDP) services or well-child care for low-income children and adolescents.

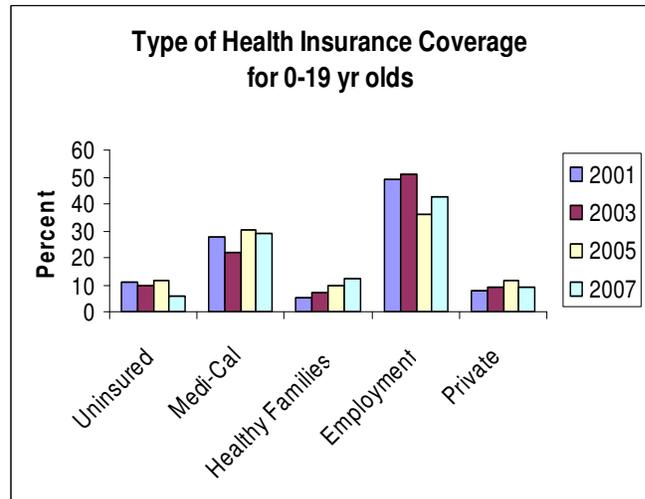
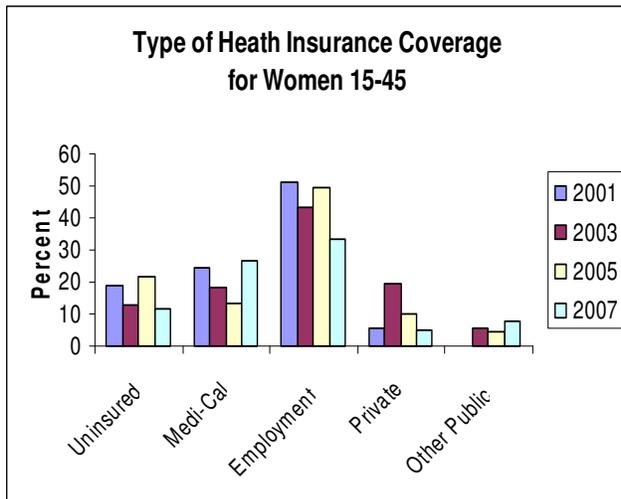
Specialty Health Care Services: Mendocino County residents frequently must look to the San Francisco Bay Area, for specialty health care. This is especially true for children whose care require pediatric specialists through California Children’s Services.

Hospitals: There are three small/rural acute care hospitals in Mendocino County: Ukiah Valley Medical Center in Ukiah and Mendocino Coast District Hospital in Fort Bragg with obstetric and emergency services and Frank R Howard Memorial Hospital in Willits with stand-by emergency services.

Perinatal Services: Obstetric care in Mendocino County is provided primarily in Ukiah and Fort Bragg, where hospital deliveries occur. Some health care providers, particularly those outside the Ukiah or Fort Bragg areas, provide prenatal services only and refer their clients to other providers for delivery services. There are four Comprehensive Perinatal Services Program¹ (CPSP) providers in the county. Two are large clinics (FQHCs), one with services in Ukiah and Willits, and the other in Fort Bragg, that provide women’s health services with Certified Nurse Midwives (CNM) and OB/GYN physicians. The other two CPSP providers are CNMs – one in Ukiah and one on the coast in Mendocino. There are seven other prenatal or perinatal providers in the county, including two OB-GYN physicians and three Family Practice physicians in Ukiah, and FQHCs in Laytonville and Gualala.

Dental Services: As of August 2008, dental services were provided by 45 private dental practices and 8 dental clinics (FQHCs or “look-alikes”) in Ukiah, Redwood Valley, Potter Valley, Willits, Laytonville, Covelo, Boonville, Fort Bragg, Pt. Arena and Gualala. Included in these dental clinics are 2 Indian Health Clinics in Redwood Valley and Covelo. All of the clinics accept Medi-Cal and Healthy Families Program Insurance, but only 2 private dentists in Willits accept Medi-Cal and 7 private dentists in the county accept Healthy Families. In January 2008, the Pediatric Dental Initiative’s dental surgery center in neighboring Sonoma County opened its doors, meeting a long-time regional need to provide a facility for dental surgery under general anesthesia to low-income young children or people with developmentally disabilities from Mendocino, Sonoma and Lake Counties.

Health Insurance: The following graphs display estimates from the 2007 California Health Interview Survey (CHIS 2007) that show patterns of health insurance coverage for women of child-bearing age and children & teens between 0 and 19 years of age.



¹ The Comprehensive Perinatal Services Program (CPSP) provides support services of nutrition, health education and psychosocial assessment and services to Medi-Cal eligible women in addition to their prenatal and postpartum medical care. Providers who wish to be certified as CPSP providers must apply to the California Department of Public Health through the Perinatal Services Coordinator at Mendocino County Health & Human Services Agency, Community Health Services.

It can be seen from the graphs that:

- For women between ages 15 and 45, employment-based and privately purchased insurance have dropped and Medi-Cal has enrollment increased between 2001 and 2007
- For children and teens ages 0-19, Healthy Families enrollment increased between 2001 and 2007
- For both populations, the percentage of uninsured has decreased. This may be due to the efforts of Healthy Kids Mendocino in enrolling children in subsidized health insurance.

From 2007 birth data, Medi-Cal paid for 65% of all births and private insurance paid for 30.4% of all births to Mendocino County residents. This breakdown for payment source for delivery is similar for the past 5 years.

The Rural Health Information Survey (RHIS) was conducted by the California Center for Rural Policy (CCRP) in 2006 in order to assess health disparities and utilization of health care among Mendocino, Humboldt, Trinity and Del Norte counties residents. According to this survey, 23% of Mendocino County respondents under age 65 were uninsured and more likely to be poor, unemployed or self-employed. Also, uninsured respondents or those with Medi-Cal were significantly more likely to report an inability to get needed health care or to have received recommended screening for breast cancer, cervical cancer, and diabetes compared to respondents with private insurance.

Social Services: According to the California Department of Social Services, in July 2007, the number of individuals in Mendocino County receiving public assistance (CalWORKS, General Relief, Welfare to Work and Food Stamps) was estimated as 9% of the population (about 7,884 people).

G. Other Indicators

Geographic Features: Mendocino County is 3510 square miles and is located in the north coastal region of the state, about 100 miles north of the San Francisco Bay Area. The Coastal Mountain Range forms a significant geographic barrier dividing the coastal and interior regions of the county. Almost two-thirds of Mendocino County's population of an estimated 90,500 people (US Census Bureau) lives in the central interior region that stretches along 40 miles of U.S. Highway 101 from Hopland in the south, through Ukiah, the county seat of government, to Willits in the north. Approximately one-third of the population is situated west of the mountains, along the Mendocino coast that stretches 129 miles from Gualala in the south to Westport in the north, and includes Fort Bragg, the largest community and business center for the coastal area. Fort Bragg is a one and one half hour drive from Ukiah along a narrow winding road.

Transportation: Transportation in Mendocino County continues to be the most frequently sited barrier to accessing services such as health care and human services, employment or child care. Mendocino is served by a public transit system, the Mendocino Transit Authority (MTA) which provides services throughout the county. The cities with the largest populations (Ukiah, Ft. Bragg and Willits) are more intensively served by public transportation. Many of the bus routes connecting less populated communities to the county's major service areas only travel one round-trip per day, picking up passengers early in the morning but not returning until late in the day. This makes bus travel for many families not feasible due to loss of a day's work or difficulty in traveling when ill or with young children.

5. Local MCAH Problems/Needs

The local MCAH Problems/Needs were identified from the top ten priorities from the previous Five-Year MCAH Needs Assessment, as well as from current Health Status Indicators (see Appendix B) in which Mendocino County was significantly worse than the State or the Healthy People Year 2010 Objectives.

A. Adolescent Tobacco, Alcohol and Other Drug Use

Alcohol & Other Drug Use and Attitudes about Use Students in Mendocino County²

Mendocino County Student Respondents	Grade 7	Grade 9	Grade 11	Continuation /Community School
Any Alcohol/Other Drug Use, Past 30 Days	22%	43%	61%	85%
Alcohol Use, Past 30 Days	18%	40%	56%	78%
Perceived Harm of Frequent Alcohol Use	71%	62%	65%	49%
Perceived Harm of Frequent Marijuana Use	78%	64%	54%	34%
Tobacco Use, Past 30 Days	5%	10%	20%	55%
Perceived Harm of Frequent Tobacco Use	87%	84%	87%	77%

This survey data gives an indication of the challenges faced in addressing adolescent substance use. Adolescent alcohol, tobacco and other drug use, including marijuana and methamphetamine, continues to be a major issue of concern throughout Mendocino County.

B. Breastfeeding

- Mendocino County has a significantly higher percentage of women who plan to exclusively breastfeed their infants compared to the state, and the county's rate has significantly increased over time³.
 - The percent of mothers who indicated exclusive breastfeeding of their newborn infants at hospital discharge for Mendocino County was 64.5% in 2002, increasing to 71.9% in 2004 and 75.5% in 2007 while the state's rate was 42.6% in 2002, 41.5% in 2004 and 42.7% in 2007.
 - Within Mendocino County, a higher percentage of women delivering inland at Ukiah Valley Medical Center, 92.1%, indicated a desire to exclusively breastfeed in 2007 compared with 72% of the women delivering at the Mendocino Coast District Hospital.
- The Loving Support Breastfeeding Program (LSBP), a collaborative project of Mendocino County Department of Public Health and Ukiah Valley Medical Center funded by FIRST 5 Mendocino to increase breastfeeding support, collected data from participants on how long they breastfed and reasons for stopping.
 - From 7/1/06-12/31/07, 312 mothers received LSBP support. Of those, 34% exclusively breastfed for at least 3 months and 20% exclusively breastfed for at least 6 months, while 47% did any amount of breastfeeding for at least 3 months and 27% did any amount of breastfeeding for at least 6 months.
- The LSBP data compares with a 2007 CDC survey of births from 2004 which found 39% of Californians breastfed exclusively through 3 months and 17% exclusively breastfed through 6 months.

Although a very high percentage of women in Mendocino County indicate their intent to exclusively breastfeed at the time of their child's birth, what little data we have on longevity shows a sharp decrease in those who continue exclusive breastfeeding for at least 3 months. This shows the need for breastfeeding support.

² Source: 2005-2007 compiled responses from the California Healthy Kids Survey

³ Data from the Newborn Screening Test Form

C. Child Abuse and Neglect

- In 2006, 1,888 children were reported to the County's Child Protective Services for suspected child abuse or neglect, down 23% from 2005. Of these referrals, 30.2% (572) were substantiated, which was an increase from the 28.3% in 2005. Of those that were substantiated, 77.2% were for general neglect, 7% were for physical abuse, 6 % were for emotional abuse, 4% were for caretaker absence and 2.3% were for sexual abuse.
- The number of Mendocino County children in foster care increased from 293 in 2005 to 314 in 2007. The rate per 1,000 children and youth ages 0-17 years in foster care in Mendocino County decreased from 16.5 in 2000 to 13.9 in 2005, but then increased to 14.6 in 2007. The county's rate continues to be significantly higher than the state's rate which steadily declined from 10.9 in 2000 to 7.3 in 2007.
- Child Abuse and Neglect continues to be a major concern of health and human services providers, educators and community members in Mendocino County who identify alcohol and other drug abuse as a major contributing factor. The current economic downturn is also adding additional stress to families.

D. Domestic Violence/Intimate Partner Violence

Experts agree that incidents of domestic violence are vastly under-reported.

- Mendocino County's rate of Domestic Violence-Related Calls for Assistance per 1,000 population decreased from 8.59 in 2000 to 6.39 in 2006, while remaining higher than the state's rates of 5.77 to 4.72 during the same time period.
- During 2006, law enforcement agencies in the county received 578 of these calls with almost half involving a weapon (including hands or fists).
- The number of arrests for spousal abuse in Mendocino County decreased from 184 in 2002 to 160 in 2005, and then increased to 169 in 2006.

E. Health Insurance for Children and Adolescents

Health Insurance for Children and Adolescents as a way to improve access to health care continues to be a community priority in Mendocino County.

- According to California Health Interview Survey (CHIS) data, in 2001 89.3 % of children and adolescents ages 0-19 years in Mendocino and Lake Counties had health insurance compared to 89.1% statewide. In 2005 the percent for Mendocino and Lake Counties decreased to 88.2% while the state rate increased to 91.8%. In 2007, Mendocino County data showed an increase to 94.1% while the state's rate increased to 92.4%.

Healthy Kids Mendocino (HKM), a local children's health initiative launched in May of 2006, is working to achieve the vision of health insurance for all children in Mendocino County. HKM provides an extensive outreach network of advocates and partners at schools, clinics, businesses and community centers across the county to identify and enroll children into one of three health insurance programs: Medi-Cal, Healthy Families, or CalKids. CalKids provides primary care coverage to those families under 300% of the Federal Poverty Level who don't qualify for Medi-Cal or Healthy Families.

- Original founders of HKM include the Mendocino County Health and Human Services Agency (Public Health Branch), FIRST 5 Mendocino, and the Alliance for Rural Community Health. Additional core partners include the Employment and Family Assistance Division of HHS and the Mendocino County Office of Education.
- HKM estimates that since the inception of this project, the percent of uninsured children in the county has been cut in half from about 16% in 2005 to 8% in 2007.
- As of December 2008, 12,820 children in the county (48% of the entire county's population of children) were enrolled in one of these three health insurance programs:
 - 9,987 children were enrolled in Medi-Cal

- 2,446 children were enrolled in Healthy Families
- 387 children were enrolled in CalKids
- In 2008 HKM supported the enrollment and retention of over 1,100 children into a health insurance program.
- HKM has 18 active partners throughout the county, 15 are enrollment sites and an additional 3 partners provide outreach support.

F. Low Birth Weight

The percent of Low Birth Weight (LBW) births in Mendocino County showed an increase from 5.4% of all births in 2003 to 7.5% in 2006 before decreasing to 6% in 2007. A preliminary review of 2008 county birth data shows a slight increase to 6.2%, remaining higher than the Healthy People 2010 Objective of 5%.

- The actual number of LBW births was 83 in 2006, 67 in 2007 and 72 in 2008.

According to 2006 county birth data:

- The following women had LBW births:
 - 17.2% of teens ages 15-17 and 11.4% of teens ages 18-19.
 - 8.4% of Hispanic women compared to 6.6% of White women.
 - 9% of women for whom this was their first live birth.
 - 39.6% of preterm births compared to 2.7% for term or post-term births.
 - 3.5% of women who received “adequate” prenatal care⁴ compared to 13.6% of women who received “inadequate” or “intermediate” prenatal care.
- There was no correlation between LBW births and trimester prenatal care began.

According to 2007 county birth data:

- There was no correlation between LBW births and teen births, race/ethnicity of the mother, or trimester prenatal care began.
- 42.6% of preterm births were LBW, compared to 2% for term or post-term births.
- Women who received “inadequate” or “intermediate” prenatal care⁵ had a LBW rate of 10.7%.

G. Oral Health in Children including Access to Dental Insurance

- According to California Health Interview Survey (CHIS) data, in 2001 76.4% of children ages 2-11 years in Mendocino and Lake Counties had dental insurance compared to 82.2% statewide. In 2005 the percent for Mendocino and Lake Counties decreased to 73.2% while the state rate was 82.7%. In 2007, Mendocino County data showed a slight increase to 74.6% while the state’s rate increased to 83.4%.
- In addition, CHIS data showed that 69.4% of children ages 2-11 years had been to a dentist in the past year compared to 73.7% statewide. In 2005 the percent for Mendocino and Lake Counties increased to 77.5% while the state rate increased to 79.6%. In 2007, Mendocino County data showed a slight decrease to 76.9% while the state’s rate continued to increase to 81.5%.

California’s decision to discontinue Denti-Cal coverage for non-pregnant adults as of July 1, 2009 is expected to have profound impact on access to dental care for children and pregnant women as an unintended consequence. In Mendocino County, the major sources of dental care for Medi-Cal eligible children are Federally-Qualified Health Centers and “look-alikes”. With the decrease in Denti-Cal reimbursable services to low-income adults, it is anticipated that many of the clinics will not be able to afford to keep their dental services at all and thus low-income children will lose access to dental care.

⁴ Using the Adequacy of Prenatal Care Utilization or “Kotelchuck” Index

⁵ Using the Adequacy of Prenatal Care Utilization or “Kotelchuck” Index

H. Overweight Children and Youth

- The percent of children less than age 5 who are overweight⁶ in Mendocino County decreased from 16.6 in 2002 to 11.6 in 2006, but increased to 13 in 2007 and was 12.3 in 2008. These were lower than the state's rates of 16.2 in 2002 and 15.5 in 2007 and 2008. However, the percent of children ages 5-19 who are overweight in the county increased from 20.4 in 2002 to 22.5 in 2006, 23.9 in 2007 and 25.9 in 2008, while the state's rates went from 20.8 in 2002 to 22.8 in 2008.
- According to California Physical Fitness Test data for 2006, 30% of 5th, 7th and 9th graders in Mendocino County were "overweight"⁷ compared to 33% statewide. In 2004, 28% of students tested in the county were overweight, with 24% of girls and 31.9% of boys overweight.
- According to the California Health Interview Survey (CHIS) 2007, the percentage of adolescents ages 12-19 in Mendocino County who were overweight⁸ was 29.1%.

I. Perinatal Tobacco, Alcohol and Other Drug Use

In July 2006, some prenatal providers in Mendocino County began implementing a system of screening, field assessment, Brief Intervention and referral using the *4 P's Plus* © Screen for Substance Abuse and Domestic Violence in Pregnancy. As of June 2009, six prenatal provider practices were using this screening and intervention tool.

4 P's Plus © data⁹ for Mendocino County and California shows that:

- In the month before they knew they were pregnant, the percent of women in the county using:
 - Alcohol, Tobacco or Marijuana was 50.6% compared to 23.7% for California.
 - Alcohol was 33.4% compared to 16.1% for CA.
 - Tobacco was 27% compared to 12.8% for CA.
 - Marijuana was 19.7% compared to 6.6% for CA.
- After they knew they were pregnant, the percent of women in the county using:
 - Alcohol, Tobacco or Marijuana decreased from 50.6% to 21.8%.
 - Alcohol decreased from 33.4% to 13.3%.
 - Tobacco decreased from 27% to 5.8%.
 - Marijuana decreased from 19.7% to 8.2%.
- In Mendocino County, in the month before they knew they were pregnant::
 - 67.9% of Caucasian women used Alcohol, Tobacco or Marijuana, decreasing to 28.5% after they knew they were pregnant.
 - 21.3% of Hispanic women used Alcohol, Tobacco or Marijuana, decreasing to 12.9% after they knew they were pregnant.
 - 45% of Caucasian women used Alcohol, decreasing to 16.8% after they knew they were pregnant.
 - 17.2% of Hispanic women used Alcohol decreasing to 10.7% after they knew they were pregnant.

In Mendocino County, Caucasian women were more likely to use alcohol, tobacco or marijuana than Hispanic women before and after knowledge of pregnancy.

⁶ Source: Pediatric Surveillance System from CHDP health assessments. Overweight is defined as \geq the 95th percentile based on height and weight measures.

⁷ Overweight children are defined as students who are not in the Healthy Fitness Zone for Body Composition.

⁸ Based on 2000 CDC growth chart percentiles for BMI-for-age at 85th - < 95th percentile.

⁹ Mendocino County data collected from 1050 women in prenatal care from July 2006-December 2008. California data collected from 78,951 women in prenatal care from 16 California counties 2001-2007 and reported in "Perinatal Substance Use Screening in California" by Ira Chasnoff, MD, et al.

Although the data is not available for Mendocino County, California data¹⁰ showed that private pay women had a significantly lower rate of tobacco use, but a significantly higher rate of alcohol use in pregnancy than Medi-Cal funded women. After realizing they were pregnant, by the time of the first prenatal visit, significantly more women with private insurance were continuing to consume alcohol than were women with Medi-Cal or no coverage.

J. Prenatal Care

Adequate¹¹ Prenatal Care

The proportion of women with “adequate” prenatal care continues to make significant improvement in Mendocino County while still remaining significantly worse than both the Healthy People 2010 objective of 90% and the state rate. The percentage of women receiving “adequate” prenatal care in the county has increased from 59.6% in 1999 to 70.3% in 2006, while the state’s rate was 77.6% in 2006.

According to 2006 county birth data:

- The following women had “adequate” prenatal care:
 - 59.6% of women with Medi-Cal as the source of payment for delivery compared to 70.5% for women with private insurance.
 - 53.8% of women ages 18-19, 57.4% of women 20-24, 62.1% of teens 15-17 and 68.6% of women 25 and older.
 - 66.8% of Hispanic women and 65.8% of White women compared to only 35.1% of Native American women.
- Women who received “adequate” prenatal care had a LBW rate of only 3.5%, whereas women who received “inadequate” or “intermediate” prenatal care had a LBW rate of 13.6%.
- Generally, women for whom this was a first or second live birth received “adequate” prenatal care at a higher percent than women who had had three or more live births.

First Trimester Prenatal Care

First trimester entry into prenatal care for Mendocino County pregnant women continues to be one of the lowest rates in the state, but is improving. Although still significantly worse than the state and the Healthy People (HP) 2010 objective of 90%, the percentage of women receiving first trimester prenatal care in the county has increased from 56.1% in 1999 to 67.6% in 2007. A preliminary review of 2008 county birth data shows a further increase to 69.6%.

According to 2007 county birth data:

- The following women entered prenatal care in the first trimester:
 - 49.2% of teens ≤ 19 years of age, compared to 65.3% of women 20-24 and 71.9% of women 25 and older.
 - 44.1% of Native American women, compared to 67.7% of White women and 71.1% of Hispanic women.
 - 62.6% of women with Medi-Cal as the source of payment for delivery, compared to 80.1% of women with private insurance.
- The higher the woman’s educational attainment, the more likely that she entered prenatal care in the first trimester (<high school = 54.1%, high school graduate or some college = 68.6%, Bachelor’s degree or higher = 79.3%)

¹⁰ *4 P’s Plus* © data on 17,898 women reported in “Perinatal Substance Use Screening in California” by Ira Chasnoff, MD, et al.

¹¹ Using the Adequacy of Prenatal Care Utilization or “Kotelchuck” Index

K. Preterm Births

There was an increase in the percent of preterm births in Mendocino County from 9.8% in 2003 to 12.7% in 2006 before decreasing to 9.4% in 2007. A preliminary review of 2008 county birth data shows a further decrease to 8.6%. The county's rate was not significantly different than the state's rate of 11% in 2006, but it continues to be higher than the Healthy People 2010 objective of 7.6%.

- The actual number of preterm births was 139 in 2006, 108 in 2007 and 100 in 2008.

According to 2006 county birth data:

- The following women had preterm births:
 - 27.6% of teens ages 15-17, 17.7% of teens ages 18-19, 13.7% of women ages 20-24, and 11.4% of women ages 25 and older, showing a correlation with age.
 - 15% of Hispanic women, 15.6% of Native American women and 11.3% of White women
 - 68.7% of LBW births compared to 8.5% of normal weight births.
 - 19.7% of women who received inadequate or intermediate prenatal care compared to a 9.2% of women with "adequate" or better prenatal care¹².
- There was no correlation between preterm births and trimester prenatal care began or whether this was the first or subsequent live birth for the mother.

L. Sexually Transmitted Infections in Adolescents

Chlamydia is the most frequently reported sexually transmitted infection in Mendocino County, and is considered to be the most common cause of infertility in women. The rate per 1,000 females ages 15-19 in the county declined from 17.97 in 2002 to 13.05 in 2006, but then rose to 16.34 in 2007. However, the county's rate continues to be significantly lower than the state's rate which was 23.09 in 2002 and 21.86 in 2007.

M. Teen Births

- Mendocino County's birth rate to teens ages 15-17¹³ has decreased significantly from its peak of 44.9 in 1995 to 26.6 in 1999 and 14.4 in 2006 and has not been significantly different than the state's rate, which was 20 in 2006. In 2007 the county saw an increase in this rate to 20.3, while a preliminary review of 2008 data shows a decrease in the rate to 19.
- These county teen birth rates translate to 29 actual births in 2006, 40 in 2007 and 35 in 2008 in Mendocino County.
- Although the actual number of teen pregnancies is not known (because California does not collect data on pregnancy terminations other than those Medi-Cal funded), Mendocino County's teen birth rate is significantly better than the Healthy People (HP) Year 2010 objective of 43 pregnancies per 1,000 females aged 15-17.
- The number of county teens under age 15 who give birth is too small (less than 5) to determine a reliable birth rate.

A review of 2007 county birth data for teens ages 17 years or younger shows that:

- 34.1% of the teen births (fourteen) occurred to Ukiah residents.
- 17% of the teen births (seven) occurred to Willits residents.
- 14.6% of the teen births (six) occurred to Fort Bragg residents.
- 56.4% of the teen births (twenty-two) were to Hispanic women.
- 35.9% of the teen births (fourteen) were to White women.
- 41.2% of the teen births were to fathers who were ≥ 20 years of age.

¹² Using the Adequacy of Prenatal Care Utilization or "Kotelchuck" Index

¹³ Rates are per 1,000 females aged 15-17 years

6. MCAH Priorities

Mendocino County used a process that updated the list of MCAH Priorities identified at the last Needs Assessment five years ago. The County Office of Education provided a meeting room for a Stakeholder Workshop on March 6, 2009 and FIRST 5 Mendocino provided food and beverages for attendees. Twenty-two people participated, half of whom were internal stakeholders (Health & Human Services Agency, Community Health Services) and half were external stakeholders, representing public agencies, schools, community-based organizations, health care providers, FIRST 5 Mendocino, family resource centers and consumers. The process for identifying MCAH Priorities included:

- A. A review of the top ten MCAH Problems/Needs prioritized in the previous Five-Year Needs Assessment and progress toward addressing five of them from 2005-2009.
- B. A handout of the updated Community Health Profile.
- C. A handout of County and State data on the twenty-seven State-mandated Health Indicators as well as additional local data on perinatal substance abuse, adolescent substance abuse and breastfeeding.
- D. A more in-depth review and discussion of MCAH Indicator Data, including trends, for the previous top ten MCAH priorities as well as four of the other Health Indicators that showed current problems or needs.
- E. Stakeholders were invited to add any additional MCAH problems/needs to the list of priorities.
- F. A total of fifteen MCAH problems/needs were identified to prioritize:
 - Child Abuse/Neglect
 - Overweight Children/Youth
 - Sexually Transmitted Infections in Adolescents
 - Oral Health in Children/including Access to Dental Insurance
 - Perinatal Tobacco, Alcohol and other Drug Use
 - Adolescent Tobacco, Alcohol and other Drug Use
 - Health Insurance for Children and Adolescents
 - Domestic Violence/Intimate Partner Violence
 - Preterm Births
 - First Trimester/Adequate Prenatal Care
 - Teen Births
 - Low Birth Weight
 - Breastfeeding
 - Motor Vehicle Accident Injuries – Youth
 - Children Living in Poverty
- G. Each Stakeholder was given five colored “dots” and instructed to put only one dot per priority on their top five priorities.
- H. The number of dots was tallied for each priority and the ten with the highest number were listed in order as the top MCAH Priorities for the next five years. Due to tied votes, our list identifies **seven levels of priority for ten MCAH issues.**

- Priority 1. Reduce the rate of Overweight Children and Youth
Priority 2. Reduce Perinatal Tobacco, Alcohol and Other Drug Use
Priority 3 A. Reduce Child Abuse and Neglect
Priority 3 B. Increase the number of Children and Adolescents who have Health Insurance
Priority 4. Reduce the Teen Birth rate
Priority 5 A. Increase the Breastfeeding rate
Priority 5 B. Reduce Adolescent Tobacco, Alcohol and Other Drug Use
Priority 6 A. Reduce Domestic Violence and Intimate Partner Violence
Priority 6 B. Improve Children’s Oral Health and increase Children’s Access to Dental Insurance
Priority 7. Reduce the rate of Sexually Transmitted in Adolescents

7. MCAH Capacity Needs

Stakeholder Input:

The Planning Team convened four Stakeholder Workshops to do the Capacity Assessment using a tool required by the State called the “m-CAST-5.” This is an assessment tool modified from the “Capacity Assessment for State Title V” by the California Department of Public Health’s MCAH Division for use by counties for their MCAH Needs Assessment. This tool assists in examining the organizational capacity of the broad-based MCAH “system” (which includes the local MCAH program as well as all other organizations that serve MCAH populations in the county) to carry out the **Ten Essential Public Health Services to Promote Maternal and Child Health**¹⁴ which are as follows:

- 1) Assess and monitor maternal and child health status to identify and address problems.
- 2) Diagnose and investigate health problems and health hazards affecting women, children, and youth.
- 3) Inform and educate the public and families about maternal and child health issues.
- 4) Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.
- 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.
- 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.
- 7) Link women, children, and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.
- 8) Assure the capacity and competency of the public health and personal health workforce to effectively address maternal and child health needs.
- 9) Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal and child health services.
- 10) Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related problems.

The first Workshop on January 21, 2009 was with internal stakeholders. Ten Program Managers and Supervisors within the agency’s Community Health Services Branch participated and all ten of the Essential Services were addressed. Attendees put their comments on papers that were then posted onto a “sticky wall” that was divided into the ten Essential Services. After the Workshop, the Senior PH Analyst recorded all of the comments into the m-CAST-5 forms.

For the External Stakeholder Workshops, the Essential Services were grouped in a way that would make it easier for stakeholders to identify which workshop(s) to attend. FIRST 5 Mendocino partnered with MCAH to provide food and beverages for the attendees. The MCAH Director facilitated the workshops and the Senior PH Analyst entered comments using a laptop and projector. MCAH staff used a tape recorder in case it was needed to identify all the comments.

- March 26, 2009 addressed Essential Services #1, 2, 9 and 10 (8 attendees)
- April 30, 2009 addressed Essential Services #3, 4 and 7 (13 attendees)
- May 11, 2009 addressed Essential Services # 5, 6 and 8 (3 attendees)

About seventeen different agencies or organizations were represented. The Senior Public Health Analyst also met individually with three internal stakeholders and two external stakeholders who were unable to attend the Workshops, in order to obtain their input for the Capacity Assessment.

¹⁴ Grason, H. and Guyyer, B., 1995. *Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America*. Baltimore, MD: Child and Adolescent Health Policy Center, the Johns Hopkins University.

Major Emerging Themes and Capacity Needs:

An outside stakeholder joined the Planning Group to assist in reviewing the m-CAST-5 data and SWOT and identifying overarching Emerging Themes and Capacity Needs as follows.

A. Theme: Lack of financial resources to assess and address identified problems

Capacity Needs:

1. Develop other sources of funding, i.e. grants or ARRA
2. Build relationships with elected representatives to communicate MCAH priorities and funding needs
3. Build capacity of staff to present data that identifies MCAH priorities and service needs
4. Partner with countywide medical services and stakeholder organizations to broaden MCAH system
5. Partner with local stakeholder groups to develop and expand services for families

B. Theme: Lack of staff resources to address essential services

Capacity Needs:

6. Develop strategies to fund, recruit, and hire qualified staff to assess and address priority MCAH needs
7. Train existing staff to assess and respond to emerging MCAH issues with health education and public awareness campaigns
8. Collaborate with colleges and universities to build resources for staff training & development

C. Theme: Inadequate resources for data analysis

Capacity Needs:

9. Build capacity for data analysis and epidemiology:
 - Train existing staff to fill in gaps left by retiring staff during the budget crisis.
 - Hire experienced data analyst or epidemiologist post crisis.
10. Collaborate with hospitals and clinics to develop sharable data sources.
11. Build capacity to develop primary data sources and to analyze primary and secondary data for biannual Community Health Status Report and other MCAH data needs

D. Theme: Lack of adequate bilingual, bicultural resources

Capacity Needs:

12. Develop opportunities on work time for existing bilingual staff to receive further education in order to advance in their public health positions

E. Theme: Limits to building and sustaining collaborations

Capacity Needs:

13. Expand capacity of staff to participate in collaborative work within MCAH system
14. Build skills in group facilitation and group process
15. Work with stakeholders to identify what is needed to build sustainability into collaborations

F. Theme: Lack of resources for program development, evaluation and research

Capacity Needs:

16. Collaboration between community resources and the HHSA to more adequately use outcome measures in program development and evaluation of effectiveness.
17. Build capacity within HHSA to collect and analyze data on consumer satisfaction on a regular basis
18. Build capacity in HHSA to conduct program evaluation:

- Train HHSA staff in program development and evaluation
- Develop capacity for local, trained evaluators within the HHSA and in the community

G. Theme: Policy issues that increase barriers to serving the MCAH population

Capacity Needs:

19. Identify barriers and increase efforts to support the use of the IZ Registry in all medical providers, clinics and schools in the county.
20. Increase insurance coverage to low income families by increasing use of Express Lane Eligibility in all schools countywide (e.g. through use of Free & Reduced Lunch program)

H. Theme: Limitations to developing and disseminating information

Capacity Needs:

21. Continue to support the development and funding of the 211 line for human services resource & referral
22. Develop data sources and data summaries for popularly requested information on the Public Health website for the general public

Prioritization of Capacity Needs:

A final Internal Stakeholder meeting of the Public Health Nursing Leadership Team was held and nine participants prioritized the Capacity Needs. Due to tied votes, our list identifies seven levels of priority for ten Capacity Needs.

The following Priority Capacity Needs were identified:

1. Work with stakeholders to identify what is needed to build sustainability into collaborations.
2. Build capacity within the county Health and Human Services Agency to collect and analyze data on consumer satisfaction on a regular basis.
- 3 A. Build capacity for data analysis and epidemiology.
- 3 B. Partner with countywide medical services and stakeholder organizations to broaden MCAH system.
4. Train existing staff to assess and respond to emerging MCAH issues with health education and public awareness campaigns.
5. Develop other sources of funding, i.e. grants, ARRA, etc.
6. Partner with local stakeholder groups to develop and expand services for families.
- 7 A. Build relationships with elected representatives to communicate MCAH priorities and funding needs.
- 7 B. Build capacity to develop primary data sources and to analyze primary and secondary data for biannual Community Health Status Report and other MCAH data needs.
- 7 C. Build collaboration between community resources and the Health and Human Services Agency (HHSA) to more adequately use outcome measures in program development and evaluation of effectiveness.

Priority Capacity Needs and Analysis

MCAH Jurisdiction: MENDOCINO 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>1. Work with stakeholders to identify what is needed to build sustainability into collaborations.</p>	<ul style="list-style-type: none"> • Build and expand local partnerships to leverage resources 	<ul style="list-style-type: none"> • Potential state and county budget cuts will decrease staffing levels for local MCAH program, County Health & Human Services Agency and community partners • Grants usually do not fund sustainability of programs/services • Competition for grant funds will increase, making it more difficult for small, rural counties to acquire funds • Staff will have less time for collaborations if they need to be more involved in direct client care 	<ul style="list-style-type: none"> • Identify funding sources for sustaining effective programs/services • Increase state and federal funding for MCAH
<p>2. Build capacity within HHSA to collect and analyze data on consumer satisfaction on a regular basis.</p>	<ul style="list-style-type: none"> • Build skill and capacity of HHSA staff to assess consumer satisfaction 	<ul style="list-style-type: none"> • Potential state and county budget cuts will decrease staffing levels for County Health & Human Services Agency • Health resources and health status will deteriorate in the face of major funding cuts 	<ul style="list-style-type: none"> • Identify local and state resources including materials and personnel
<p>3 A. Build capacity for data analysis and epidemiology.</p>	<ul style="list-style-type: none"> • Identify resources to train in-house HHSA staff in data analysis to fill in gaps • Hire experienced HHSA data analyst or epidemiologist post budget crisis 	<ul style="list-style-type: none"> • Potential state and county budget cuts will decrease staffing levels for County Health & Human Services Agency (HHSA) 	<ul style="list-style-type: none"> • Increase state and federal funding for MCAH • Increase state/federal funding for the Family Health Outcomes Project as resource to local MCAH programs • Seek grant funding for data analysis and epidemiology resources • Identify regional resources for epidemiology

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 B. Partner with countywide medical services and stakeholder organizations to broaden MCAH system.	<ul style="list-style-type: none"> • Build and expand collaborative relationships with local hospitals, health providers and MCAH stakeholders • Create a forum to identify, discuss and address existing and emerging MCAH issues 	<ul style="list-style-type: none"> • Potential state and county budget cuts will decrease staffing levels for County HHSA and community partners 	<ul style="list-style-type: none"> • Increase state and federal funding for collaborative work to address MCAH needs and priorities • Provide adequate state and federal funding to cover the cost of health services
4. Train existing staff to assess and respond to emerging MCAH issues with health education and public awareness campaigns.	<ul style="list-style-type: none"> • Build skill and capacity of HHSA staff to use evidence-based methods to create effective health education and public awareness campaigns • Partner with local stakeholders to develop health education and public awareness campaigns 	<ul style="list-style-type: none"> • Potential state and county budget cuts will decrease staffing levels for County HHSA and community partners • Population-based campaigns are time consuming and difficult to evaluate effectiveness and may not be a priority for funding 	<ul style="list-style-type: none"> • Identify local and state resources, including materials and personnel, for effective social marketing training and public awareness campaigns • Increase state and federal funding for MCAH • Seek grant funding for public awareness campaigns
5. Develop other sources of funding, i.e. grants, ARRA, etc.	<ul style="list-style-type: none"> • Develop/expand in-house capacity for grant writing as well as identifying local expertise • Develop/expand process to collaborate with other stakeholders to identify and share information on funding opportunities 	<ul style="list-style-type: none"> • Potential state and county budget cuts will decrease staffing levels for County HHSA and community partners • Competition for grant funds will increase, making it more difficult for small, rural counties to acquire funds 	<ul style="list-style-type: none"> • Identify funding sources to address MCAH Priorities and Capacity Needs • Identify grant writing training opportunities
6. Partner with local stakeholder groups to develop and expand services for families.	<ul style="list-style-type: none"> • Develop/expand in-house capacity as well as collaborate with local stakeholders to research best practices to address MCAH needs and priorities • Building on existing collaboratives, work with stakeholders to develop and expand services to families 	<ul style="list-style-type: none"> • Potential state and county budget cuts will decrease staffing levels for County HHSA and community partners • Competition for grant funds will increase, making it more difficult for small, rural counties to acquire funds 	<ul style="list-style-type: none"> • Identify funding sources to address MCAH Priorities • Increase state and federal funding for 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
7 A. Build relationships with elected representatives to communicate MCAH priorities and funding needs.	<ul style="list-style-type: none"> • Increase capacity to educate and inform elected officials regarding MCAH population priorities and needs • Build on existing collaboratives to communicate MCAH priorities and needs to elected officials 	<ul style="list-style-type: none"> • Potential state and county budget cuts will decrease staffing levels for County HHSA and community partners • Elected officials will have larger interests than MCAH 	<ul style="list-style-type: none"> • Local organizations and agencies can share opportunities to communicate MCAH priorities and funding needs with elected officials
7 B. Build capacity to develop primary data sources and to analyze primary and secondary data for biannual Community Health Status Report and other MCAH data needs.	<ul style="list-style-type: none"> • Train in-house HHSA staff in data analysis to fill in gaps • Hire experienced HHSA data analyst or epidemiologist post budget crisis 	<ul style="list-style-type: none"> • Potential state and county budget cuts will decrease staffing levels for County HHSA • Pending retirement of experienced staff will impact ability to continue to provide data development and analysis 	<ul style="list-style-type: none"> • Increase state and federal funding for MCAH • Seek grant funding for data analysis and epidemiology resources
7 C. Build collaboration between community resources and the Health and Human Services Agency (HHSA) to more adequately use outcome measures in program development and evaluation of effectiveness.	<ul style="list-style-type: none"> • Build capacity of HHSA staff and community stakeholders to use outcome measures in program development and evaluation • Collaborate with local stakeholders on trainings and resources for program planning and outcome evaluation 	<ul style="list-style-type: none"> • Potential state and county budget cuts will decrease staffing levels for County HHSA and community partners 	<ul style="list-style-type: none"> • Increase state and federal funding for MCAH • Identify funding opportunities for local trainings on program planning and outcome evaluation