California Department of Public Health/Maternal, Child, and Adolescent Health
Fiscal Year 2019-20 Annual Report

Agency: Santa Barbara County Public Health Department
Agreement Number: 201942 **Fiscal Year:** 2019-20

All Local Health Jurisdictions (LHJs) are required to complete and submit an Annual Report.

Agency Information	
Street Address:	345 Camino Del Remedio
Mailing Address: *(Blank if same as above)*	
City, State, Zip Code:	Santa Barbara, CA 93110

Annual Report Contact	
Title:	Kelley Barragan, Director – Maternal, Child & Adolescent Health Program
Telephone Number:	805-681-5476
E-mail:	kelley.barragan@sbcphd.org

MCAH Toll Free Telephone Number and Website			
Telephone Number:	**1-800-288-8145**	Website URL:	**https://www.countyofsb.org/phd/mcah**

MCAH Director Signature		
Certification by MCAH Director:	Type Name: Kelley Barragan, RN/PHN *I certify that I have seen and reviewed this Annual Report for compliance with CDPH/MCAH Program Policies and Procedures.*	Date: 11/3/2020

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Instructions	
Instructions:	Complete the Annual Report template and accompanying Year-End survey referencing your fiscal year 2019-20 MCAH Scope of Work (SOW). • When describing activities, accomplishments, barriers and solutions, use lists, bullets and very short narratives.

Due Date	
Due Date:	**The MCAH Annual Report for the fiscal year ending on June 30th is due August 15th each year**. Extension of due date to November 15th was granted to Santa Barbara County by CDPH.
Extension Requests:	LHJs may request an extension for up to 30 days past the due date to submit the Local MCAH Annual Report. Please send requests in writing (email is acceptable) to your Local MCAH Program Consultant.

Compliance	
Compliance:	CDPH/MCAH Division may withhold payment on invoices for failure to submit a complete and timely report.

Naming Convention	
Naming Convention:	Title your reports with your LHJ name, the fiscal year, the program name, and the type of report, for example "Los Angeles 19-20 MCAH AR", where AR means "Annual Report ".

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Annual Report Components	
Components to Submit:	Complete and submit the following as applicable according to the instructions on each document template: • MCAH Annual Report template (Required) • MCAH Client Story template (Optional) • Product Developed template (Optional)

FIMR Annual Report Components (FIMR LHJs Only)	
Components to Submit (FIMR LHJs only):	Complete and submit the following FIMR documents: • FIMR Annual Report (located within this Annual Report template) • FIMR Committee Membership Form(s) • FIMR Tracking Log Form • Local Health Officer Authorization letter to conduct FIMR activities dated in FY 2019-20

How to Submit	
Document Format:	Submit all documents in Word format • Some documents can be pasted directly into the Annual Report as applicable (see template below)
Email:	Email all components of the MCAH and FIMR Annual Report(s) to: MCAHAR@cdph.ca.gov

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All LHJs are required to report on the Objective 1.1 deliverables from your 2019-20 MCAH SOW

Goal 1:
WOMAN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services.

- Increase access to oral health services[1]
- Increase screening and referral for mental health and substance use services[1]
- Increase utilization of preventive health services[1]
- Target outreach services to identify pregnant women, women of reproductive age, infants, children and adolescents and their families who are eligible for Medi-Cal assistance or other publicly provided health care programs and assist them in applying for these benefits [2]

Short and/or Intermediate Objective(s)	Place Evaluation/Performance Measures in the Columns Below	
	Process Measures	Short and/or Intermediate Outcome Measures

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1.1
All women of reproductive age, pregnant women, infants, children, adolescents and children and youth with special health care needs (CYSHCN) will have access to needed and preventative, medical, dental, and social services.

Briefly list or describe here:

1.1a

This deliverable is fulfilled by completing and submitting your Community Profile with your Agreement Funding Application for 2019-20.

Answer the question below:

How did you share your data within your LHJ?

☒ Stakeholder Meetings
☐ Community Roundtables
☒ Management Meetings
☒ Board of Supervisors
☒ Other (please list):
Collaborative Meetings
Emails to Stakeholders
Santa Barbara County MCAH Website

Supplemental data to previously submitted FY 19/20 Community Profile:

MediCal births by SBC Geographic Region▪, 2018		
Region	Count	%
North	2058	67.19%
Central	495	16.16%
South	510	16.65%
Total	3063	100.00%

1.1a

Briefly list changes in local maternal health status or data during this reporting year.

Please see graphs to the left (under process measures) for changes in local maternal health data.

Below speaks to the local MCAH Field Nursing Unit (FNU) Data:

MCAH FNU served 1338 unique individual families.

- Santa Maria 624
- Santa Barbara 439
- Lompoc 281

Of the 1338 families, 65% (876) were postpartum mothers, referred by the SBC PHD Health Care Center OB departments.

Program Standard: See 75% of postpartum referrals within 5 working days of mother's discharge date. Goal met = 86% (755/876)

Program standard: See 85% of high risk referrals within 10 working days of referral date. Goal met = 85% (837/989)

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SBC Fertility and Crude Birth Rates

	2015	2016	2017	2018
SBC Births	5673	5501	5506	5252
SBC Female (15-44 yr) Population	92845	93075	93354	93801
SBC Fertility Rate of Women (15-44) per 1,000	61.10	59.10	58.98	55.99
SBC Population	444491	447309	450216	453733
Crude Birth Rate per 1,000 population	12.76	12.30	12.23	11.58

Race/Ethnicity of All Births in SBC, 2018

	Count	%
White	1485	28.27%
Hispanic	3347	63.73%
Black	59	1.12%
American Indian	14	0.27%
Asian	186	3.54%
Hawaiian Pacific Islander	6	0.11%
Multi-race	155	2.95%
Total	5252	100.00%

There were 1026 women, 13 years of age and older, seen by the Field Nursing Unit (FNU). Of the 1026 women, 90% (919) had Medi-Cal as their insurance source (88 women were missing data).

Race & Ethnicity, as self-identified by these women over 12 years of age, served by the FNU are as follows (denominator 1025):

- 91% (936) Hispanic; Hispanic (824), Hispanic-mixed (3), Mexican/Mexican American/Chicano (109)
- 6% (57) White/Caucasian
- 1% (6) Other
- **1**% (10) Asian; Asian (2), Filipino (2), Hmong (1), Japanese (1), Middle Eastern (3), Vietnamese (1)
- 1% (7) Black; Black (6), African (1)
- 0% (2) American Indian; American Indian (1), Alaska Native (1)
- 1% (7) Missing data

20 Pregnant High Risk Teens were served by the MCAH Field Nursing Program between 7/1/19-6/30/20:

- Santa Maria – 2 females
- Santa Barbara – 8 females
- Lompoc – 10 females

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Mothers who received prenatal care in the first trimester in SBC by Race/Ethnicity

	1st trimester	All births	% of births by race with prenatal care in the 1st trimester	% of SBC births with prenatal care in the 1st trimester
White	1311	1485	88.28%	24.96%
Hispanic	2437	3347	72.81%	46.40%
Black	43	59	72.88%	0.82%
American Indian	11	14	78.57%	0.21%
Asian	162	186	87.10%	3.08%
Hawaiian Pacific Islander	5	6	83.33%	0.10%
Multi-race	132	155	85.16%	2.51%
Total	4101	5252	78.08%	78.08%

153 Non-pregnant High Risk Teens Served by MCAH Field Nursing Program between 7/1/19-6/30/20:

- Countywide – 145 females and 8 males
- Santa Maria – 91 females and 3 males
- Santa Barbara – 20 females and 3 male
- Lompoc – 34 females and 2 males

16,002 community-wide referral sources were discussed or referred to by the FNU.

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Births to Teenage Mothers (15-19), 2018				
	2015	2016	2017*	2018
Count (15-17)	97	106	95	85
Count (18-19)	280	215	267	204
Count (15-19)	377	321	362	289
Female Pop (15-17)	9440	9479	9336	9239
Female Pop (18-19)	9653	9605	9685	9779
Female Pop (15-19)	19093	19084	19021	19018
Rate (15-17)	10.28	11.18	10.18	9.20
Rate (18-19)	29.01	22.38	27.57	20.86
Rate (15-19)	19.75	16.82	19.03	15.20
CA Rate (15-19)	17.6	15.7	13.9	NA

* 4 births to mothers under 15

Births to Teenage Mothers by Race/Ethnicity, 2018		
	Count**	%
Hispanic	263	91.00%
Non-Hispanic White	13	4.50%
Other	13	4.50%
Total	289	100.00%

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Births to Teenage Mothers by City, 2018			
	Total births	Teenage Mother births	%
Guadalupe	124	10	8.06%
Santa Maria	2515	208	8.27%
Lompoc	814	39	4.79%
Santa Barbara	1094	14	1.28%
Carpinteria	154	2	1.30%
Other	551	16	2.90%
SBC	5252	289	5.50%

Underweight births, 2018		
	Count	%
BW 1500-2499 g	306	5.83%
BW less than 1500	47	0.89%
Total underweight births (under 2500 g)	353	6.72%
2500g and above	4546	86.56%
Total SBC Births	5252	100.00%

SBC Birth Data Source: Cal-IVRS - CDPH Vital Records
Population Estimates: State of California, Department of Finance, State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2018.
CA data: MCAH Division of CDPH: https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/Data/Adolescent-Health-Data.aspx

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1.1b **Collaborative Efforts:** The term 'collaborative efforts" describes what also might be called a collaborative, coalition, community group or partnership.	**1.1b** **Note: LHJs no longer have to complete a collaborative survey online. This section replaces the online survey.** **Report the total number of collaborative efforts with MCAH active participation.** 17 **Briefly share at least one outcome from your collaborative efforts.** MCAH partnered with the PHD Carpinteria Health Care Center and Carptinteria Children's Project on a pilot project to increase ACEs screening rates in the pediatric department and provide an intervention aimed at increasing resiliency of families who screened positive. Staff from the three agencies was educated on ACE and resilience science and trauma-informed practices. A Business Associate Agreement was executed to allow for sharing of PHI to enhance client transitions between partners. An independent organization, Just Communities, was brought in to conduct focus groups and key informant interviews of the project which will be shared in FY 20/21.

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	Briefly list or describe here: **1.1c** **Briefly list or describe types of policies developed or revised to facilitate access to health care services.** MCAH FNU updated the following policies which standardize assessments during home visits related to MediCal, MediCal related services, and other relevant programs. Staff was in-serviced on all policies. Policies include: • MCAH Home Visiting assessment • MCAH Home visiting assessment: Basic Needs/Housing/Physical Environment • MCAH home visiting assessment: Community living Needs/Vocational-Educational • MCAH home visiting assessment: Medical, Dental, Mental Health • MCAH home visiting assessment: Familial-Social Support/Social-Emotional MCAH FNU updated standardized procedure to facilitate easy access and scheduling related to PHD lactation services.	**Briefly list or describe here:** **1.1c** **Briefly list the formal and informal agreements in place including Memoranda of Understanding with Medi-Cal Managed Care Plans or other organizations that address the needs of mothers and infants**. • MOU between MCAH and CommUnify (formerly Community Action Commission) who is the AFLP provider in SBC • MOU between MCAH and Children and Family Services Inc. related to provision of services to children prenatal to 5 years old and their families including home visiting services in SBC • Draft MOU between MCAH and Cen-Cal Health (MCMC plan) related to CPSP services – will be reviewed next fiscal year • Community Partnership Agreement with Resilient Santa Barbara County (focused on preventing and reducing impact of ACEs) • Informal agreement related to collaboration between MCAH FNU and Marian Regional Medical Center's Medically Vulnerable Care Coordination Program (MVCCP) **Describe and summarize the impact of protocols or policy and systems changes that facilitate access to Medi-Cal CCS, Covered CA, and WIC.**

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	The SBC PHD remains a leader in the outreach and enrollment community in coordination with Department of Social Services, County Education Office and Behavioral Wellness. An Interagency Committee facilitated by the PHD meets monthly during the enrollment season and as needed during the remainder of the year. The PHD Health Care Centers (HCC) staff Covered California Certified Application Counselors (CACs) at all locations. The PHD ensures that enrollment and renewal services are available to anyone in the community. The PHD has established a Benefits and Referral Center (BRC) to assist with outreach and enrollment efforts and Medi-Cal renewal services throughout the county. The PHD has created, updated and continues to broadly distribute brochures and other language appropriate marketing materials to inform our community about the Affordable Care Act (ACA) and its benefits. The PHD continues to participate in community events, including health fairs and farm worker events, to educate the community on health coverage benefits and enrollment options. The goal of the PHD is to continue to stay focused on our outreach and enrollment activities.	Staff were able to standardize assessments and interventions related to MediCal, MediCal services, and other relevant programs. Warm handoffs and improved communications regarding client needs were enhanced through clarity and in-services. In FY 19/20, the PHD had 28 Certified Application Counselors (CACs) complete recertification training and currently has 27 CACs. The PHD has assisted over 4,877 community members with enrollment and renewal information which included assisting clients with completion of applications for those enrolling. The PHD estimates that more than 488 people were enrolled into Medi-Cal or a Covered California health exchange plan. Over 3,472 individuals were assisted with renewals. ***CenCal Members Assigned FY19/20*** **Clinic** / **Members** Carpinteria HCC — 2,349 Franklin HCC — 4,191 Lompoc HCC — 10,802 Santa Barbara HCC — 6,262 Santa Maria HCC — 4,736

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	1.1d **Briefly list or describe the trainings attended/provided and number of attendees.** Staff development at MCAH staff meetings: WIC Services Overview 9/11/2019 Child Welfare Services Overview 9/11/2019 Mind Body Wellness 12/11/2019 Foster Care and Rx Nurse Roles 12/11/2019 Census 2020 2/19/2020 Community Classes: MCAH Leaders Advancing Anti-Racism for Health Equity 10/24/2019 Substance Use and Perinatal Depression Webinar 11/1/2019 CPSP Provider Overview Online Training 1/23/2020 Human Trafficking 101: Dispelling the Myths and the PEARR Tool 1/24/2020 System Approaches to Healthy Communities 12/20/20 Bridges out of Poverty 2/6/2020 CWS Stakeholder Meeting 2/20/2020 Trauma-Informed Care-SLO 2/20/2020	**1.1d** **Briefly share an example of workforce development training in MCAH and public health competencies.** All MCAH FNU staff either attended the classes listed or the information was reviewed after at staff meetings or via email. All PHNs in the FNU attended a blood borne pathogen class, disaster, and nursing skills training. **What are the trainings you think all MCAH staff should have?** (1) Adverse Childhood Experiences (ACEs)/Resiliency (2) Perinatal Substance Use (3) Perinatal Mood Disorders (4) Breastfeeding (5) Child Development (6) Immunizations (7) SIDS/Safe Sleep (8) Reflective Supervision/Case Management (9) Motivational Interviewing (10) Environmental impacts on development and health across the lifespan

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	PHD Classes: Disaster Preparedness-The Great Shakedown 10/16/2019 2019 DOC Disaster Training 10/28/2019 Fiscal Management Training 10/31/2019 Mixteco Cultural Training 12/3/2019 Perinatal Women and Opioid Use Disorder 1/30/2020 ARC Disaster Response Training 2/27/2020 Webinars: Using Holistic Strategies to Improve Outcomes in Mood Disorders 7/11/2019 ACOG Addressing Perinatal Mood and Anxiety Disorders – Strategies for Women's Health Care Providers 7/11/2019 Methamphetamine Addiction and Strategies for Getting Women into Treatment 8/2/2019 Building Trauma-Informed Connections via Telehealth During COVID-19 4/29/2020	

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	1.1e **Briefly list or describe the activities to facilitate referrals to health insurance and programs.** All clients and immediate family members receiving case management services from the MCAH FNU are assessed for and linked to health insurance. Staff distributed MCAH Program brochures and referral forms at the following community events: 8/8/19 – Lompoc Health Care Center – Health Care Week Fair 9/21/19 – Resource and Referral's Safe Sleep Walk – Santa Maria 10/11/19 – Carpinteria Children's Project Family Resource Center Health Fair 10/11/19 Postpartum Support International (PSI) PMAD Training – Santa Maria 10/24/19 – Good Farms Health Fair in Lompoc 12/1/19 – Day of the Farmworker in Santa Maria Information was provided on access to care and health insurance as well as healthy messaging for pregnant women and families including: nutrition, folic acid, perinatal mental health and substance use, well-baby care, and healthy living.	**Complete the table below:** **1.1e** The number of referrals your local MCAH Program made to Medi-Cal, Covered CA, CCS, or other no/low cost health insurance programs for health care coverage. **Insert numbers in the table.** **Program Name** / **Medi-Cal** / **CovCA** / **CCS** / ***No/low cost health insurance** **Number Referred** / **861** / **XX** / **7** / **XX** The data above is specific to the MCAH FNU actual referrals and based on individual clients.

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	1.1f **Briefly list or describe the methods of communication, including the cultural and linguistic challenges and solutions, to linking the MCAH population to services.** The one office professional (AOP) that answers the MCAH hotline is bicultural, speaks Spanish, and is available M-F. This AOP has been oriented to referral systems and how to address specific needs of clients. She works in collaboration with the MCAH Director and Supervising PHNs (SPHNs). The AOP updated county-wide referral sources. MCAH is listed in the directory for 211 which is a hotline that links residents of SBC to resources for social services. Staff within all three regions speaks various languages (Spanish, Hmong, and Tagalog) which help to meet the language and cultural needs of the community. SBC has a large indigenous population that speaks various Mixtec languages. This language barrier is difficult at times, but staff has access to two different language lines depending on a client's insurance coverage. MCAH as well as the PHD have been tracking needs related to the indigenous population in efforts to develop solutions to this barrier. MCAH Director provided materials to PHD PIO to	**1.1f** **Report the number of toll free calls:** 9 **Report the number of web hits to the appropriate local MCAH Program webpage:** 1654

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	promote campaigns and education through social media posts from the PHD. The following awareness campaigns were promoted via Twitter and PHD Facebook Home page: • October: SIDS (4 posts) • Breastfeeding and COVID The Early Childhood and Family Wellness Coalition (EC+FW) created and published a Resource Directory outlining the various organizations using screening tools for children prenatal to 5 and/or parents as well as local resources listed based on the 5 protective factors. MCAH Director was interviewed by Fist 5 CA for a blog post (May 2020) on importance of home visiting and impacts related to COVID.	

All LHJs are to report on the Locally Developed Objective(s) for 1.2 from your 2019-20 MCAH SOW

WOMEN/MATERNAL DOMAIN:

Objective 1.2: Insert a local objective to address increasing access to and utilization of preventive health services[1] for reproductive age women.

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Short and/or Intermediate Objective(s)	Place Evaluation/Performance Measures in the Two Columns Below		
	Process		Short and/or Intermediate Outcome Measures
1.2 By June 30, 2020, build capacity of local organizations working with families to address the effects of Perinatal Mood and Anxiety Disorders (PMADs) on fathers through the use of screening, referral for treatment, and prevention.	**1.2a** • Perinatal Wellness Coalition (PWC) to coordinate and host a local training for organizations working with families to address the effects of PMADs on fathers • PWC to coordinate training logistics (identify training location, time, date, invitees, objectives, agenda, speakers, registration, etc.) • PWC to identify local referral resources for PMADs including those related to fathers • Distribute training flyers to local organizations working with families • Distribute training evaluations at the training and collect completed evaluations	**1.2a** • Describe the planning process including # of planning meetings held • List # of local (or regional) referral resources identified for treating PMADs including those related to fathers • List # of organizations training flyers were distributed to • List # of people attending training and programs they are from • List # of training evaluations completed PWC met monthly between June and October 2019 to plan the “Paternal Perinatal Mental Health 101” Conference. A location and keynote speaker were secured. Questions for the panel of fathers were developed. Save the date flyers were distributed at the PSI Training on 10/11/19 and	**1.2a** • Discuss barriers and challenges encountered in identifying local referral resources for treating PMADS including those related to fathers • Report on the % of attendees that have increased their knowledge and skills related to the effects of PMADS on fathers including prevention of, screening and referral N/A - see process outcomes section.

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		they were sent out to PWC members to share. During internal Public Health Department meetings on how to handle grants that PWC may apply for to fund the conference there were discussions on what PWC is and who serves as the backbone entity for the coalition; particularly given there are financials associated with the coalition. While a MCAH Director has continued to chair the coalition since 2012, the PHD does not own this coalition. It was decided that if PWC were to continue it would be ideal for a non-governmental partner be the backbone entity. This information was shared during the October 30th PWC Meeting. MCAH Director/PWC Chair also met with the active members of PWC who were not present during that meeting to discuss. There were discussions with multiple	

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		agencies, but ultimately none elected to be the backbone entity for PWC. The June conference was cancelled. Due to the COVID-19 pandemic, members have not been able to meet to discuss the potential for PWC to continue. This will be assessed in the next FY.	

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All LHJs are required to report on the Objective 1.3 deliverables from your 2019-20 MCAH SOW

WOMEN/MATERNAL DOMAIN:
Objective 1.3: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age.

- Decrease unintended pregnancies
- Decrease the burden of chronic disease
- Decrease intimate partner violence
- Assure that all pregnant women will have access to early, adequate, and high quality perinatal care with a special emphasis on low-income and Medi-Cal eligible women

Short and/or Intermediate Objective(s)	Place Evaluation/Performance Measures in the Two Columns Below	
	Process	**Short and/or Intermediate Outcome Measures**
1.3 All women will have access to quality maternal and early perinatal care, including CPSP services for Medi-Cal eligible women.	**Briefly report the following:** **1.3a** **1. Do you have a resource and referral guide?** Yes ☒ No ☐ **2. If so, copy and paste link here, if available.** MCAH has several different resource guides for general resources, perinatal substance use, PMADs, and dental. Please visit: https://countyofsb.org/phd/mcah/community-resources.sbc **3. List name(s) of staff who attended the Annual PSC Statewide meeting?** Due to the COVID-19 Pandemic, the Annual PSC Statewide	**Briefly list or describe here:** **1.3a** **Provide the number and briefly describe the outcomes of:** • Roundtable meetings Click or tap here to enter text. • Regional Meetings Click or tap here to enter text. • Other maternal and perinatal meetings -MCAH and Santa Maria HCC partnered to host a Mixteco Cultural Training on with Herencia Indigena on 12/3/19 -PSC provided presentation on local PMAD activities and resources at the Cottage Hospital

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	meeting was cancelled in FY 19/20. **4. List activities implemented to increase access of women to early and quality perinatal care. Identify barriers and opportunities to improve access to early and quality perinatal care.** At the various health fairs listed below, staff provided information on how to access healthcare (such as CPSP/OBGYN services) and Medi-Cal/health insurance. Messaging was also provided on nutrition, folic acid, perinatal mental health and substance use, well-baby care, and healthy living. 8/8/19 – Lompoc Health Care Center – Health Care Week Fair 9/21/19 – Resource and Referral's Safe Sleep Walk – Santa Maria 10/11/19 – Carpinteria Children's Project Family Resource Center Health Fair 10/11/19 Postpartum Support International (PSI) PMAD Training – Santa Maria 10/24/19 – Good Farms Health Fair in Lompoc 12/1/19 – Day of the Farmworker in Santa Maria	Breastfeeding Collaborative on 1/28/20 and PHD OB Case Conference on 1/29/20.

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	At the Santa Maria WIC Breastfeeding Celebration on 8/14/20 a MCAH staff member who is certified as car seat technician answered questions regarding car seat safety PSC attends quarterly Southern Area Perinatal Advocates (SAPA) meetings and is chair of the Perinatal Wellness Coalition (PWC). See objective 1.2 for info on work related to PMADs. A MCAH SPHN sits on the North County PMAD Coalition which is working to increases PMAD screening rates amongst family practitioners, OBYGNs, and pediatricians in addition to increasing peer-to-peer support groups.	
	Briefly describe here: **1.3b** **Describe the local network of perinatal providers, including CPSP providers (e.g. concentration of Medi-Cal Managed Care, Fee-for-Service, etc.).** • **How many Medi-Cal obstetric providers did you provide enrollment information about becoming a CPSP provider?** 1 • **How many active enrolled CPSP providers do you have?** 12 ○ **Of those providers, how many were new to the CPSP program?** 0 • **List technical assistance activities provided to perinatal and CPSP providers (e.g. resources,**	**Briefly list or describe here:** **1.3b** **Do you have an adequate number and type of perinatal providers to meet the needs of your maternal population?** **☐Yes ☒No** **If no, describe the issue here:** • The rate of OBGYN Providers/100K population is 19 in San Luis Obispo County, 18.9 in Ventura County and 17.7 in Santa Barbara County. San Luis Obispo and Ventura are neighbor counties. Source: http://ahrf.hrsa.gov/arfdashboard/HRCT.aspx

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	referrals, tracking system for follow-up, assessments, interventions, infant care, etc.). • Oriented new SLO County PSC to role and CPSP program 7/5/19 • TA to Santa Maria HCC on integrating behavioral health specialist into CPSP services (recommendations on documentation, coding, workflow). Presentation on CPSP integration at the PHD Behavioral Health Specialist Meeting - 7/18/19 • TA re: DPAs between Dignity Clinics and PHD Lactation Services • End Dated POG site on 8/20/19 • Provided CPSP Orientation on chart/site reviews to SLO County PSC 11/14/19 • Met with WIC Director and Beccah Rothschild, Consultant to CA Health Care Foundation for My Birth Matters Campaign, to discuss distribution of educational information to clients on C-section education in SB County. Presentation to MCAH staff during December staff meeting. • TA to Dignity clinics and Dr. Adler re: Cen-Cal denials and CPT billing changes 1/2020 • Presentation on MCAH and CPSP Program to Cen-Cal Case Managers 1/21/20 • CPSP Overview presentation to Santa Maria HCC Leadership, AOPs, and OB staff 3/3/20	• For clients in MCMC, according to the 2020 HEDIS measure "Timeliness of Prenatal care"; Santa Barbara County (SBC) achieved 97.81% with a benchmark of 90.98%, SBC ranked in the 95th percentile or higher. For the 2020 HEDIS measure "Timeliness of Postpartum care", Santa Barbara County (SBC) achieved 91.48 with a benchmark of 74.36%, SBC ranked in the 95th percentile or higher. Source: https://www.cencalhealth.org/~/media/files/pdfs/quality/hedis-results-2020.pdf?la=en

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	• TA re: CPSP application for a current site transiting to an intermittent site • Periodically sent emails to CPSP providers with educational and resource information related to perinatal and infant health	
	Briefly list or describe here: **1.3c** **Describe activities conducted in collaboration with your local Regional Perinatal Programs of California (RPPC) Director and coordinated perinatal activities between MCAH and the RPPC to improve maternal and perinatal system care, including coordinated post-partum referral systems for high-risk mothers and infants upon hospital discharge.** PSC outreached to RPPC rep to discuss outcomes of the Title V Needs Assessment and key priority areas for SBC and how RPPC and MCAH can partner. Further activities have been delayed due to COVID, but will be re-assessed in the next FY.	**1.3c** **Do you meet with your RPPC?** **☒Yes ☐No**

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	Briefly list or describe here: **1.3d** **1. List your MCMC liaison contacts.** Michael Harris and Theresa Scott at Cen-Cal **2. Report the number of face-to-face QA/QI site visits conducted with CPSP providers.** 0 **3. Did you conduct site visits?** **☒Yes ☐No** **a. If so, how many?** 5 **b. List the types of CPSP provider QA/QI activities conducted during site visits (i.e. chart administrative, protocol review).** • Annual site visits were scheduled for early 2020, but were postponed due to the COVID-19 pandemic as PSC was assigned full-time to the DOC • PSC had 5+ face-to-face visits with CPSP providers to provide TA • PSC had 100+ email contacts with CPSP providers to provide TA	**1.3d** **Which QA/QI Chart Review tool do you use?** While no QA/QI chart reviews were conducted in FY 19/20 due to COVID, the state MCAH developed chart review tool Is routinely used. **What do you do with the results of the QA/QI review?** While no QA/QI chart reviews were conducted in FY 19/20 due to COVID, same day feedback is provided and a follow-up email is sent outlining strengths/weaknesses and corrective action plan.

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California Department of Public Health/Maternal, Child, and Adolescent Health
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Agency: Santa Barbara County Public Health Department
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All LHJs are to report on the Locally Developed Objective(s) for 1.4 from your 2019-20 MCAH SOW

WOMEN/MATERNAL DOMAIN:

Objective 1.4: Insert a local objective to address increasing access to and utilization of health services[1] for pregnant women.

Short and/or Intermediate Objective	Place Evaluation/Performance Measures in the Columns Below		
	Process		Short and/or Intermediate Outcome Measures
1.4 By June 30, 2020, eligible pregnant and postpartum (PP) moms in need of MCAH Field Nursing home visit services that deliver at Santa Barbara Cottage Hospital, Lompoc Valley Hospital and Marian Medical Center obstetric (OB) department will be referred to the MCAH FNU.	**1.4a** MCAH staff will perform the following activities: • Engage existing community partners/collaboratives • Meet with hospital OB staff • Inform hospital OB staff of the family benefits of involvement in MCAH or other public health programs • Educate hospital OB staff on how to make referrals to the MCAH FNU that best meets client needs • Assist hospitals to develop and implement referral policies for their high risk pregnant and PP women to the appropriate public health program	**1.4a** Briefly describe: • MCAH staff number of visits to hospital OB departments • Briefly describe referral process developed and implemented • Briefly describe the technical assistance provided to the hospital OB staff • Briefly describe the CQI/QA process developed 7/19/19 - MCAH Director presented on MCAH FNU services at the Cottage Hospital SCAN meeting which included leadership from perinatal, pediatrics, and social work departments, and other	**1.4a** • # of pregnant and PP women referred from the hospital OB departments 141 • Briefly describe policies developed and implemented • Describe the outcome of the CQI/QA process including methods of measurements and results Tracking of the referrals from the three delivering hospitals was added to the PHN database and procedure reviewed with all staff that enters referrals. During the monthly meetings with the SPHNs, the “Referred from” report is reviewed to ensure (1) those entering referrals are choosing the correct referring agency description (2) to assess which organizations may need refreshers on referring to the MCAH program. Due to the COVID-19 pandemic, these meetings were

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	• Provide technical assistance and ongoing contact with the hospital OB staff to ensure that referral system is implemented Develop and implement a Continuous Quality Improvement/Quality Assurance (CQI/QA) process to monitor implementation of policies/processes, a regular feedback mechanism to continually improve the process and a plan to evaluate the impact	community partners. 9/17/19 – MCAH Leadership met with Welcome Every Baby – Family Connects (WEB-FC) and Marian Home Health leadership to discuss services. WEB and Marian Home Health both refer to MCAH for clients needing case-management. Marian alerts families that PHD nurse will come to see them if they received OB care at the HCCs. An MOU has been in place with WEB-FC as to not duplicate home visiting services for post-partum women. 9/18/19 – MCAH staff met with Marian Regional Medical Center Social Work staff to review MCAH field nursing, SIDS, CPSP, and strategic planning. Discussed service area and type of referrals. Due to the COVID-19 pandemic, MCAH was not	suspended between March-June 2020 as 80% of MCAH staff was re-directed to the COVID response.

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		able to offer a formal presentation to Lompoc Hospital staff. Leadership teams between the two organizations are in communication with each other on separate projects/groups. A formal presentation will be offered next fiscal year when MCAH has capacity.	

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Ongoing PHD Field Nursing Measure **Objective 1.5** By June 30, 2020, all Medi-Cal eligible pregnant and postpartum women who are clients in the Field Nursing Unit (FNU) will be enrolled in Medi-Cal and have timely access* to care. ***Timely access to care for:** • **Eligible pregnant women = Within 1 month from initial referral.** • **Eligible postpartum women = Within 2 months of obtaining insurance**	**Ongoing PHD Field Nursing Measure** **1.5** MCAH staff will: • Assess each MCAH program client for eligibility for Medi-Cal. • Refer to the "Medi-Cal Eligibility and Covered CA website: https://www.coveredca.com/ • California Department of Health Care Services: Presumptive Eligibility for Pregnant Women: http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/PE.aspx • Refer unenrolled but potentially eligible clients for application assistance and assist as necessary • Follow-up with referred clients to determine if they become enrolled • Encourage enrolled clients to complete an	**Ongoing PHD Field Nursing Measure** **1.5** • Describe rationale for interventions, recommendations and strategies developed The policy "MCAH Home Visit Assessment: Medical, Dental, Mental" describes the program standards for assessment and referral for Medi-cal. All clients are assessed for MediCal eligibility and enrollment status on initial visit. Assistance is provided on how to enroll. Follow up on status (including but not limited to: assisting clients with making calls to DSS and/or MCMC, assist with form completion, and/or assist with transportation as needed) with enrollment is conducted through case closure.	**Ongoing PHD Field Nursing Measure** **1.5** • Numerator: Number of pregnant women in the MCAH FNU who are enrolled or are in the process of applying for Medi-Cal have a scheduled appointment with a provider within one month of the initial referral Denominator: All pregnant women in the MCAH FNU program eligible for Medi-Cal 43 / 47 – 91% Health Indicator – "Pregnant all ages: Medi-Cal / timely access to care" Health Indicator Outcomes - 91% (43/47) Has or obtained Medi-Cal; has scheduled apt within 1 month of referral - 2% (1/47) Has or obtained Medi-Cal; no scheduled apt within 2 months of obtaining Medi-Cal -4% (2/47) Medi-Cal in process; has scheduled apt within 1 month of referral -2% (1/47) Unable to locate

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	appointment with a health care provider and follow-up to assure completion • Develop and implement a Continuous Quality Improvement/Quality Assurance (CQI/QA) process to monitor implementation of policies/processes, a regular feedback mechanism to continually improve the process and a plan to evaluate the impact	• Briefly describe barriers, challenges and solutions to enrollment in Medi-Cal and follow-up to see a provider • Briefly describe the CQI/QA process developed • Describe access to care issues identified MCAH Leadership team typically conducts monthly CQI to review number of clients not meeting goals. These meetings were suspended between March-June 2019 as most MCAH staff was redirected to the COVID response. Challenges and reasons for not meeting goals were identified and addressed. Barriers for clients included concerns of applying for Medi-Cal d/t immigration status and clients moving back to country of origin after birth of baby without finishing Medi-Cal process.	• Numerator: Number of postpartum women in the MCAH FNU who enrolled in Medi-Cal and have a scheduled appointment with a provider within 2 months of obtaining insurance Denominator: All pregnant women in the MCAH FNU program eligible for Medi-Cal 891 / 908 = 98% Health Indicator – "Postpartum (within 2 months of delivery), all ages: Medi-Cal/timely access to care" Health Indicator Outcomes - 98% (891/908) Has or obtained Medi-Cal; has scheduled appt within 2 months of obtaining Medi-Cal - 0% (2/908) Has or obtained Medi-Cal; no scheduled appt within 2 months of obtaining Medi-Cal - 1% (6/908) No Medi-Cal (self-pay); has scheduled apt - 0% (1/908) No Medi-Cal (self-pay); no scheduled appt - 1% (8/908) Unable to locate • Describe referral process developed • Describe the outcome of the CQI/QA process

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		Changes in the Federal Administration have resulted in families reluctant to access social services due to fear of deportation and undocumented status.	including methods of measurements and results Outcome of CQI process has led to having community resources related to healthcare access at staff meetings. CQI process identified staff needed clarification on how to use health indicator and best choice to use for outcome. SPHNs clarified documentation process with staff on an individual basis each month. Between March - June 2020, approximately 80% of MCAH field nursing staff was re-directed to COVID related activities. During this time in-home visits were shifted to phone visits to protect the safety of staff and the families served. Due to the reduced number of staff, low-risk clients may have had their cases closed prior to confirming if Medi-Cal was fully attained if it was determined that the family did not have any barriers to following through with Medi-Cal process. This could be the reason for the cases with “Medi-Cal in process” or “No Medi-Cal” noted.

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Agency: Santa Barbara County Public Health Department
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Ongoing PHD Field Nursing Measure **Objective 1.6** By June 30, 2020, 85% of clients with a risk factor/history of Domestic Violence (DV) and/or current DV receiving MCAH Field Nursing Unit (FNU) home visits will receive information, referral and follow-up care or assistance. **1.7** By June 30, 2020, 35% of clients with a risk factor/history of Domestic Violence (DV) and/or current DV will have a verbal or written safety plan.	**Ongoing PHD Field Nursing Measure** **1.6 & 1.7** Perform the following activities: Field Nursing Unit home visit interventions include: • Assess family for history of and/or current issues with DV. • FNU staff will input information re: individual cases into the PHN Database under health indicator status. • Local information on DV resources will be current. Field Nursing Unit home visit interventions include: • Assist client in planning for a safe exit from home if needed. • Ask that the client specify what her plan is at a subsequent home visit.	**Ongoing PHD Field Nursing Measure** **1.6 & 1.7** Briefly describe: • Assessment, intervention, referral process, provider access and barriers to obtaining domestic violence resources. Discuss documentation of health indicators • Field nursing assistance for safety planning and health indicators. MCAH Field Nursing Unit (FNU) staff screen all clients seen for domestic violence The FNU staff provides brief intervention/education and review/offer a list of resources on domestic violence. The FNU staff review and/or provide a list of resources that was developed for each	**Ongoing PHD Field Nursing Measure** **1.6** • Numerator: Number of clients with a risk factor/history/current DV receiving a brief intervention, referral and follow-up care or assistance Denominator: Number of MCAH FNU home visiting clients with a risk factor/history of Domestic Violence (DV) and/or current DV 91 / 112 = 81% **1.7 Report the following:** • Numerator: Number of clients with a risk factor/history/current DV who have a verbal or written safety plan Denominator: Number of MCAH FNU home visiting clients with a risk factor/history of Domestic Violence (DV) and/or current DV 79 / 112 = 71% Health Indicator – “Domestic Violence” Health Indicator Outcomes

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		region in coordination with Perinatal Wellness Coalition– 'Parent Links Healthy Coping'. The list of resources includes contacts for services ranging from DVS, Legal Aid, Victim Witness, mental health, Rape Crisis, etc. Follow-up case management is provided to this population. FNU staff enters information re: individual cases into the PHN Database under the health indicator status "Domestic Violence". Referrals are frequently made to Domestic Violence Solutions, Victim Witness, Legal Aid, and CALM (Child Abuse Listening and Mediation). CALM has multiple services for high risk women, including SafeCare, psychiatrist services,	• 59% (66/112) Referral for DV Resources received and acknowledged – Verbalized Safety Plan • 11% (12/112) Referral for DV Resources received and acknowledged • 8% (9/112) Declined FNU Services • 11% (12/112) Not Found • 11% (12/112) Referral for DV Resources received: Clt/Family receiving services – Verbalized Safety Plan • 1% (1/112) Referral for DV Resources received: Clt/Family receiving services

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		counseling, and support groups in both English and Spanish. Increased capacity of support services is needed in this community. The main community based organization that administers long-term case management, CALM, struggles with capacity from a resource and fiscal perspective resulting in long or closed waitlist at times. Documentation of domestic violence support given by the FNU staff is assessed on individual chart reviews. This is an ongoing process and all documentation is reviewed by the Supervising PHNs. Case conferences are conducted within each region when challenges are identified. These meetings were suspended between March-June 2019 as most MCAH staff was redirected to the COVID response.	

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		1.7 FNU staff provides assistance in safety planning to all clients that have a risk factor/history of domestic violence and/or have current domestic violence. FNU staff enters information re: individual cases into the PHN Database under the health indicator status "Domestic Violence". Documentation of domestic violence support given by the FNU staff is assessed on individual chart reviews. This is an ongoing process and all documentation is reviewed by the Supervising PHNs. Case conferences are conducted within each region when challenges are identified. These meetings were suspended between March-June 2019 as most MCAH staff was redirected to the COVID response.	

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Ongoing PHD Field Nursing Measure **Objective 1.8** By June 30, 2020, 100% of FNU clients seen in the antepartum and immediate (2mo) postpartum period that have a diagnosis of GDM will be given information on GDM and on the importance of self-care using the GDM PHN toolkit and will follow diet, monitoring and scheduled appointments as assessed by the PHN.	**Ongoing PHD Field Nursing Measure** **1.8** Perform the following activities: • The MCAH Field Nursing Unit will provide GDM education that promotes self-management of diet, weight, and blood sugar to clients with a diagnosis of GDM in the antepartum and/or postpartum period. • Utilize the GDM PHN Toolkit.	**Ongoing PHD Field Nursing Measure** **1.8** • Briefly describe the process of FNU home visitation to promote diet, weight and blood sugar utilizing the GDM PHN toolkit on clients seen with a diagnosis of GDM or Type II DM in the antepartum or postpartum period. • Number of FNU clients with diagnosis of GDM that were referred to the FNU for GDM education. • Number receiving materials FNU staff utilizes the GDM PHN Toolkit for all pregnant and postpartum clients with a diagnosis of GDM or Type II Diabetes. The GDM PHN Toolkit addresses GDM, diet education, exercise and healthy lifestyle choices.	**Ongoing PHD Field Nursing Measure** **1.8** • Numerator: Number of clients seen in the antepartum and immediate (2 mo.) postpartum period that have a diagnosis of GDM that are given information on GDM and on the importance of self-care using the GDM PHN toolkit and following diet, monitoring, and scheduled appointments Denominator: Number of clients seen in the antepartum and immediate (2 mo.) postpartum period that have a diagnosis of GDM 142 / 147 = 97% Health Indicator – “Gestational Diabetes Mellitus” Health Indicator Outcomes • 97% (142/147) Information received on importance of self-care r/t GDM – following diet, monitoring, and scheduled appointments • 3% (4/147) Information received on importance of self-care r/t GDM – not following medical recommendations • 1% (1/147) Information not received on importance of self-care r/t GDM – client

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		In addition to referring clients to their OB provider for GDM management and follow up, FNU staff refers south and mid county Spanish speaking clients to the William Sansum Diabetes Center for the Semillas de Cambio program. Women are eligible for Semillas de Cambio if they have experienced a high risk pregnancy (ex: obesity, gestational diabetes, type 2 diabetes.), are "between" pregnancies, and/or at risk for future high risk pregnancy (ex: overweight/obese, pre-diabetic, type 2 diabetes). FNU staff refers clients to the Alliance for Pharmaceutical Access if assistance is needed for diabetic medication. The cost of diabetic medication	declined

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		often is identified as a barrier for clients served in SBC. Documentation of GDM education provided by the FNU staff is evaluated through individual chart reviews. Evaluation is completed by the Supervising PHNs on an ongoing basis. MCAH Leadership team conducts monthly CQI to review number of clients not meeting goals. Case conferences are conducted within each region when challenges are identified. These meetings were suspended between March-June 2019 as most MCAH staff was redirected to the COVID response. PSC has continued to provide consultation on CPSP requirements to the William Sansum Diabetes Center regarding GDM centering-like pilot project for	

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		prenatal clients at SBHCC.	

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Agency: Santa Barbara County Public Health Department
Agreement Number: 201942 **Fiscal Year:** 2019-20

All LHJs are required to report on the Objective 2.1 deliverables from your 2019-20 MCAH SOW

Goal 2:
CHILD/CYSHCN DOMAIN: Improve the cognitive, physical, and emotional development of all children, including children and youth with special health care needs (CYSHCN).

- Provide developmental screening for all children[1] in the MCAH programs
- All children, including CYSHCN, receive a yearly preventative medical visit
- Increase the rate of developmental screening for children ages 0-5

Short and/or Intermediate Objective(s)	**Place Evaluation/Performance Measures in the Two Columns Below**	
	Process	**Short and/or Intermediate Outcome Measures**
2.1 • All children, including CYSHCN, receive a yearly preventive medical visit • Developmental screening for children ages 0-5 years according to AAP guidelines – 9 months, 16 months and 30 months	**Briefly report on the following:** **2.1** **1. Describe activities to promote the yearly preventive medical visit.** (See SBC specific objective below) **2. Describe protocol/policies, including QA/QI processes to screen, refer, and link all children in MCAH program.** (See SBC specific objective below) MCAH promoted the CCS Parent Survey within the MCAH Field Nursing Unit during home visits and CHDP program	**Briefly report on the following:** **2.1** Below numbers are based on SBC MCAH FNU data. **1. Number of children, including CYSHCN, receiving a yearly preventive medical visit.** 946 **2. Number of children in local MCAH programs receiving developmental screening.** 946 **a. Number of children with positive screens that complete a follow-up visit with their primary care provider** 9

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	via email.	**b. Number of children with positive screens linked to services** 9 **c. Number of calls received for referrals and linkages to services** No calls received on toll free line for above reason.
SBC specific objective: By June 30th, 2020, 75% of children 0-17 in the MCAH Field Nursing Unit program with an identified developmental delay risk factor will have a developmental screen completed and anticipatory guidance and resources given.	Briefly describe: 1. Protocols/policies to screen, refer and link all children in MCAH programs The following MCAH policies are annually updated and address program standards for identifying children at risk for developmental delay: • "Health Indicator" • "MCAH Nursing Documentation" • "MCAH Home Visit Assessment: Medical, Dental, Mental" • "Perinatal Mood and Anxiety Disorder Screening in MCAH" 2. Assessment, intervention, referral process, provider access, and barriers to obtaining resources for	Briefly describe: 1. Briefly describe the policies developed to screen children for high risk factors, follow-up as needed with a developmental screening tool, refer and link children who screen positive to a provider and services and promote well-child visits. The Health Indicator policy addresses when and how the developmental screening should take place. The Nursing Documentation policy addresses follow up/outcome of screening process relevant to the specific health indicator (Developmental delay risk). The MCAH Home visit assessment policy discusses developmental screening tools to use. The PMAD policy addresses that if a mother has a positive EPDS

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	developmental delay risk. All families in the MCAH Field Nursing Unit (FNU) are screened for high risk factors (ex: substance use, domestic violence, maternal positive Edinburgh, mental health issues, and other traumatic influences) during home visits. If a high risk factor is identified, FNU staff screen children 0-17 with a developmental screening tool such as the ASQ-3, ASQ-SE 2, or Ireton. FNU staff refers and links at risk children to referral resources for follow up. Identified children with special health care needs less than 18 years are offered and given referral resources. FNU staff promotes the yearly medical visit for children, including CYSHCN. 3. List QA process developed to ensure screening, referral and linkage SPHNs continuously monitor individual charts to ensure clients identified as having screened positive for developmental delay or special healthcare needs are referred appropriately. Case conferences are conducted within each region when challenges are identified. The Health Indicators and outcomes for "Well Child Visit: 0-18", "Developmental Delay Risk", and "Children with Special Health Care Need: 0-18" are reviewed on a monthly basis by the MCAH leadership team. These meetings were suspended between March-June 2019 as most MCAH staff was redirected to the COVID response. Barriers and opportunities for improvement are discussed and brought back to staff for further discussion and implementation.	then child should be screened for developmental delay. 2. Outcomes of QA activities to ensure screening, referral and linkage Measures include: • Number of children in the MCAH FNU, including CYSHCN, receiving a yearly preventive medical visit – see objective 2.3 for "Well Child Visit: 0-18" health indicator and outcomes. • <u>Numerator</u>: Number of children 0-17 in the MCAH FNU with an identified developmental delay risk factor who had a developmental screen completed and given anticipatory guidance and resources. <u>Denominator</u>: All children 0-17 in the MCAH FNU with an identified developmental delay risk factor who had a developmental screen completed 120 / 124 = 97% <u>Health Indicator</u> - Developmental Delay Risk <u>Health Indicator Outcome</u>

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	4. Describe activities to promote the yearly preventive medical visit Each client enrolled in the MCAH FNU is provided education on the importance of the yearly preventive medical visit. Staff ensures that an appointment is made or that client/guardian is aware of when to schedule.	-90% (111/124) Negative Developmental Screen – anticipatory guidance and resources received -7% (9/124) Positive Developmental Screen – anticipatory guidance and resources received / f/u w/ PCP recommended and received – referred and linked to services -2% (3/124) Developmental Screen not done -1% (1/124) Never Found <u>Health Indicator</u> – Child with Special Health Care need: under 18 yrs <u>Health Indicator Outcome</u> -99% (67/68) Referral resources received: followed recommended referral resource -1% (1/68) Unable to locate for status of referral

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All LHJs are required to report on the Objectives selected from 2.1b through 2.1j on your 2019-20 MCAH SOW

Objectives 2.1b-2.1j: Choose at least one activity from activities 2.1b-2.1j.

- **Highlight the activity you chose to implement from your MCAH SOW in yellow in the first column.**
- **Report on the activities you chose to implement in the second column.**
- **Describe the requested information regarding the activities you chose to implement in the third column.**

Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
	Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
2.1b Promote the use of the Birth to 5; Watch Me Thrive; Learn the Signs, Act Early or other screening materials consistent with AAP guidelines.	**2.1b** Report the number of providers or provider systems receiving information about Birth to 5, Learn the Signs, Act Early or other screening materials. Click or tap here to enter text.	**2.1b** **Nothing is entered here.**
2.1c Participate in Help me Grow (HMG) or program that promote the core components of HMG.	**2.1c** Briefly describe participation in HMG or HMG-like programs. Click or tap here to enter text.	**2.1c** • Briefly list or describe the outcomes of participation in HMG or HMG like programs. Click or tap here to enter text. • Briefly describe results of work to implement HMG core components. Click or tap here to enter text.

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2.1d Increase understanding of the specific barriers to referral and evaluation by early intervention or pediatric specialists (including mental/behavioral health).	**2.1d** Briefly describe barriers to referral and evaluation by early intervention or pediatric specialist. Click or tap here to enter text.	**2.1d** **Nothing is entered here.**
2.1e Plan and implement a family engagement project to improve local efforts to serve children and youth with special health care needs (e.g., convene a family advisory group to assess how CYSHCN are served in local home visiting or case management programs)	**2.1e** Briefly describe project activities, goals, and outcomes such as number of family members engaged, number of community meetings, and other process measures specific to the planned project. Click or tap here to enter text.	**2.1e** **Nothing is entered here.**
2.1f Work with health plans (HPs), including MCPs to identify and address barriers to screening, referral, linkage and to assist the HPs in increasing developmental screening for their members, per AAP guidelines, through education, provider feedback incentives, quality improvement, or other methods.	**2.1f** Briefly describe the barriers and strategies to increase screening, referral and linkage. Click or tap here to enter text. • List the number of HPs requiring screening per AAP guidelines below. Click or tap here to enter text.	**2.1f** **Nothing is entered here.**

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2.1g Identify methods to measure and monitor rates of developmental and other types of childhood screening, referrals, and successful linkages to care in your jurisdiction.	**2.1g** If applicable, provide data on developmental and other screening rates, referrals, and successful linkages to care for the target population. Click or tap here to enter text.	**2.1g** **Nothing is entered here.**
2.1h Based on local needs, develop strategies to promote awareness of and address childhood adversity and trauma, including Adverse Childhood Experiences (ACEs), and build family and community resilience.	**2.1h** Provide a description, and data if applicable, on process measures and outcomes relevant to the planned activities. **(See Obj. 2.5)**	**2.1h** **Nothing is entered here.**
2.1i Outreach and education to providers to promote developmental screening, referrals and linkages.	**2.1i** Briefly describe type of outreach/education performed and results of outreach to providers. Click or tap here to enter text.	**2.1i** **Nothing is entered here.**

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2.1j Provide care coordination for CYSHCH, especially non-CCS eligible children or children enrolled in CCS in need of services not covered by CCS. **(See SBC specific objective above in 2.1)**	**2.1j** Briefly list or describe activities for care coordination provided. **(See SBC specific objective above in 2.1)**	**2.1j** List the number of children receiving care coordination. **(See SBC specific objective above in 2.1)**

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Required to report only if the LHJ had an Optional Locally Developed Objective(s) on the 2019-20 MCAH SOW

CHILD/CYSHCN DOMAIN:

Objective 2.2: An optional local objective that improves the, cognitive, physical, and emotional development of all children, including children and youth with special health care needs.

Short and/or Intermediate Objective(s)	Place Evaluation/Performance Measures in the Two Columns Below		
	Process		Short and/or Intermediate Outcome Measures
2.2 By June 30, 2020, explore the feasibility, through development of a staffing model, identifying referral sources, and identifying the population to be served,of including an evidence-based home visitation model into the current MCAH Field Nursing Unit through research of the Healthy Families America Model and/or other models and assessing current resources available in the community.	**2.2** • Explore requirements for implementing an evidence-based home visitation model, such as Healthy Families America • Explore funding opportunities • Interview other counties with evidence-based home visiting models, such as Healthy Families America, and that may also have a general MCAH field nursing program. • Conduct a community needs assessment to assess availability and capacity of local home visitation and evidence-	**2.2** Describe: • # and outcomes of interviews conducted and discussion • # and outcomes of planning meetings with internal MCAH Leadership team A local MPH student assisted MCAH in conducting a needs assessment to assess the existing case-management and home visiting services for pregnant and postpartum women and children 0-18 years old in Santa Barbara County. Qualitative Data through semi-structured key stakeholder interviews and secondary quantitative data	**2.2** Describe: • Staffing model developed • Referral sources • Population to be served MCAH Director developed a business plan which included a staffing model using a portion of current MCAH staff that will transition to HFA. HFA would be offered to those families that are at risk for child abuse and who would benefit from longer-term more intense case management services to increase positive parenting practices, improve child health, maternal health, child development and school readiness, and family economic and self-sufficiency. Eligibility criteria will include (1) Medi-Cal eligible or low-income (2) Pregnant or within 2 months postpartum (3) Has at least 1 risk factor, such

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	based programs serving pregnant, postpartum, and children 0-18.	sources such as online articles and reports were used. A total of 15 organizations were interviewed through the needs assessment. Average duration of case management services ranged from 1 month to 1 year. This assessment identified a paucity of longer-term evidence-based home visiting models in Santa Barbara County. An MCAH SPHN and MCAH Director interviewed 6 counties on their HFA programs. Discussions focused on implementation, operations, budget, and staffing. MCAH Director/Leadership team had several meetings with national HFA, PHD Human Resources, and fiscal to discuss the requirements and feasibility of including a HFA program.	as, childhood history of abuse or other adverse childhood events, substance use, mental health issues, and/or domestic violence. Pregnant women who are referred to MCAH will be offered HFA if they are deemed eligible. Those not eligible for HFA or those declining HFA will be offered short-term case management by a MCAH PHN. Eligible postpartum clients will be referred to HFA by their MCAH PHN with a warm hand-off to the HFA home visitor. The HFA application and supporting documents were completed, approved by PHD executive leadership, and ready for submission in March 2020. However, due to the COVID-19 pandemic, 80% of the MCAH staff, including the MCAH Director, was deployed to assist with the County's COVID response and HFA plans were placed on hold. Plans to move forward with an HFA program will be re-assessed in FY 20/21 when staff has returned to the MCAH program.

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Ongoing PHD Field Nursing Measure	**Ongoing PHD Field Nursing Measure**	**Ongoing PHD Field Nursing Measure**	**Ongoing PHD Field Nursing Measure**
Objective 2.3 By June 30, 2020, all eligible children and adolescents ages 0-18 who are clients of the Field Nursing Unit (FNU) will be enrolled in health insurance. **Objective 2.4** By June 30, 2020 all children and adolescents ages 0-18 who are clients of the FNU will have a scheduled appointment or are aware of the next well child visit based on Bright Futures periodicity schedule.	**2.3 and 2.4** MCAH staff develops and implements policies to: • Assess each child ages 0-18 who are clients of the FNU to determine if they are enrolled in health insurance within a two month period • Refer unenrolled but potentially eligible children for application assistance or directly provide application assistance for appropriate insurance type • Follow-up with referred children to determine if they become enrolled and incentive by offering low cost health promotion equipment. • Determine and educate families on upcoming/next well child visit per Bright Futures Schedule. • Develop and implement a	**2.3 and 2.4** • Describe policies implemented The MCAH policy "MCAH Home Visit Assessment: Medical, Dental, Mental" addresses program standards for assessing all MCAH Home visiting clients and their children for insurance status and needed well-child appointments. • Describe rationale for interventions, recommendations and strategies/policies developed • Briefly describe referral process developed and implemented Each child, ages 0-18, is assessed to determine if they are enrolled in health	**2.3 and 2.4** • Numerator: Number of eligible children and adolescents who are clients of the FNU who enroll in health insurance Denominator: All eligible children and adolescents seen by FNU 902 / 961 = 94% Health Indicator – "Insurance: 0-18" Health Indicator outcomes -93% (893/961) Obtained Insurance within 2 months -1% (9/961) Obtained insurance after 2 month -3% (32/961) Insurance application in process -2% (24/961) Lost to follow-up -0% (3/961) Insurance not obtained 2.3 • Numerator: Number of children and adolescents who are clients of FNU with scheduled appointment or are aware of the

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	Continuous Quality Improvement/Quality Assurance (CQI/QA) process to monitor implementation of policies/processes, a regular feedback mechanism to continually improve the process and a plan to evaluate the impact	insurance. Unenrolled but potentially eligible children are referred for application assistance or directly provided with application assistance for appropriate insurance type. Staff follow-up with referred children to determine if they have become enrolled. Families are educated on upcoming/next well child visit per Bright Futures schedule. • Briefly describe the CQI/QA process developed SPHNs continuously monitor individual charts to ensure children are enrolled in insurance and have a well-child visit scheduled. Case conferences are conducted within each region when challenges are identified. These meetings were suspended between March-June 2019 as most MCAH staff was redirected to the COVID response.	next well child visit based on Bright Futures Denominator: All eligible children and adolescents seen by FNU 946 / 965 = 98% Health Indicator – "Well Child Visit: 0-18" Health Indicator outcomes - 98% (946/965) Has scheduled appointment or is aware of the next well child visit - 2% (14/965) Lost to follow-up - 1% (5/965) Does not have a scheduled appointment or is not aware of the next well child visit • Describe the outcome of the CQI/QA process including methods of measurements and results During monthly leadership meetings, health indicators are reviewed. Supervising PHNs drill-down to identify reasons why the outcomes of "unable locate for status of referral", "Insurance not obtained", and "application in process" were used. After chart review and analysis is done, SPHN take back findings to discuss with their staff. Access to care barriers were identified and addressed. It was found that sometimes another

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		The Health Indicators and outcomes for "Well Child Visit: 0-18"and "Insurance: 0-18" are reviewed on a monthly basis by the MCAH leadership team. These meetings were suspended between March-June 2019 as most MCAH staff was redirected to the COVID response. Barriers and opportunities for improvement are discussed and brought back to staff for further discussion and implementation. • Describe access to care issues identified Barriers identified included losing families at the follow-up visits and mothers moving back to their native countries with their children.	outcome would have been more appropriate to use, staff were educated, and outcome corrected. Between March - June 2020, approximately 80% of MCAH field nursing staff was re-directed to COVID related activities. During this time in-home visits were shifted to phone visits to protect the safety of staff and the families served. Due to the reduced number of staff, low-risk clients may have had their cases closed prior to confirming if Medi-Cal was fully attained if it was determined that the family did not have any barriers to following through with Medi-Cal process. This could be the reason for the cases with "Medi-Cal in process".

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Ongoing PHD Field Nursing Measure	**Ongoing PHD Field Nursing Measure**	**Ongoing PHD Field Nursing Measure**	**Ongoing PHD Field Nursing Measure**
Objective 2.5 By June 30, 2019, all Head of Household (HOH) in the MCAH FNU will be screened for ACES and those with scores ≥ 4 will be referred to parenting classes and/or community support.	**2.5** • All HOH will be offered an ACES screening and NEAR@Home visit. • List of updated parenting classes and community resources are available to MCAH staff	**2.5** • Discuss the ACE screening and NEAR@Home process • Describe the process for educating staff about NEAR science, screenings, and when to refer clients • Describe the process of integrating the policy related to ACES screening and referrals MCAH integrated the NEAR@Home framework in early 2018. The leadership team was initially trained on reflective supervision and case conferencing before the integration of the NEAR@Home framework. Additional trainings on Reflective Practice were provided by CALM for the MCAH Leadership team and front line staff in 2019.	**2.5** Goal: Parents with ACE scores equal/greater than 4 referred to parenting classes and/or community support Numerator: Number of parents with ACE score ≥ 4 referred to parenting classes and/or community support Denominator: Total number of parents with ACE score ≥ 4 score 115 / 119 = 97% Goal: 75% of clients seen during home visits will verbalize effect of ACEs on parenting and its role in health • Numerator: Number of clients in the MCAH FNU able to verbalize effect of ACEs on parenting and its role in health Denominator: Number of clients in the MCAH FNU who received NEAR@Home visit 584 / 770 = 72%

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		The MCAH Coordinator became a trainer in the Community Resiliency Model (CRM) in 2017. CRM is a set of six easy skills that can be used by people who have experienced trauma or as a wellness practice to help build resilience. Staff has had several CRM trainings. CRM skills have been incorporated into staff and leadership meetings. The "MCAH Field Nursing Documentation" and "Health Indicators" policies were updated to include protocols for NEAR@Home visits in 2018 and are updated annually. A "NEAR@Home" policy was finalized in 11/1/19 and will be updated annually. ACE screening is conducted on all HOH. Education on protective factors and resilience is provided during home visits. Referrals to needed resources are made based on assessment. Pre	Health Indicator – "ACEs Screening" Health Indicator Outcomes • 39% (297/770) ACES < 4: Parents verbalized effect of ACEs on parents and health • 3% (25/770) ACES < 4: Parents unable to verbalize effect of ACEs on parents and health • 0% (1/770) ACES > or = 4: Not referred to resources/support; parents unable to verbalize effects of ACEs on parents and health • 0% (3/770) ACES > or = 4: Not referred to resources/support; Parents verbalized effect of ACEs on parents and health • 0% (2/770) ACES > or = 4: Referred to resources/support; Parents unable to verbalize effect of ACEs on parents and health • 15% (113/770) ACES > or = 4: Referred to resources/support; Parents verbalized effect of ACEs on parents and health • 2% (15/770) ACES Screening declined: Parents unable to verbalize effect of ACEs on parents and health • 11% (88/770) ACES Screening declined; Parents verbalized effect of ACEs on parents and health • 7% (49/770) ACES Screening not

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		and post-test on family resilience is given to all families seen. MCAH has been working with the Carpinteria Health Care Center in collaboration with the Carpinteria Children's Project on a pilot project to screen infants/children (0-24 months) and their parents at their well-child visits. MCAH has been providing consultation on this project. Please see obj. 1.1b for examples of outcomes of this project. • Describe QA process The Health Indicators and outcomes for "ACEs screening" is reviewed on a monthly basis by the MCAH leadership team. These meetings were suspended between March-June 2019 as most MCAH staff was redirected to the COVID response. Barriers and opportunities for improvement	completed; parents unable to verbalize effect of ACEs on parents and health • 11% (83/770) ACES Screening not completed: Parents verbalized effect of ACEs on parents and health • 12% (94/770) Lost to follow-up Between March - June 2020, approximately 80% of MCAH field nursing staff was re-directed to COVID related activities. During this time in-home visits were shifted to phone visits to protect the safety of staff and the families served. Due to the reduced number of staff, low-risk clients may have had their cases closed prior to completing the NEAR@Home visit which is typically done on subsequent visits after trust is established. Staff shared during this time they typically provided education on NEAR science and resiliency, but found assessing for sensitive subjects such as ACEs, DV, and SA was difficult due to the length of the assessment forms, language barriers, and unknown safety of participant when not in the same space. We will continue to explore these barriers and look for opportunities to enhance the NEAR@Home visit during virtual visits in the next FY.

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		are discussed and brought back to staff for further discussion and process improvement.	

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All LHJs are required to report on the Objective 3.1 and 3.2 deliverables from your 2019-20 MCAH SOW

Goal 3:
PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality by reducing the rate of SIDS/SUID deaths.

- Reduce pre-term births and infant mortality[1]
- Increase safe sleep practices[1]
- Increase exclusive breastfeeding initiation and duration [1]

Short and/or Intermediate Objective(s)	**Place Evaluation/Performance Measures in the Two Columns Below**		
	Process		**Short and/or Intermediate Outcome Measures**
3.1 All parents/caregivers experiencing a sudden and unexpected death will be offered grief and bereavement support services.	**Assurance - 3.1a** **Report the number of parents/caregivers who experienced a presumed SIDS death during fiscal year 2019-20.** 0	**3.1a** **Report the number of parents/caregivers who were contacted for grief support services during fiscal year 2019-20**. 0 – N/A If unable to contact, why? N/A	**3.1a** **Nothing is entered here.**
	3.1b **Report the number of coroner's notifications received during fiscal year 2019-20 below.**	**3.1b** **Briefly describe barriers in receiving notifications from coroners.** Coroner's office has a protocol to inform SIDS Coordinator of	**3.1b** **Nothing is entered here.**

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	0	all sudden and unexpected infant deaths. New SIDS Coordinator began on 11/1/2019 with email introductions to the Sargent. SIDS Coordinator and Sargent from the Coroner's Office participate on the Child Death Review Team which met twice this fiscal year. In the next FY, the SIDS Coordinator will maintain communication with the Coroner's office to ensure protocol is still in place.	

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3.2 All professionals, para-professionals staff, and community members will received information and education on SIDS risk reduction practices and infant safe sleep.	**3.2a** Disseminate AAP guidelines on infant sleep and SIDS risk reduction to providers, parents, community members and other caregivers of infants.	**3.2a** **Report the numbers receiving AAP guidelines on infant safe sleep during fiscal year 2019-20:** • **Providers** See # of pediatricians and CPSP providers • **Pediatricians** Regularly provide Safe Sleep and SIDS education and updates to CHDP staff to pass along to their 34 provider sites. • **CPSP Providers** At yearly CPSP visits provide info on Safe Sleep and SIDS to the 12 CPSP Provider Sites • **Child Care Providers** MCAH partnered with Children's Resource and Referral (CRR) during the 1st Annual Safe Sleep Walk (9/21/20). CRR has been	**3.2a** **Nothing is entered here.**

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		working to provide safe sleep education to the licensed child care providers they oversee. • **Parents** 318 See objective 3.3. • **Other (please list):** MCAH Director had discussions with WIC/Nutrition Services director and local breastfeeding advocates on Academy of Breastfeeding Medicine protocol on Bedsharing and Breastfeeding and CA SIDS Council response. Shared CDPH Safe Sleep Strategy: Family Centered Approach document and Recall on Inclined Sleepers with MCAH staff, CPSP providers, CHDP providers, and other community organizations.	

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	3.2b Attend the SIDS Annual Conference / SIDS training(s) and other conferences / training related to infant health.	**3.2b** **List the name(s) of attendees to the Annual SIDS Conference.** Zoua Vang took over as SIDS Coordinator from Kelley Barragan effective 11/1/19 Zoua Vang attended the SIDS Coordinator Training on 10/16/19 Zoua Vang and Kelley Barragan attended the Annual CA SIDS Conference on 10/17/19. Kelley Barragan presented on the Community Resiliency Model at the conference. Zoua Vang attended the SIDS/SUID Spring training, Part 2 session on 5/4/20, which transitioned to a virtual training due to the coronavirus pandemic. Jennie Stitt, PHN, attended the SIDS/SUID Spring training, Part 1 session on 4/24/20. Olivia Gray, PHN,	**Briefly list or describe here:** **3.2b** **The results of staff trainings related to infant health.** SIDS Coordinator received training on current SIDS theories, research, and risk reduction practices, roles of the first responder, coroner, and medical examiner, grief support, SIDS home visit, and community outreach. Training information shared at SBC MCAH FNU staff and via f/u email. SBC MCAH FNU provides support and education services to families of all presumed SIDS, SUID, and undetermined cases. This approach is due to the varied use of different diagnoses for unexplained infant deaths that are sudden and unexpected. SIDS Coordinator attends Child Death Review Team (CDRT) SIDS Coordinator attends CA SIDS Advisory Council and Southern CA SIDS Council meetings via teleconference as able.

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		attended the SIDS/SUID Spring training Part 1 on 4/24/20 and Part 2 on 5/4/20.	

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All LHJs are required to report on the Locally Developed Objective(s) for 3.3 and 3.4 from the 2019-20 MCAH SOW

PERINATAL/INFANT DOMAIN:
Objective 3.3: Provide objective(s) that reduce the risk of SIDS/SUIDS.

Short and/or Intermediate Objective(s)	Place Evaluation/Performance Measures in the Two Columns Below		
	Process		Short and/or Intermediate Outcome Measures
3.3a By June 30, 2020 develop and implement a community awareness campaign targeting the Hispanic and Mixtec communities aimed at increasing awareness of safe sleep practices and SIDS risk reduction.	**3.3a** • Outreach to organizations to partner with such as Promotores de Salud, SBCEO, First 5, and/or local agricultural businesses (ex: Driscoll Farms Health Center) • Develop materials with pictures of safe sleep for those with limited written language skills • SIDS coordinator and/or MCAH field nursing unit staff provide infant safe sleep education and SIDS risk reduction to Hispanic and Mixtec community members • Develop and implement a Continuous Quality Improvement/Quality	**3.3a** Briefly describe: • Community partnerships, linkages, and outreach • Number of parents receiving education about infant safe sleep practices and SIDS risk reduction • Presentations given • Materials developed • Evaluation tool developed • Results of the evaluations • Barriers, challenges, and opportunities to improve infant safe sleep practices • The CQI/QA process developed MCAH FNU staff and SIDS Coordinator participated in health fairs promoting safe sleep education for the community, including the	**3.3a** Numerator: Number of parents demonstrating increased knowledge and intention to follow infant safe sleep practices and SIDS risk reduction Denominator: Total number of parents educated 315 / 315 = 100 % • Briefly describe the results of evaluation • Describe the outcomes of the CQI/QA process including methods of measurements and results Families/individuals were given safe sleep education and were able to verbalize unsafe sleep behaviors demonstrating knowledge gained. Forms were provided for participants to write down their answers for the safe sleep game. Staff kept track of number of forms and participants that stopped by for safe sleep education. Future recommendations include staff assisting with writing down answers for participants unable

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	Assurance (CQI/QA) process to monitor implementation of SIDS and safe sleep education and a feedback mechanism to evaluate the impact	Hispanic and Mixtec communities. Safe sleep education and pamphlets were provided to families in English/Spanish language. A safe sleep game was developed where participants wrote down answers for unsafe sleep practices. Pencils were given as prize for participation in the game. 9/8/19 Lompoc HCC Health Care Week Fair – 25 participants 9/21/19 – Resource and referral Safe Sleep Walk –15 participants 10/11/19 – Carpinteria Children's Project Family Resource Center Health Fair – 50 participants 10/24/19 – Good Farms Health Fair in Lompoc – 85 participants 12/1/19 – Day of the Farm worker (Santa Maria Vets	to read and/or write or have them point out unsafe practices instead to increase participation in the safe sleep game.

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		Hall) - 140 participants Barriers: Some participants did not want to play the game. Participants informed the reason for not playing related to their inability to read/write down answers. Safe Sleep/SIDS risk reduction messaging was highlighted during the month of October on the PHD's social media accounts.	

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All LHJs are required to report on the Locally Developed Objective(s) for 3.3 and 3.4 from the 2019-20 MCAH SOW

PERINATAL/INFANT DOMAIN:

Objective 3.4: Provide a local objective that improves infant health by reducing pre-term births and infant mortality[1], Increase infant safe sleep practices[1], or Increase breastfeeding initiation and duration[1].

Short and/or Intermediate Objective(s)	Place Evaluation/Performance Measures in the Two Columns Below		
	Process		Short and/or Intermediate Outcome Measures
3.4a By June 30, 2020, build capacity of local MCAH and related program staff to address opioid use disorder (OUD) and substance use disorder (SUD) in perinatal populations through the use of screening, referral for treatment, and prevention.	**3.4a** • Work with FHOP and/or ACOG to coordinate and host a local training(s) for public health staff from MCAH, AFLP, the WIC program, prenatal care providers, and other relevant programs on screening, referral for treatment, and prevention of opioid use disorder (OUD) and substance use disorder (SUD) in perinatal populations using the "Opioid Use and Substance Use Disorder Public Health Toolkit" developed by ASTHO, and to distribute the	**3.4a** Local MCAH worked with FHOP to coordinator the training which was held on 1/30/20 from 9am-Noon. Information on the training was widely distributed via email. CEUs were offered by the PHD to RNs. • List # of people attending training and programs they are from 31 participants • List # of training evaluations completed 8 training evaluations were completed online • List # of local (or regional) referral resources identified for	**3.4a** • Discuss barriers and challenges encountered in identifying local referral resources for treating OUD/SUD in perinatal populations During the discussion of resources, participants were able to identify various resources throughout the county. There were even representatives from some of the agencies to provide a deeper insight into services provided. • Report on the % of staff attending the training that have increased their knowledge and skills related to prevention of, and screening and referral for OUD/SUD in perinatal populations 100% (8/8) of the participants who completed the evaluation stated that their

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	toolkit locally • Work with FHOP and/or ACOG to coordinate Perinatal OUD/SUD training logistics (identify training location, time, date, invite attendees, identify vendor for refreshments, etc.) • Distribute training evaluations at the training and collect completed evaluations and send to FHOP • Work with FHOP to identify local referral resources for Perinatal OUD/SUD • Distribute posters and handouts at county public health sites and share with community partners as appropriate	treating OUD/SUD in perinatal populations During the meeting, 7 local referral resources were identified and discussed. A follow-up email was sent to all participants with links for the referral resources. • List # of brochures and handouts distributed 100 of the "Opioids and Pregnancy – What you need to know" brochures/handouts were distributed during the training along with 100 copies of the locally MCAH produced "Pregnant and Using" and "Caring for a Substance Exposed Baby" pamphlets	knowledge and skills increased. One participant noted that they would conduct a mini training of what they learned during the day. Six participants noted that they had read the Toolkit. Five participants noted that they "Strongly agreed" that the toolkit was valuable to the work they do.

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Goal 4:
CROSSCUTTING DOMAIN: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy weight.

- Increase consumption of a healthy diet[1]
- Increase physical activity[1]

Short and/or Intermediate Objective(s)	Place Evaluation/Performance Measures in the Two Columns Below		
	Process		Short and/or Intermediate Outcome Measures
4.1 **Ongoing PHD Field Nursing Measure** **Objective 4.1** By June 30, 2020, 80% of MCAH FNU breastfeeding clients will continue to breastfeed at closure of case.	**4.1** **Ongoing PHD Field Nursing Measure** **4.1** Perform the following activities: • Identify and monitor trends on breastfeeding in SBC. • Work with community organizations to influence policy and address disparities. • Field Nursing Unit staff will attend at least one training on breastfeeding. • Assessment of	**4.1** **Ongoing PHD Field Nursing Measure** **4.1** Briefly describe: • Breastfeeding trends in Santa Barbara County. Santa Barbara County local hospital data compared to CA breastfeeding data: SBC breastfeeding Initiation percentage during early postpartum in the area of: any breastfeeding – increased from 96.2% in 2017 to 96.6% in 2018.	**4.1** **Ongoing PHD Field Nursing Measure** **4.1** • Numerator: Number of clients in the MCAH FNU who were breastfeeding at closure of case Denominator: Number of clients in the MCAH FNU who breastfed 789 / 913 = 87% Health Indicator – “Breastfeeding” Health Indicator Outcomes • 26% (236/913) No problems – Breastfeeding adequate, no

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	breastfeeding for all postpartum mothers. • Support of breastfeeding and/or assistance is given as needed by FNU staff. • Encourage mothers to exclusively breastfeed on all pregnant and postpartum visits. • Provide referrals for WIC, Lactation Consultants and • Peer Counseling as needed. • FNU staff input information re: individual cases into the PHN Database under health indicator status. • Documentation of breastfeeding support given assessed on individual chart reviews. • All documentation is reviewed by the Supervising PHNs.	Compared to CA breastfeeding initiation percentage during early postpartum – any breastfeeding decreased from 93.9% in 2017 to 93.8% in 2018. HP 2020 Target – 81.9% SBC breastfeeding Initiation percentage during early postpartum in the area of: exclusive breastfeeding – increased from 61.6% in 2017 to 66.4% in 2018. Compared to CA breastfeeding initiation percentage during early postpartum – exclusive breastfeeding which increased from 69.6% in 2017 to 70.4% in 2018. In 2018, 82.8% of white women compared to 59.2% of Hispanic women exclusively breastfed upon discharge from hospital. This demonstrates a continued need for education and support for breastfeeding within the Hispanic community and collaborative work to address barriers. Source: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CDPH%20Docum	supplementation • 18% (162/913) No problems – Breastfeeding adequate with supplementation • 6% (58/913) No problems – No longer breastfeeding • 18% (160/913) Breastfeeding support – Breastfeeding adequate, no supplementation • 16% (150/913) Breastfeeding support – Breastfeeding adequate, supplementation • 4% (38/913) Breastfeeding support – No longer breastfeeding • 5% (44/913) Referral for breastfeeding consultation received – Breastfeeding adequate, no supplementation • 4% (37/913) Referral for breastfeeding consultation received – Breastfeeding adequate, supplement • 1% (13/913) Referral for breastfeeding consultation received –No longer breastfeeding • 2% (14/913) Not Found • 0% (1/913) Declined Field Nursing Services

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		ent%20Library/BFP/BFP-Data-InHospital-Residence-RaceEthnicity-2018.pdf The Public Health Department has a Lactation Services Program that is very successful and is utilized by the MCAH FNU and the public. There is a two-way texting program that Lactation Services developed that is quite popular. • Describe MCAH staff participation in the Breastfeeding Coalition. A MCAH PHN attends Breastfeeding Coalition meetings and shares information at the FNU staff meetings and case conferences. • Describe breastfeeding training for Field Nursing Unit staff. Nutrition Services Director provided an overview of WIC/Lactation services to MCAH staff on 9/11/19.	Additional work: MCAH supported BOS proclamation for National Childhood Obesity Awareness Month – September 2019

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		• Describe Field Nursing Unit breastfeeding interventions and referrals to WIC and Lactation Services. • List three successful strategies used to sustain exclusive BF Collaborated with WIC/Nutrition Services Director on algorithm to facilitate timely lactation services for FNU clients. Worked with local hospitals and other nurse home visiting programs to ensure breast pumps are made available to families at all times. FNU staff intervention on postpartum home visits include: • Assessment of breastfeeding is done on all postpartum mothers. A majority of the PP referrals are received from the PHD Health Care Center OB department. • Support of breastfeeding and/or assistance is given as needed by FNU. • All pregnant and postpartum referrals are encouraged to exclusively breastfeed.	

[1] 2016-2020 Title V State Priorities
[2] Title V Requirement

		• Current information on breastfeeding is shared with staff. • Referral to Lactation Services, WIC, and Breastfeeding Peer Counseling for breastfeeding problems not resolved with PHN intervention. • If client is seen in pregnancy, PHN will promote WIC and lactation services. • FNU staff inputs information re: individual cases into the PHN Database under health indicator status. • Documentation of breastfeeding support given by the FNU staff assessed on individual chart reviews. This is an ongoing process and all documentation is reviewed by the SPHNs. Case conferences are conducted within each region when challenges are identified. • Cottage Hospital became a Baby-Friendly Hospital in early 2018. • Describe barriers to BF Barriers to exclusive breastfeeding in SBC:	

[1] 2016-2020 Title V State Priorities
[2] Title V Requirement

		• There is a cultural norm in the Hispanic community to supplement. The FNU and other home visitation agencies attempt to dispel these myths. • Formula companies send advertising and free formula samples to our clients. • Early return to work is also a barrier. Although there are free breast pumps through Lactation Services at the PHD and baby friendly companies. Many of our clients are farm workers that are paid by how much they pick as a crew (or) are in minimum wage jobs and do not feel comfortable or may not have adequate time to pump at the workplace.	

[1] 2016-2020 Title V State Priorities
[2] Title V Requirement

California Department of Public Health/Maternal, Child, and Adolescent Health
Fiscal Year 2019-20 Annual Report

Agency: Santa Barbara County Public Health Department
Agreement Number: 201942 **Fiscal Year:** 2019-20

Required to report only if the LHJ had an Optional Locally Developed Objective(s) on the 2019-20 MCAH SOW

Goal 5:
ADOLESCENT DOMAIN: Promote and enhance adolescent strengths, skills, and supports to improve adolescent health.

- Decrease teen pregnancies[1]
- Reduce teen dating violence, bullying and harassment[1]

Short and/or Intermediate Objective(s)	Place Evaluation/Performance Measures in the Two Columns Below		
	Process		Short and/or Intermediate Outcome Measures
5.1 • Not addressed in this SOW • MCAH Director collaborates with AFLP Manager • CalPREP MOU with Teen Services grantee in North County for referrals • See Obj. 1.1a for number of pregnant and non-pregnant high risk teens served by MCAH field nursing unit	**5.1** Click or tap here to enter text.	**5.1** Click or tap here to enter text.	**5.1** Click or tap here to enter text.

[1] 2016-2020 Title V State Priorities
[2] Title V Requirement

California Department of Public Health/Maternal, Child, and Adolescent Health
Fiscal Year 2019-20 Annual Report

Agency: Santa Barbara County Public Health Department
Agreement Number: 201942 **Fiscal Year:** 2019-20

This section of the Annual Report is now where the LHJs complete the Year-End survey. LHJs no longer have to complete the Year-End survey later in the year.

TITLE V ANNUAL SURVEY OF LOCAL PROGRAMS

State Fiscal Year 2019-20

The survey attached in the Annual Report email is a print version of the survey for reference only.

All LHJs are REQUIRED to complete the Title V Survey using this link:

https://www.surveymonkey.com/r/FRGNKP9

Survey completed on 11/3/20 for Santa Barbara County

[1] 2016-2020 Title V State Priorities
[2] Title V Requirement