California Department of Public Health (CDPH)
Maternal, Child and Adolescent Health (MCAH) Program
Scope of Work (SOW)

☒ **IMPORTANT**: By clicking this box, I agree to allow the state MCAH Program to post my Scope of Work on the CDPH/MCAH website.

The Local Health Jurisdiction (LHJ), in collaboration with the State MCAH Program, shall strive to develop systems that protect and improve the health of California's women of reproductive age, infants, children, adolescents and their families. The goals and objectives in this MCAH SOW incorporate local problems identified by LHJs in the 5-Year Needs Assessments and reflect the Title V priorities of the MCAH Division. The local 5-Year Needs Assessment identified problems that LHJs may address in their 5-Year Action Plans. The LHJ 5-Year Action Plans inform the development of the annual MCAH SOW.

All LHJs must perform the activities in the shaded areas in Goals 1-3 and monitor and report on the corresponding evaluation/performance measures. In addition, each LHJ is required to develop at least two local objectives in Goal 1, one to address the health of reproductive age women and one to address the needs of pregnant women and two local objectives for Goal 3, a SIDS/SUID objective and an objective to improve infant health. LHJs that receive FIMR funding will perform the activities in the shaded area in Goal 3.5, including one local objective addressing fetal, neonatal, post-neonatal and infant deaths. In the second shaded column of 3.5a, Intervention Activities to Meet Objectives, insert the number and percent of cases that will be reviewed for the fiscal year. Lastly, if resources allow, LHJs should develop additional objectives, which can be placed under any of the Goals 1-5. All activities in this SOW must take place within the fiscal year. Please see the MCAH Policies and Procedures for further instructions on completing the SOW.

The development of this SOW was guided by several Public Health (PH) frameworks including the ones listed below. Please consider integrating these approaches when conceptualizing and organizing local program, policy, and evaluation efforts.

- The Ten Essential Services of Public Health
- The Spectrum of Prevention
- Life Course Perspective
- The Social-Ecological Model
- Social Determinants of Health
- Strengthening Families

All Title V programs must comply with the MCAH Fiscal Policies and Procedures Manual, which is found on the CDPH/MCAH website

CDPH/MCAH Division expects each LHJ to make progress towards Title V State Performance Measures and Healthy People 2020 goals. These goals involve complex issues and are difficult to achieve, particularly in the short term. As such, in addition to the required activities to address Title V State Priorities and requirements, the MCAH SOW provides LHJs the opportunity to develop locally determined objectives and activities that can be realistically achieved given the scope and resources of local MCAH programs.

LHJs are required to comply with requirements as stated in the MCAH Program Policies and Procedures Manual, such as attending statewide meetings, conducting a Needs Assessment every five years, submitting Agreement Funding Applications, and completing Annual Progress Reports.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1: Women/Maternal Domain: Improve access to and utilization of comprehensive, quality health and social services

The shaded and/or highlighted areas represent required activities.

Short and/or Intermediate Objective(s)	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)
Objective 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 preventive, medical, dental, and social services by:** • Targeting 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] • Decreasing Medi-Cal eligible women, children, post-partum women without insurance[1]	**Assessment** **1.1a** i. Identify and monitor the health status of women of reproductive age, pregnant women, infants, children, adolescents, and CYSHCN, including the social determinants of health and access/barriers to the provision of: • Preventive, medical, dental, and social services ii. Review data books and monitor trends over time, geographic areas and population group disparities iii. Annually, share your data with key local health department leadership	**1.1a** i. This deliverable will be fulfilled by completing and submitting your Community Profile with your Agreement Funding Application each year ii. Briefly describe process for monitoring and interpreting data iii. Report the date data shared with the key health department leadership. Briefly describe their response, if significant.	**1.1a** Nothing is entered here.

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	1.1b Participate in collaboratives, coalitions, community organizations, etc., to review data and develop policies and products to address social determinants of health and disparities.	**1.1b** Report the total number of collaboratives with MCAH staff participation. Submit online Collaborative Surveys that document participation, objectives, activities and accomplishments of MCAH – related collaboratives.	**1.1b** List policies or products developed to improve infrastructure that address MCAH priorities.
	Policy Development **1.1c** i. Review, revise and enact protocols or policies that facilitate access to Medi-Cal, California Children's Services (CCS), Covered CA, and Women, Infants, and Children (WIC)	**1.1c** i. List types of protocols or policies developed or revised to facilitate access to health care services.	**1.1c** i. List formal and informal agreements in place including Memoranda of Understanding with Medi-Cal Managed Care Plans (MCP) or other organizations that address the needs of mothers and infants

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	ii. Develop and implement protocols to ensure all clients in MCAH programs are enrolled in a health insurance plan, linked to a provider, and complete an annual visit. Protocols include the following key components: • Assist clients to enroll in health insurance • Link clients to a health care provider for a preventive and/or medical visit • Develop a tracking mechanism to verify that the client enrolled in health insurance, completed a preventive or well medical visit	ii. Briefly describe the key components of the protocols developed to ensure all clients in MCAH programs are enrolled in insurance or a health plan, linked to a provider and complete an annual preventative and/or medical visit.	ii. Describe and summarize the impact of protocols or policy and systems changes that facilitate access to Medi-Cal, CCS, Covered CA, and WIC.
	Assurance **1.1d** Develop staff knowledge and Public Health (PH) competencies for MCAH related issues	**1.1d** Summarize staff knowledge and competencies gained	**1.1d** Nothing is entered here

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Short and/or Intermediate Objective(s)	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)	
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	1.1e Conduct activities to facilitate referrals to Medi-Cal, Covered CA, CCS, and other low cost/no-cost health insurance programs for health care coverage[2]	**1.1e** Describe activities to ensure referrals to health insurance, programs and preventive visits	**1.1e** Report the number of referrals to Medi-Cal, Covered CA, CCS, or other low/no-cost health insurance or programs.
	1.1f Provide a toll-free or "no-cost to the calling party" telephone information service and other appropriate methods of communication, e.g., local MCAH Program web page to the local community[2] to facilitate linkage of MCAH population to services	**1.1f** Describe the methods of communication, including the, cultural and linguistic challenges and solutions to linking the MCAH population to services	**1.1f** Report the following: • Number of calls to the toll-free or "no-cost to the calling party" telephone information service • The number of web hits to the appropriate local MCAH Program webpage

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Goal 1.2: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for <u>reproductive age women.</u>

Short and/or Intermediate Objective(s)	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)**
<u>REQUIRED LOCAL OBJECTIVE</u>: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ is required to develop at least one specific short and/or intermediate SMART outcome objective(s) to address access to needed preventive services. ***Number each locally developed objective as follows: 1.2, 1.2a, 1.2b, 1.2c, 1.2d, etc.***			
Objective 1.2 **By June 30, 2020, the rate of women of childbearing age (12-45yo) infected with Gonorrhea and Chlamydia will decrease by 10% compared to FY 18/19**	**1.2a** **Assessment** 1. Work with the LHJ STD branch to compile, analyze baseline data on recent trends of Gonorrhea and Chlamydia infection for females ages 12 to 45 years old in Lake County. **Policy Development** 2. Identify local providers, schools, colleges, local bars, and other local agencies to provide condoms and sexual health information for distribution to the public. 3. Compile and distribute informational packets to local healthcare providers to provide to any patient who tests positive for an STD. 4. Develop media and social media materials to raise awareness of STD rates in Lake County and importance of testing.	**1.2a** • List of agencies condoms and materials are distributed to, include number of condoms distributed to each agency. • List of schools represented at county-wide meetings and curriculum identified to fulfill Sexual Education requirements. • Total number of enhanced surveillance interviews for women of childbearing age (12-45 yr) completed. • Number of social media posts and number of times viewed and shared. • Number of press releases published in social media. • Description and quantity of other media and social media materials released.	**1.2a** • Rate of women of childbearing age 12-45 yo infected with Gonorrhea and Chlamydia for FY 19/20.

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Goal 1.2: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for <u>reproductive age women.</u>

Short and/or Intermediate Objective(s)	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)
<u>REQUIRED LOCAL OBJECTIVE</u>: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ is required to develop at least one specific short and/or intermediate SMART outcome objective(s) to address access to needed preventive services. ***Number each locally developed objective as follows: 1.2, 1.2a, 1.2b, 1.2c, 1.2d, etc.***			
	5. Present to local parent groups and Parent Teacher Associations, to inform parents of STD rates in transitional age youth as well as requirements of sexual health education. 6. Provide information to all Middle School and High School teachers regarding STD rates and ways to talk to their students about STDs and testing. 7. Develop or utilize an existing surveillance tool to interview all gonorrhea and chlamydia cases in females age 12 to 45 **Assurance** 8. Compile and analyze data on Gonorrhea and Chlamydia for females ages 12 to 45 years in lake County at the end of FY 19/20.		

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Goal 1.3: WOMEN/MATERNAL DOMAIN: <u>All pregnant women</u> 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)	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)
Objective 1.3 **All women will have access to quality maternal and early perinatal care, including CPSP services for Medi-Cal eligible women by:** • Increasing first trimester prenatal care initiation[1] • Increasing postpartum visit[1] • Increasing access to providers that can provide the appropriate services and level of care for reproductive age women[1]	**Assurance** **1.3a** i. Develop MCAH staff knowledge of the system of maternal and perinatal care ii. Develop a comprehensive resource and referral guide of available health and social services iii. Attend the yearly CPSP statewide meeting iv. Conduct local activities to facilitate increased access to early and quality perinatal care	**1.3a** Report the following: i. List of trainings received by staff on perinatal care, such as roundtables, regional meetings, collaborative work ii. Submit resource and referral guide iii. Date and attendance at the CPSP yearly meeting iv. 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	**1.3a** Provide the number and describe the outcomes of: • Roundtable meetings • Regional meetings • Other maternal and perinatal meetings

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Goal 1.3: WOMEN/MATERNAL DOMAIN: <u>All pregnant women</u> 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)	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)
	1.3b Outreach to perinatal providers, including Medi-Cal Managed Care i. Enroll in CPSP (Fee-for-Service and FQHC/RHC/IHC providers) ii. Identify and work with MCP liaisons to provide CPSP comparable services iii. Assist MCP providers to provide CPSP comparable services	**1.3b** i. Enroll FFS and FQHC/RHC/IHC providers Identify the MCP liaison(s). ii. Work with MCP(s) to provide CPSP comparable services iii. Work with MCP providers to provide CPSP comparable services	**1.3b** Nothing is entered here
	1.3c Coordinate perinatal activities between MCAH and the Regional Perinatal Programs of California (RPPC) to improve maternal and perinatal systems of care, including coordinated post-partum referral systems for high-risk mothers and infants upon hospital discharge	**1.3c** List number of meetings attended to facilitate coordination of activities between RPPC and MCAH and briefly describe outcomes	**1.3c** Nothing is entered here.
	1.3d Conduct technical assistance and face-to-face quality assurance/quality improvement (QA/QI) activities with CPSP providers or managed care providers in collaboration with	**1.3d** Report the number of CPSP provider technical assistance activities conducted by phone or email	**1.3d** Describe the results of technical assistance provided by phone or email

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Goal 1.3: WOMEN/MATERNAL DOMAIN: <u>All pregnant women</u> 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)	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)**
	MCP(s) liaison to ensure that CPSP services are implemented and protocols are in place	Report the number of QA/QI face-to-face site visits conducted with: • Enrolled CPSP providers • MCPs providers (with MCP liaison(s)) • Number of chart reviews List common problems or barriers and successful interventions	Describe the results of QA/QI activities that were conducted with: • Enrolled CPSP providers • MCPs providers (with MCP liaison(s)) • Summary of findings from the chart reviews

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Goal 1.4: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for <u>pregnant women.</u>

Short and/or Intermediate Objective(s)	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)**
<u>REQUIRED LOCAL OBJECTIVE</u>: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ is required to develop at least one specific short and/or intermediate SMART outcome objective(s) to address access to needed preventive services. ***Number each locally developed objective as follows: 1.4, 1.4a, 1.4b, 1.4c, 1.4d, etc.***			
Objective 1.4 **By June 30, 2020 80% of Lake County OB, Pediatrics, and Mental Health practitioners providing services to pregnant/ postpartum women will be trained in Perinatal Mood and Anxiety Disorders (PMADs).**	**1.4** **Assessment** 1. Develop a group of stakeholders to plan and obtain funding for Postpartum Support International (PSI) 2-Day Training. **Policy Development** 2. Partner with PSI to implement 2-day training for Lake County Providers. 3. Partner with CPSP, Pediatric providers, and other agencies in Lake County to establish a referral pathway for women to obtain Maternal Mental Health services. 4. Update and maintain a referral guide with Maternal Mental Health resources. 5. Develop a plan to participate in the BlueDot Project for Maternal Mental Health Awareness month, including purchasing of BlueDot campaign materials and social media outreach. **Assurance** 6. Survey providers to identify if gaps in knowledge have been addressed and if screening and referrals are being made.	**1.4** • Total number of attendees for PSI 2-day training. • Describe policies developed to ensure screening and referral for pregnant and postpartum women with CPSP, Pediatric providers and other agencies in Lake County. • Describe knowledge change and intent to change practice for providers. • List of agencies participated in BlueDot project and number of social media posts and views of those social media posts.	**1.4** • Number of OB, Pediatric, birth hospitals, and other agencies identified that have policies to screen all pregnant/ postpartum women for PMADs and refer to services as needed. • Total Number of practitioners trained: a. OB b. Pediatric c. Mental Health/ Therapists d. Other Providers

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

The shaded and bolded areas represent required activities.

Short and/or Intermediate Objective(s)	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)**
Objective 2.1 **Provide developmental screening for all children[1] in MCAH programs** • All children, including CYSHCN, receive a yearly preventive medical visit • Increase the rate of developmental screening for children ages 0-5 years according to AAP guidelines – 9 months, 18 months and 30 months	**Child Objective** **2.1a** Promote the American Academy of Pediatrics (AAP) developmental screening guidelines. **The following bolded activities, i, ii, are required:** **i. Promote regular preventive medical visits for all children, including CYSHCN, in MCAH Home Visiting and Case Management programs, per Bright Futures/AAP,** **ii. Adopt protocols/policies, including a QA/QI process, to screen, refer, and link all children in MCAH Home Visiting or Case Management Programs**	**2.1a** **Required** **Describe or report the following for MCAH programs:** **i. Activities to promote the yearly preventive medical visit** **ii. Describe protocols/policies including QA/QI process to screen, refer and link all children in MCAH programs**	**2.1a** **Required** **Describe or report the following for children in MCAH programs** **i. Number of children, including CYSHCN, receiving a yearly preventive medical visit** **ii. Number of children in MCAH programs receiving developmental screening** • **Number of children with positive screens that complete a follow-up visit with their primary care provider** • **Number of children with positive screens linked to services** • **Number of calls received for referrals and linkages to services**

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	CYSHCN Objective(s) At least one activity is required. Choose from activities 2.1.b-2.1. (highlight your choices in yellow):	***Report the following based on the activities you chose to implement in the second column (highlight your choices in yellow):***	***Describe the following based on the activities you chose to implement in the second column (highlight your choices in yellow):***
	2.1b Promote the use of Birth to 5; Watch Me Thrive, Learn the Signs, Act Early or other screening materials consistent with AAP guidelines	**2.1b** Number of providers or provider systems receiving information about Birth to 5, Learn the Signs, Act Early or other screening materials	**2.1b** Nothing is entered here
	2.1c Participate in Help Me Grow (HMG) or programs that promote the core components of HMG	**2.1c** Describe participation in HMG or HMG like programs	**2.1c** Outcomes of participation in HMG or HMG like programs. Describe results of work to implement HMG core components
	2.1d Increase understanding of the specific barriers to referral and evaluation by early intervention or pediatric specialists (including mental/behavioral health)	**2.1d** Describe barriers to referral and evaluation by early intervention or pediatric specialists	**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	**2.1e** Describe project activities, goals, and outcomes such as number of family members engaged, number of community meetings, and other	**2.1e** Nothing is entered here

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	advisory group to assess how CYSHCN are served in local home visiting or case management programs)	process measures specific to the planned project	
	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 screenings for their members, per AAP guidelines, through education, provider feedback, incentives, quality improvement, or other methods	**2.1f** Describe barriers and strategies to increase screening, referral and linkage • Number of HPs requiring screenings per AAP guidelines	**2.1f** Nothing is entered here
	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	**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	**2.1h** Provide a description, and data if applicable, on process measures and outcomes relevant to the planned activities	**2.1h** Nothing is entered here

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	(ACEs), and build family and community resilience		
	2.1i Outreach and education to providers to promote developmental screening, referral and linkages	**2.1i** Describe type of outreach/education performed and results of outreach to providers	**2.1i** Nothing is entered here
	2.1j Provide care coordination for CYSHCN, especially non-CCS eligible children or children enrolled in CCS in need of services not covered by CCS	**2.1j** Describe activities for care coordination provided	**2.1j** List the number of children receiving care coordination

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OPTIONAL LOCAL OBJECTIVE: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. ***Number each locally developed objective as follows: 2.2, 2.2a, 2.2b, 2.2c, etc.***			
Objective 2.2 **By June 30, 2020 an ongoing Home Visiting Programs Multidisciplinary Team meeting will be established and meet on a monthly basis with the purpose to ensure that families are receiving coordinated services tailored to their needs.**	**2.2** **Assessment** 1. Identify key players in Multidisciplinary team to invite to the table for collaboration and care coordination. 2. Review previous MDT meeting policy and protocols. 3. Identify current research and laws as it pertains to the Multidisciplinary team approach. **Policy Development** 4. Develop a release of information to cover all agencies present at Multidisciplinary Team Meetings. 5. Establish a standing monthly meeting day for all Home Visitors and Home Based Service providers. 6. Develop a procedure to submit clients and families that there are concerns about prior to monthly meetings. 7. Develop a format for monthly meetings to ensure all agencies are able to meet the needs of their clients.	**2.2** • List of key players and agencies involved. • Describe methods of communications for establishing MDT meeting. • Describe current research and laws as it pertains to Multidisciplinary Team Approach. • Submit example of ROI for all agencies. • Number of monthly meetings and number of agencies involved in each meeting. • Describe process of preparation for meetings and format of meetings. • Describe results of survey of those providers participating in monthly meetings.	**2.2** • Number of monthly meetings. • Number of agencies who participated in monthly meetings. • Total Number of families/ clients who were discussed at MDT meetings.

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OPTIONAL LOCAL OBJECTIVE: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. ***Number each locally developed objective as follows: 2.2, 2.2a, 2.2b, 2.2c, etc.***			
	Assurance 8. Survey providers and agencies involved in MDT on a quarterly basis to determine efficacy of meeting.		

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

The shaded area represents required activities.

Short and/or Intermediate Objective(s)	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)**
Objective 3.1 **All parents/caregivers experiencing a sudden and unexpected death will be offered grief and bereavement support services**	**Assurance** **3.1a** Establish contact with parents/caregivers of infants with presumed SIDS death to provide grief and bereavement support services[3] Provide grief and support materials to parents	**3.1a** (Insert number) of parents/caregivers who experience a presumed SIDS death and the number who are contacted for grief and bereavement support services.	**3.1a** Nothing is entered here
	3.1b Contact local coroner office to ensure timely reporting and referral of parents of all babies who die suddenly and unexpectedly regardless of circumstances of death	**3.1b** Report the coroner's notifications received Briefly describe barriers and opportunities for success	**3.1b** Nothing is entered here
Objective 3.2. **All professionals, para-professionals, staff, and community members will receive information and education on SIDS risk reduction practices and infant safe sleep**	**3.2a** Disseminate AAP guidelines on infant safe sleep and SIDS risk reduction to providers, pediatricians, CPSP providers, parents, community members and other caregivers of infants	**3.2a** Numbers receiving AAP guidelines on infant safe sleep: • Providers • Pediatricians • CPSP providers • Child care providers • Other – list	**3.2a** Nothing is entered here

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

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

The shaded area represents required activities.

Short and/or Intermediate Objective(s)	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)
	3.2b Attend the SIDS Annual Conference/SIDS training(s), SIDS Coordinators' meeting and other conferences/trainings related to infant health[3].	**3.2b** Provide staff member name and date of attendance at SIDS Annual Conference/SIDS training(s) and other conference/trainings related to infant health.	**3.2b** Describe results of staff trainings related to infant health.

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Short and/or Intermediate Objective(s)	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)**
REQUIRED LOCAL OBJECTIVE: Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ must provide at least one specific short and/or intermediate SMART outcome objective(s) to address SIDS/SUID. ***Number each locally developed objective as follows: 3.3, 3.3a, 3.3b, 3.3c., etc.***			
Objective 3.3 **1. By June 30, 2020, Lake County MCAH will Partner with North Coast Opportunities to ensure that all licensed child care providers for children under the age of 2 years old will receive education on SIDS risk reduction and infant safe sleep activities and will demonstrate understanding and intent to implement what was learned.**	**3.3** **Assessment** 1. Review data as it relates to SIDS/ SUID (including roll over) for Lake County and determine trends for previous 10 years. 2. Survey of child care providers current safe sleep practice in Lake County. **Policy Development** 3. Provide education and information to childcare providers. Develop a process to measure knowledge change and intent to implement what was learned. 4. Develop media and social media campaign materials for SIDS awareness month as well as materials to promote safe sleep throughout the FY. 5. Develop outreach materials for local community events to promote safe sleep practices for all caregivers. **Assurance**	**3.3** • Describe barriers to implementation of safe sleep practices by child care centers in Lake County. • Describe activities used to outreach and provide education to child care providers. • List of community events attended and education material provided to the public. • Describe process to measure knowledge change and intent to implement what was learned.	**3.3** • Number of child care providers in Lake County who are provided outreach and education about safe sleep. • Percent of child care providers who report increased in knowledge of safe sleep practices and intent to implement what was learned via post-surveys completed. • Number of surveys collected at community events, report of overall understanding of safe sleep recommendations and intent to implement what was learned based on survey results. • Number of times social media posts, views, and other media releases.

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Short and/or Intermediate Objective(s)	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)
	6. Survey of safe sleep knowledge of attendees who visit the booth at family-oriented fairs. 7. Post-intervention survey of safe sleep practices at child care centers in Lake County.		

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Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality

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Short and/or Intermediate Objective(s)	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)**
<u>REQUIRED LOCAL OBJECTIVE</u>: Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ must provide at least one specific short and/or intermediate SMART outcome objective(s) to address perinatal/infant health. ***Number each locally developed objective as follows: 3.4, 3.4a, 3.4b, 3.4c., etc.***			
Objective 3.4 **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.**	**3.4** **Assessment** 1. Work with Family Health Outcomes Project (FHOP) to coordinate and host a local training for public health staff from MCAH, BIH, AFLP, Home Visiting, WIC, and other relevant programs on screening, referral for treatment and prevention of OUD and SUD in the perinatal populations using the "Opioid Use and Substance Use Disorder Public health Toolkit" developed by ASTHO, and to distribute the toolkit locally. **Policy Development** 2. Work with FHOP to coordinate Perinatal OUD/SUD training logistics (identifying training locations, time, date, invite attendees, identify vendor for refreshments, etc.)	**3.4** • List the number of people attending training and programs they are from. • List number of training evaluations completed. • List number of local or regional referral resources identified for treating OUD/SUD in perinatal populations. • List number of brochures and posters distributed.	**3.4** • Discuss barriers and challenges encountered in identifying local referral resource for treating OUD/SUD in perinatal populations. • Report on the percentage of staff attending the training that have increased their knowledge and skills related to prevention of, and screening and referral of OUD/SUD in perinatal populations.

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Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality

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Short and/or Intermediate Objective(s)	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)
	3. Work with FHOP to identify local referral resources for Perinatal OUD/SUD. 4. Distribute posters and handouts to county public health sites and share with community partners as appropriate.		

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[3] State Requirements