Imperial County Public Health Department

Maternal Child Adolescent Health

Five Year Needs Assessment

2010-2014

Executive Summary

For the Imperial County MCAH Needs Assessment 2010-2014 process, a stakeholder group was convened to provide input and direction for different sections of the needs assessment process. These sections are as follows: a) defining the MCAH Mission and Goals, b) confirming the MCAH priority areas, and c) completing the capacity assessment component (mCAST-5 worksheets). Stakeholder group members included individuals representing the March of Dimes, Clinicas de Salud del Pueblo-Community Clinic Network, Child Abuse Prevention Council, Imperial Valley College Nursing Program and the provider community, Children and Families First Commission, Pioneers Memorial Hospital, Public Health Nutritionist, Imperial County Public Health Department Maternal Child Adolescent Program areas (i.e., Adolescent Family Life Program, Comprehensive Perinatal Services Program, Dental Disease Prevention Program), and others.

A total of 27 health status indicators were analyzed as part of the MCAH 2010-2014 needs assessment process. Imperial County highlights are as follows;

a) Overweight and obesity
b) Breastfeeding
c) Teen pregnancy and subsequent pregnancy
d) Prenatal care
e) Asthma
f) Access to health insurance

The capacity assessment process allowed the local MCAH system to come together and identify strengths, weaknesses, opportunities and threats within the context of "The 10 MCAH Essential Services." During this interesting process, several themes resonated and are discussed in detail in this document. As the local MCAH system looks to the future and works to enhance existing strengths and opportunities, and address the identified capacity needs, it is also important to acknowledge emerging public health issues. For Imperial County, emerging public health issues include emergency preparedness, increases in sexually transmitted diseases such as chlamydia and gonorrhea, and the impact of substance abuse, specifically methamphetamines. These public health issues could have immediate and long term effects on the local MCAH population. Addressing our capacity within the MCAH system to meet the needs within the "Ten MCAH Essential Services," as well as our emerging public health issues, will ensure improved health outcomes for our community now and in the future.

Mission Statement and Goals

Mission

The Maternal Child and Adolescent Health System of Imperial County will work to promote, coordinate, and assess the capacity of health care and human services for all children and families regardless of disparities. Children and families are provided with opportunities to develop healthy lifestyles in a safe and nurturing environment through equal access to and appropriate utilization of culturally sensitive health care and human services."

Goal 1: Programs and agencies serving children and families collaborate to assess the capacity of the MCAH system to ensure provision and to facilitate appropriate utilization of comprehensive health care and human services in Imperial County.

Goal 2: All children and families in Imperial County, regardless of disparities, must have equal access to culturally sensitive health care and human services.

Goal 3: The promotion of a safe, healthy, and nurturing environment for children and families is achieved by providing coordinated opportunities for education and outreach in Imperial County.

The MCAH Mission and Goals that are outlined above are an updated version of the 2005-2009 MCAH Mission and Goals. The current Mission and Goals were developed with the input and perspective from a convened Imperial County stakeholder group. This stakeholder group is discussed in detail in the following section and members are outlined in the Worksheet A: MCAH Stakeholder Input Worksheet. The MCAH Mission and Goals were updated, following numerous discussions among the MCAH stakeholder community. Ultimately, the stakeholder community felt it necessary to update the Mission and Goals based on the current needs assessment focus of "systems" and "agency coordination."

Stakeholder Input and Process

For the Imperial County MCAH Needs Assessment 2010-2014 process, it was determined that convening a planning group was unnecessary for completion of this project. Instead, a stakeholder group was convened to provide input and direction for different components of the needs assessment process. These components are as follows: a) defining the MCAH Mission and Goals, b) confirming the MCAH priority areas, and c) completing the capacity assessment component (mCAST-5 worksheets). Stakeholder group members included individuals representing the March of Dimes, Clinicas de Salud del Pueblo-Community Clinic Network, Child Abuse Prevention Council, Imperial Valley College Nursing Program and the provider community, Children and Families First Commission, Pioneers Memorial Hospital, Public Health Nutritionist, Imperial County Public Health Department Maternal Child Adolescent Program areas (i.e., Adolescent Family Life Program, Comprehensive Perinatal Services Program, Dental Disease Prevention Program), and others.

Community Health Profile

Geographic Features: Imperial County is located in the southeastern corner of the state of California and extends over 4,597 square miles surrounded by Riverside County to the north, San Diego County to the west, the state of Arizona to the east, and Mexico to the south. The terrain varies from desert, with an elevation low point of 235 feet below sea level at the Salton Sea, to 4,548 feet at Blue Angel Peak.

Population Demographics: Imperial County has experienced steady population growth in recent years, *with an estimated population of 179,798 in 2008*, according to the California Department of Finance. *Seventy-eight* percent of the population lives in the incorporated cities of Brawley, Calexico, Calipatria, El Centro, Holtville, Imperial, and Westmorland. The remaining 22% lives in the unincorporated rural areas. Imperial County has the highest percentage of Latino/Hispanic residents of all counties in California. Approximately *76.2%* of Imperial County residents are Latino, *16.7%* are white, non-Latino, *4.3%* are Black, *2%* are American Indian, and *2.6%* are Asian. In the past decade, the Latino population *has continued to* increase, while the white, non-Latino population has declined.

Women of childbearing age (15-44 years) comprise *20.2%* of the total population. About one-quarter of the population (*26.4%*) is under 18 years of age, *similar to* California as a whole (*26.2%).* Thirty-two percent of the people living in Imperial County from 2005-2007 were foreign born. Sixty-eight percent was native, including 56 percent who were born in California. *Among people at least five years old living in Imperial County from 2005-2007, 69% spoke a language other than English at home. Of those speaking a language other than English at home, 97% spoke Spanish and 3 percent spoke some other language; 48% reported that they did not speak English "very well."*

Socioeconomic Status: Imperial County's population is poorer than that of California as a whole. A higher proportion of County residents live at or below the Federal Poverty Level compared to other counties in California. In *2006*, an estimated *26.4%* of the County's population under age 18 was living in poverty, compared to *17%* statewide. Imperial County's median household income *(in 2007 inflation-adjusted dollars)* was *$35,933*, which is lower than the median income for California as a whole *($58,361)*, according to the U.S. Census Bureau, 2005-2007 American Community Survey.

From 2005-2007, for the employed population 16 years and older, the leading industries in Imperial County were educational services, health care, and social assistance (23%), and retail trade (14%).

Imperial County has a significantly higher unemployment rate in 2009 (*25.1%)*, more than double the statewide rate *(11.5%)*, according to the California Employment Development Department. The County's unemployment rate is down from a high of 29.5% in 1996. The high unemployment rate is due in part to marked seasonal fluctuations in employment that are characteristic of the County's agricultural and tourism-based economy.

Education Status: *From 2005-2007, 62% of people 25 years and over had at least graduated from high school and 10% had a bachelor's degree or higher. Thirty-eight percent were dropouts; they were not enrolled in school and had not graduated from high school.*

Vital Statistics: *Imperial County's fertility rate (number of live births per 1,000 women) was 89.5 on average in 2004-2006, which represented a significant increase during 1997-2006. Imperial County's fertility rate is significantly higher than the statewide average fertility rate of 70.5 during 2004-2006.*

Imperial County's birth rate to teen mothers between the ages of 15 to 17 is 34.1 per 1,000 female population aged 15-17. The rate declined significantly from a high of 61.6 births per 1,000 female population aged 15-17 in 1995-1999, but has decreased only slightly from 1999-2006. The County's teen birth rate is significantly higher than the statewide rate of 20.3.

In *2004*, Medi-Cal and other government health insurance coverage represented the principal payment source for *55.5%* of all birth deliveries in Imperial County. Statewide, *47.4%* of birth deliveries were paid for by government sources. Thirty-two (32) percent of births were paid for with private insurance in Imperial County, compared to *22.5%* of birth deliveries in California as a whole.

In 2004-2006, 74.5% of pregnant women received prenatal care during their first trimester, which represents a significant increase from 69.1% in 1995-1997. This is significantly lower than the statewide average of 85.6%, and lower than the Healthy People 2010 objective of 90% of pregnant women receiving prenatal care in the first trimester.

The proportion of Imperial County women who received adequate prenatal care over the course of their pregnancy according to the Kotelchuck Index has decreased to 61.1%, significantly lower than 68.2% of women who received adequate care in 1995-1997. This is significantly lower than the statewide average of 77.0%, and does not meet the Healthy People 2010 objective of 90% of pregnant women receiving adequate prenatal care.

Health Care Access: Access to quality medical care is an important determinant of health. Access to care can be limited by many factors including an inability to pay for services, a lack of insurance to cover medical costs, a shortage of health-care providers, and no regular source of ongoing health care. Many low-income residents end up seeking care in hospital emergency rooms because they cannot afford health insurance, have no medical provider for primary care, and have little or no access to preventive care. In a 1998 Health Risk Assessment Survey conducted in Imperial County, nearly one-third (31%) of respondents reported that primary care was difficult to access or not accessible at all. Of those respondents, 56% stated that the cost was prohibitive; 35% reported that care was not available to the best of their knowledge; and 23% stated that care probably was available but they did not know where to go.

According to the 2005 California Health Interview, 13.5% of Imperial County residents reported no usual source of care. Of those who reported a usual source of care, 57.1% reported going to a doctor's office; 26.3% went to a community clinic; and 1.3% sought care in an urgent care center or emergency department at a hospital.

Health Insurance: *Having health insurance is associated with better health status and improved access to care. A significantly greater proportion of Imperial County residents are uninsured, compared to California as a whole. Overall, 20% of Californians, or 6.5 million people, lacked health insurance coverage for all or part of the year in 2005, according to the findings of the 2005 California Health Interview Survey (CHIS). Imperial County reported one of the highest uninsured rates (27.7%) of all counties in California. Imperial County had correspondingly low rates of employment-based coverage. Only 40.5% of Imperial County residents reported employment-based insurance, compared to 54.3% statewide.*

Air Quality: Air pollution is a widespread public health problem and environmental problem. Poor air quality contributes to a variety of health problems including respiratory illness, cardiovascular disease, cancer, and premature death. Asthma can be triggered or worsened by exposure to ozone, particulate matter, and tobacco smoke. Ozone is a major component of urban smog and can trigger various health problems such as chest pains, throat irritation and congestion, and can worsen bronchitis, heart disease, emphysema, and asthma. In 2006, Imperial County reported *51 days* during which the ozone levels exceed state standards. Particulate matter pollution is an even greater problem. In 2008, the particulate matter air pollution exceeded state standards *187 days (51%), which remains high but represents nearly a two-thirds' reduction in the number of days per year since 1999.*

Chronic Disease: Asthma is the most common chronic disease in children in the United States. It is a serious and growing problem in Imperial County. Recent studies show a substantial proportion of the County's population suffers from asthma*. According to the findings of the 2005 California Health Interview Survey (CHIS), 14.7% of Imperial County residents reported having been diagnosed with asthma by a health-care provider during their lifetime compared to 13.6% of all California residents. Imperial County continues to report the highest hospitalization rates for asthma of all counties in California.*

Sexually Transmitted Diseases **--** Chlamydia accounts for the majority of reported STD cases in Imperial County. Chlamydia is the most common reportable communicable disease in Imperial County, as well as California overall. Imperial County's crude case rate for chlamydia on average *in 2005-2007 was 326.6 cases* per 100,000 population, *which represents a significant increase over previous years* and a higher rate than in most counties in California. The County's rate is *lower* than that of California as a whole (291.1) during the same period.

Gonorrhea is the second most common reportable STD in Imperial County, as well as in the state as a whole. *Imperial County's crude case rate in 2005-2007 was 33.1 cases per 100,000 residents, compared to 88.3 per 100,000 population statewide.*

Describe how the local MCAH program functions within the larger organizational structure of the local Public Health Department:

The Imperial County Public Health Department is divided into three divisions, and is as follows: a) Health and Support Services, b) Environmental Health Services, and c) Community Health. A Deputy Director oversees each of the three divisions. The MCAH program falls within the Community Health Division. Further, the MCAH program is under the direction of an approved MCAH Director in accordance with the State MCAH/OFP Branch Policies and Procedures. The MCAH Director, as part of the MCAH program, oversees the Perinatal Services Program, Prenatal Care Guidance, SIDS program, and Adolescent Family Life Program. The MCAH staff participates in the Imperial County Breastfeeding Coalition Grant funded by the First Five Commission and acts as the fiduciary agent. Additionally, the MCAH Director manages all programs that pertain to the MCAH population. These programs include California Children's Services, Childhood Health and Disability Program, the California Dental Disease Prevention Program, and the Childhood Lead Prevention Program.

Describe the functional role of the local MCAH program within the larger MCAH system:

In accordance with the State MCAH-Office of Family Planning Branch policies and procedures, and under the direction of the MCAH director, the local MCAH program provides a coordinated effort to improve the outreach and access to services for the MCAH population. As part of this effort, the MCAH director and staff collaborate with a variety of agencies that support the health and well-being of the population. Imperial County MCAH activities also include providing support to other MCAH programs that are available through local provider and clinic venues. Another MCAH focus is the active participation in local collaboratives and coalitions, for example, the Imperial County Immunization Coalition, the Child Abuse Prevention Council, Migrant Health Education, March of Dimes, Coalition for Expectant and Parenting Teens, and the Imperial County Office of Education Early Childcare and Childhood Development program.

Health Status Indicators

This section details a variety of health status indicators for the Imperial County jurisdiction. Please refer to completed Worksheet B for required information.

Local MCAH Problems and Needs

The MCAH problems and needs section includes a list of major problems and unmet needs to be addressed over the next five years. Additionally, a brief description of each identified problem is provided. It should be noted that the current list is very similar to the prior problems and unmet needs that were identified in the 2005-2009 Imperial County MCAH Needs Assessment. The major problems and unmet needs for 2010-2014 are as follows:

- Overweight and Obesity
- Asthma
- Breastfeeding
- Teen Pregnancy and Subsequent Pregnancy
- Prenatal Care
- Access to Health Insurance

State-required MCAH Indicators have been reviewed and summarized using FHOP data templates. Please see Appendix D for a complete data description. Below is a summary of Imperial County Indicator Data, with comparisons to California and Healthy People 2010 (as appropriate). Health Indicators notably different from Healthy People 2010, State Levels, or past years are discussed below.

I. Overweight and Obesity: Since the mid-1970s the prevalence of obesity and overweight has increased dramatically in the United States. *In 2007, 15.3% of Imperial County's children aged 2 to 5 were overweight and 17.7% were obese, according to the Pediatric Nutrition Surveillance System. For Imperial County's 5- to 20-year-old population, 17.7% were overweight and 24.8% were obese. Based on two height and weight questions on the California Healthy Kids Survey conducted in 2004-2005 and 2005-2006 school years, 23% of 7th graders, 20% of 9th graders, and 18% of 11th graders in Imperial County were overweight based on calculated body mass index (BMI).*

Overweight children face a greater risk of developing many health problems, including Type 2 diabetes, high blood pressure and asthma, as well as low self-esteem, poor body image, and symptoms of depression. Fifty percent of obese adolescents become obese adults, putting them at much higher risk for heart disease, cancer, stroke, and diabetes later in life. Physical inactivity and nutrition-related diseases are the second leading cause of preventable death. These diseases account for 28% of preventable deaths each year.

II. Breastfeeding: The American Academy of Pediatrics has identified breastfeeding as the ideal method of feeding and nurturing infants and recognizes breastfeeding as primary in achieving optimal infant and child health, growth, and development. The need to increase breastfeeding initiation and duration rates is of concern not only in Imperial County, but also throughout the state and nation. Imperial County has been identified as a County with significantly low

breastfeeding rates compared to other counties and California as a whole. *In 2006, the proportion of mothers who breastfed their newborns exclusively in-hospital totaled 8.4% in Imperial County, compared to 42.8% for California during the same period. Exclusive breastfeeding in-hospital is the ultimate goal.*

Another way to define breastfeeding initiation is the percentage of infants who are breastfed in conjunction with formula feeding ("any breastfeeding"). During 2004-2006, on average 82.9% of Imperial County mothers reported "any breastfeeding," compared to 86.3% of mothers statewide. Imperial County achieved the Healthy People 2010 target of 75% of mothers initiating breastfeeding during the early postpartum period.

A recent communitywide Health Risk Assessment Survey completed as a collaborative effort between Imperial County Public Health Department and UCLA School of Public Health Technical Assistance Group provided invaluable insight regarding attitudes, beliefs, and values of our community residents. Eighty-two percent of the respondents indicated that the best nutrition for babies comes from breast milk. Eighty percent completely agreed that it is best if a mother breastfeeds her baby. Another 13.6% of respondents somewhat agreed with this statement. More than 47% indicated that a mother should breastfeed between seven months to a year.

The benefits of breastfeeding include bolstering infants' immune system; reducing the chance of infections; protection against some chronic diseases and conditions; reducing childhood obesity; and protection against dental cavities, among others.

III. Teen Pregnancy and Subsequent Pregnancy

Imperial County has one of the highest teen birth rates of all counties in California. In 2004-2006, there were 446 live births on average to mothers aged 15-19 in Imperial County, for a birth rate of 57.2 live births per 1,000 female population, or 14.3% of all live births.

In 2004-2006 on average 19.5% of women aged 12-19 who gave birth were already mothers. This is a significantly higher percentage of women than a decade earlier in 1995-1997 (15.2%).

Several short- and long-term consequences may occur as a result of teen pregnancy. For example, a) teen mothers are less likely to complete high school, b) children of teen moms are more likely to perform poorly in school, and c) the sons of teen mothers are more likely to end up in prison while teen daughters are more likely to become teen mothers themselves. Further, the likelihood that a teen mom will finish high school diminishes rapidly with the arrival of each succeeding baby.

IV. Prenatal Care: *In 2005, 75.6% of pregnant women in Imperial County accessed prenatal care during the first trimester of their pregnancy, compared to 86.6% of pregnant women in California as a whole.*

While the percentage of women who begin prenatal care in the first trimester of their pregnancy has increased significantly over the past decade, Imperial County continues to lag behind the state of California as a whole and the Healthy People 2010 objective of at least 90% of women who begin prenatal care in their first trimester. In Imperial County, white, non-Latino women were more likely to begin prenatal care in their 1st trimester of pregnancy than were women of other races or ethnicities. A possible factor influencing this may be that some women who give birth in Imperial County obtain their prenatal care in Mexico, and it is unclear whether care received out of the country is accurately documented on the birth certificates.

Documenting the trimester in which prenatal care began does not indicate whether prenatal care continues over the course of the pregnancy. For this reason, prenatal care also is assessed using the Adequacy of Prenatal Care Utilization (Kotelchuck) Index. *The proportion of women who received adequate prenatal care in Imperial County has decreased over the past decade from an average of 68.2% in 1995-1997 to only 61.1% on average of pregnant women who reported receiving adequate care. This is a significantly smaller proportion than California as a whole or the Healthy People 2010 objective of 90% of all pregnant women.* Latina women were less likely to receive adequate prenatal care than women of other race/ethnic groups.

Related risk factors for not obtaining prenatal care early in the pregnancy or inadequate prenatal care throughout the pregnancy include low income; young maternal age/teen pregnancy; low maternal education level; race/ethnicity (Black, Latino/Hispanic, American Indian/Alaska Native); high parity; maternal substance abuse; lack of health insurance; and lack of obstetric providers.

V. Asthma: Asthma is one of the most common chronic diseases in children in the United States. The prevalence is increasing, with an estimated 100 million asthma patients worldwide. In the United States alone, there are an estimated 14-15 million persons with asthma. The increasing prevalence of this disease is associated with increased morbidity and mortality. Although it is highly prevalent in the general population, asthma disproportionately affects individuals of lower socioeconomic status and of racial and ethnic minority groups. Asthma-related health care expenditures continue to increase with asthma-related costs including both direct expenses such as hospital care, clinic visits, and drug therapy; and indirect costs, including time lost from work and daily activities.

Asthma hospitalization rates in Imperial County have been significantly higher over the past decade compared to California as whole and the Healthy People 2010 target. Imperial County has consistently reported the highest asthma hospitalization rates of all counties in California. Among children ages 0 to 14, Imperial County has the most elevated rate for all race/ethnicity groups combined, and the highest rate for white, non-Latinos and Latinos/Hispanics. The high

hospitalization rates among children in Imperial County may be partially due to the high levels of poverty and poor air quality.

Asthma hospitalization rates represent the most severe cases, as well as those who may not be receiving adequate care or treatment to properly control their asthma. Asthma symptom prevalence gives a better indication of the number of people who have asthma. Recent studies show that a substantial proportion of the County's population suffers from asthma.

According to the 2003 California Health Interview Survey (CHIS,) an estimated 21,000 Imperial County residents have been diagnosed with asthma by a health-care provider during their lifetime. Children were disproportionately affected by asthma. The study estimated that 17% of children and 11% of adults in Imperial County have a lifetime diagnosis of asthma. An analysis of the 2001and 2003 CHIS survey data show that while estimates of asthma diagnosis for adults remained stable across years (~11%), rates for children increased dramatically from 15% to 19 between 2001 and 2003.

VI. Access to Health Insurance: Many Imperial County residents lack health insurance coverage of any kind. The Healthy People 2010 objective calls for everyone to have health insurance. Health insurance facilitates and increases access to health care. Without health insurance, families are less likely to access primary care or preventative services and more likely to have a higher incidence of preventable illness or complications of illness. Children with health insurance are more likely to be immunized and to receive timely preventative care than uninsured children. According to the 2001 California Health Interview Survey (CHIS), 14.58% (14.27-14.9 C.I.) of children ages 0-19 in Imperial County are uninsured. This is significantly higher than California as a whole (11.7%). Many children also have no dental insurance coverage. According to the CHIS Survey, a significantly higher percentage of Imperial County children ages 2-11 lack dental insurance (29.17%, 28.59-29.74 C.I.) compared to California as a whole (23.27%).

Imperial County has a high proportion of immigrant families. Children in immigrant families were more than three times as likely as children in non-immigrant families to lack health insurance (15% vs. 4%), according to the findings of 2001 California Health Interview Survey.

Insurance coverage varies significantly in Imperial County in relation to demographic variables such as ethnicity, income, and education. An estimated 40% of Spanish speakers, 33% of Latinos, and 40% of those with incomes below $23,000 have no insurance, in sharp contrast to the near universal coverage among non-Latinos (89%). According to the California Employment Development Department, the monthly unemployment rate ranged from a low of 14.7% to a high of 22.6% in 2003.

Imperial County residents also face significant language barriers. The Imperial County Office of Education found that 47% of students in county schools have limited English proficiency and several local communities report significant percentages of their community are linguistically isolated (Calexico reports 30.7%) with 99% of the linguistic isolation identified as Spanish speaking only. These large numbers have a substantial impact on the amount of people without access to health care coverage, except through public programs. When surveyed, a large proportion of residents did not know where to go for care and had no medical home.

The issues facing Imperial County are 1) limited access to health care, because of cultural and linguistic barriers, lack of insurance or knowledge about programs, services, cost, shortage of providers, and lack of trust; 2) over-reliance on the emergency room; and 3) lack of valuable health and demographic data on our population for decision making.

MCAH Priorities

Maternal Child Adolescent Health priorities for 2010-2014 are as follows: a) the rate of children (5 to 19 years of age) who are identified as overweight and obese should be reduced; b) the rate of asthma hospitalizations among children (0 to 17 years of age) should be reduced; c) the rate for exclusive breastfeeding at the time of hospital discharge should be increased; d) the barriers to receiving adequate prenatal care for women should be reduced; e) the rate of teen pregnancy and subsequent births among women (12-19 years of age) should be reduced; and f) the barriers to health care access for women, children, and adolescents should be reduced.

The above 2010-2014 priorities mirror the 2005-2009 MCAH priorities with the exception of injuries being dropped. The reasoning to not include injuries as part of this needs assessment is because the data indicates there to be an overall improvement in childhood injuries. *Conversely, short inter-pregnancy intervals for women 12-19 years of age, was added to the teen pregnancy priority. The reasoning to include this indicator is because the data indicate that women aged 12-19 who are already mothers are having subsequent children (subsequent pregnancies among our 12-19 years of ages have increased)*.

Stakeholder input was collected to help determine and confirm the 2010-2014MCAH priorities.

MCAH Capacity Needs

The mCAST-5 tool was completed with stakeholder input. This process took place over the course of our MCAH Needs Assessment planning meetings. The group offered input and perspective over the course of completing this assessment process, including the completion of this section. There were several needs identified (as well as a variety of strengths and opportunities) during this process. The major themes that resonated are as follows:

- Unaware /limited means to access data because
    - Community agencies don't know where to go to find data
    - Conflicting data sources
    - Inconsistent data sources
    - Incomplete and/or inaccurate data collection procedures
- Inability to interpret data by some of the MCAH community agencies
- Lack of qualified instructors/personnel to establish sufficient graduate level nursing programs
- Different career paths currently being pursued by nursing professionals (currently, it appears that nurses are choosing career paths for the monetary benefits)
- Disjointed and sporadic sharing and dissemination of MCAH-focused information in the community
- MCAH program is "budget driven"
- Current and future budget crisis and fiscal restrictions
- Shrinking resources and increasing needs
- Aging MCAH workforce

In preparing to complete the MCAH capacity needs worksheet, the above themes were further distilled: a) data, b) communication network across the MCAH system, c) MCAH workforce, d) policy development, and e) academic partnerships. In further distilling our major themes, we expect that this will allow us additional clarity and a focused purpose so that, over the next five years, we can work towards building our capacity as a local MCAH system to ensure that the Ten Essential Public Health Services to Promote Maternal and Child Health in America are carried out.

MCAH Jurisdiction: Imperial County – Worksheet A

Stakeholder Participant's Initials	Organizational Affiliation	Sector Represented	Section Provided Input On					
			Mission Statement & Goals	Community Health Profile	Health Status Indicators	Local MCAH Problems/Needs	MCAH Priorities	Capacity Assessment
C.A.	March of Dimes	F	x	x	x	x	x	x
A.B.	Clinicas de Salud	C						
B.B.	ICOE	B						
Y.B.	ICPHD	A	x	x	x	x	x	x
A.B.	ICPHD	A	x	x	x	x	x	x
E.B	ECRMC	C						
C.C.	EC Fact Center	E						
D.D.	IVC	E	x	x	x	x	x	x
B.D.	PMH	C	x	x	x	x	x	x
D.S.	Behavioral Health	C						
A.F.	Regional Center	C	x					
G.F.	ICPHD	A	x	x	x	x	x	x
L.F	ICPHD	A						
A.F.	ECRMC	C						
M.G.	ICPHD	A	x					
X.G.	Family Resource Center	E						
Y.G.	CAP Council	E	x					
M.G.	IV Women's clinic	C						
L.I	Clinicas	C						
P.Ky.	ICPHD	A	x	x	x	x	x	x
P.Kr.	ICPHD	A	x	x	x	x	x	x
C.M.	ICPHD	A	x					
I.M.	WIC	B						
R.N.	Family Treehouse	E						
M.P.	ECRMC	C						
A.R.	ICPHD	A						
M.R.	ECRMC	C						
J.R.	First Five	B	x	x	x	x	x	x
G.R.	Migrant Head Start	B						
V.R.	ICPHD	A	x					
M.S.	ICPHD	A	x	x	x	x	x	x
C.T.	ICPHD	A	x	x	x	x	x	x
H.V.	ICOE	B						

MCAH Priorities Worksheet C3 (Required)

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

MCAH Jurisdiction: <u>Imperial County</u>

Priority 1. The rate of children (5-19 years of age) who are identified as overweight and obese should be reduced.
Priority 2. The rate of asthma hospitalizations among children (0-17 years of age) should be reduced.
Priority 3. The rate for exclusive breastfeeding at the time of hospital discharge should be increased.
Priority 4. The rate of teen pregnancy and subsequent births among women (12-19 years of age) should be reduced.
Priority 5. The barriers to receiving adequate prenatal care for women should be reduced.
Priority 6. The barriers to health care access for women, children, and adolescents should be reduced.

MCAH Capacity Needs Worksheet E (part B)

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

MCAH Jurisdiction: Imperial County

Capacity Need	How this capacity could be improved (include any short term or long term strategies)	Potential challenges on improving this capacity (e.g., impact on local MCAH services, stakeholder concerns, availability of resources)	How other local organizations, local jurisdictions, or the State MCAH Program can help improve this capacity
Available and Accessible Data	Making data accessible to appropriate local MCAH stakeholders Possibly expand Child Health and Disability Prevention (CHDP) newsletter to include more data, or a link to access data/information. Periodically highlighting MCAH data in the Public Health Bulletin.	Many data sources are available but people might not know about them. Staff resources are limited at ICPHD and other agencies. Insufficient resources.	Centralized data source or links in one website. ICPHD can make data more accessible by posting data on www.icphd.org website. Possibly coordinate with SDSU, IVC or other colleges/universities to maximize use of computer equipment/software programs, expertise, and statistical analysis. Local and State MCAH program can ensure that data is available to incorporate into bulletin/newsletter.
Meaningful Data	Provide meaningful data to providers via ICPHD website, Public Health Bulletin and/or link to web resources.	People from different disciplines may collect data using different methods. Lack of information/direction on how to collect data appropriately.	ICPHD, local/state MCAH programs, and/or colleges/universities can provide data collection/interpretation recommendations when possible. Offer a) training sessions, b) webinars, or c) other online opportunities for local MCAH system partners.

Communication network among the local MCAH system	Facilitate and improve information Dissemination to MCAH partners (disseminate briefs, local updates, legislation, ordinance, etc) Engage all MCAH partners/stakeholders and assess their readiness.	Time constraints of key members Unclear about roles and responsibilities	Post information, data sets/links and other appropriate MCAH resources on ICPHD website under MCAH. Reassess the convening of a local MCAH Advisory Structure Update website information periodically to ensure update to date information. An online meeting or in person meeting once a quarter or semi-annually. Different agencies can take the lead. Create a local MCAH list serve to facilitate online communication/discussion among agencies.
Adequate and competent MCAH workforce	Work with local and out of the area colleges and universities to promote MCAH and the benefits of working in MCAH area. Offer additional job shadowing/internship opportunities for those who have an interest in MCAH. Promote MCAH at health fairs and other community events.	Time constraints of key members. Buy-in by MCAH staff and key members of colleges and universities. Limited staff availability for job shadowing/mentoring. Limited resources to meet these needs.	Offer MCAH focused trainings/webinars for MCAH partners and key stakeholders. Develop MCAH focused curriculums and presentations for local agencies to use.
Policy Development skills	Include perspectives of community members and organizations regarding policies addressing MCAH. Provide current information regarding public health trends to elected officials. Communicate with local providers and community	Time constraints of key members. Limited resources to address MCAH policy concerns. Buy-in by policy makers to MCAH concerns.	Help identify and or coordinate policy driven courses/classes.

	members and listen to their concerns. Respond to concerns through policy changes. Provide leadership to formulate policy. Consult with and participate in local and state advisory councils.		
Academic Partnerships	For student trainings, internships opportunities or continuing education. Formalize internship opportunities/program for several disciplines to rotate through the ICPHD and other local MCAH agencies	It may be challenging at time for professionals to stay current with the latest information and obtain continuing education. Financial restriction to provide stipends to intern students. Students may choose to go where they will be paid.	Offer in-services/roundtable discussions and provide current information or journal articles with the option to earn CEUs for different professional disciplines. Offer incentives to encourage attendance. Secure funding/grant to pay interns.

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

Strengths *(e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)*

There is available data.
Able to utilize Health Department; very cooperative.
Agencies are using, compiling data related to MCAH status, and a number of reports are available, including state-wide databases (CDHS, CDE, etc.)
ICPHD has good Epidemiology Dept.
Data is avaialble from a few sources.
Increased data collection and availability to this information.
Small community, many coalitions, same people get involved which create higher level of trust and efficacy as we know people stenght.

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

Community is not aware of a areas of data access.
MCAH program unable to analyze data without help of epidemiology.
Resouces are limited.
Resources are deficient, including time and additional expertise in specific MCAH areas, and financial supprot. How can MCAH agencies best access information.
Limited local expertise to offer guidance, analyses of data/trends.
Community agencies not aware of how to access/interpret data.
Community agencies have limited means to access data.
Lack of knowledge re: how to access stats and what information is availiable.
Community agencies unaware of resources.
Lack of knowledge re: how to access stats and what information is available .
Community agencies unaware of resources.
Many groups, higher risk for duplication of services.
Lack of centralized information system.

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

Technological developments (i.e., increased access to internet allows expanded access to data/information to community).
Improve online access.
Inform MCAH agencies of availability.
These are opportunities to develop briefs, that could address the status of the identified priority areas, that may ### data available though can centralize the source and simplify the method of community the status of a priority area. Commission can partner with MCAH program.
Wide open to establish ways to share data and resources with community.

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

Decrease in staffing and funding does not allow program to access information without interfering in workload of epidemiology.
Not everyone knows where to find data/information; many people continue to feel unaware/poorly informed; possibly even disenfranchised.
Pending legislation on special election for May 19th, in addition to fiscal crisis.
Financial issues re: staffing to collect, analyze and disseminate information.
Current economic situation.

SWOT Analysis for Essential Service # 2: Diagnose* and investigate health problems and health hazards affecting women, children, and youth.

Strengths *(e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)*

>This is a good access to resources for data, and analyses for health problems and hazards from hospitals.
>Networking is possible.
>Small, dedicated MCAH community
>Data on some levels is available, in addition to intestes related to trends, political, factors, that prioritize general healthcare issues. Agencies and priorities locally tend to work well together.
>Good communication between agencies – leads to cooperation when planning, implementing care.
>Small community where most of the MCAH agencies are familiar with one another.

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

>Poor focus on ### resources from hospitals.
>Who knows about MCAH.
>Lack of utilization on a more regular basis.
>Limited resources.
>The recurrent issue of funding an organization to work this are and the sustainability of the process.
>Financial limitations to implementation.

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

>Use directors from each specific hospital area to assist with resources and data collection
>Continued participation in local collaborative and meeting with agencies.
>Can take advantage of dedicated/committed MCAH community to attempt more in-depth review/assessment/analyses.
>Other counties may already have a similar process in place.
>Possibly institute a committee to work on how to better investigate and share results.
>Huge opportunity to begin diagnosing and investigating.

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

>Regulatory needs take priority with hospitals and CBO's
>Lack of interest at the Health Department level of MCAH
>Limited staff, funding and other resources to do these types of activities.
>Funding changes if the propositions pass may decrease availability to services that now improve health status.
>Lack of funding.

SWOT Analysis for Essential Service # 3: Inform and educate the public and families about maternal and child health issues.

Strengths *(e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)*

>Organization & Collaboration amongst service orgs is very good.
>Excellent Title V report with priorities well established.
>Strong, committed community dedicated to children & families w/a dedicated interest in informing & educating community re: MCAH issues.
>Agencies work well together at a local level to share information.Therefore a uniform method that can be accepted to educate the public can work well within the county.
>Several areas have good collaborative working network.

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

>Lack of community oversight & support from a central agency to push efforts in education MCAH does not seem to help in this capacity.
>Lack of interest in MCAH by ICPHD.
>Lack of human and financial resources.
>Funding, an agreement to what is a "best" practice and the method that is used for agency buy-in.
>Lack of clinical resources for fam. Plng., preg testing has decreased education being done.

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

>Resources are there many CBOs have excellent education programs & people willing to pass on info to community.
>Continue meeting with collaboratives. Stress importance of toll free no. – 2 area codes.
>More collaboration between interested groups to focus on targeted efforts/needs.
>Agencies will need to assess their flexibility to work on a centralized plan to maximize resources.
>Funding to promote MCAH issues needs to continue. Involve business community.

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

>Lack of support from admin in CBOs unless seen to be profitable.
>budget constraints.
>Lack of focus; too many competing issues/needs.

>There are competing resources available that may not necessarily agree on what is the method to inform the public, in addition to special interests that drive studies that lead to “evidence-based practices.”

>Funding from State threatened by upcoming vote.

SWOT Analysis for Essential Service #4: Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal, child and adolescent health problems.

Strengths *(e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)*

Some agreements are already available
Small community, easy to contact people and get an answer
Community partnerships are very strong
Community works together to help identify problems
Dedicated, committed community intersted in MCAH and related issues
Work closely with other agencies to provide information
Programs within HD (CHDP) provides information

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

Lack of connection with agencies outside of Imperial County.
We tend to stay in this area, but with information from outside resources we could exand our ideas
Limited resources, both human and financial
Scattered groups
Funding, continuity, leadership roles and clearly defined roles
Lack of public input
Unable ot participate in all programs

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

Opportunity to begin a process based on problem resolution could be easily established
Programs have good relationship with providers
Expand contacts within MCAH field and have an umbrella agency or advisory committee to oversee it.
Consolidate to avoid duplication of efforts
Providing incentives for participation in these partnerships and working with funding partners that may place a higher value on this

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

Organizational changes, fiscal changes
Too many conflicting/competing interests, mean inability to attend/participate in various interests
Lack of interest, complexity of some processes
Regulations and cultural factors cause a difficulty
Organizations have tendency to “throw money” at a problem instead of assisting in solution funding.

SWOT Analysis for Essential Service #5: Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth and their families.

Strengths *(e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)*

Some leadership is already in place; generally Imperial County agencies show stability with respect to administrative/lead positions.
Small community, easier for contacts.
Strong interest from many stakeholders and a desire to improve services.
Network well with other agencies – serve on boards and participate actively in collaboratives.
Strong committeed local group/individuals committed to supporting community efforts to assure the health of women, children, youth and families.

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

Many individuals may be over-burdened with their roles, therefore itmay be effective to diversity roles within an agency.
Limited resources and lack of understanding of what other agencies are doing.
State collaboratives difficient due to distance and restriction of travel
Limited personnel/resources ot do these.

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

Again, incentives are a plus.
More public relations, exposure in media to MCAH issues, funding realities.
“Politeness” in the community, not wanting to state things that may ruffle feathers.
Utilization of data available.
Consolidate efforts/communications perhaps via a coalition with committee representing various areas (prenatal care, breastfeeding, women’s health, child health to target issues) areas of need.

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

Economic uncertainty; changes related to staff turnover, capacity to include all interested individuals in the process.
Money….
.Continued budget cuts……..
Further reductions in funding; staff that further hamper efforts to collaborate for common goals/good of community.

SWOT Analysis for Essential Service #6: Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being.

Strengths *(e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)*

Working closely with other entities to asssure that the MCAH population needs are met through standard quality of care.

Local MCAH program reviews legislation and policy updates; MCAH Director participates in MCAH Action; Public Health MCAH staff are available to collaborate with other MCAH agencies as needed.
Small community allows for easier communication.

Many agencies should have an understanding of the legal requirements, regulations and/or policies that they have that are are relevant to this issue.

Working well with provider offices, state and other stakeholders

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

Not enough manpower.
MCAH public health not meeting with local MCAH agencies and disseminating information regularly
Many who are actively involved in providing services don't have the extra time needed to participate in analysis.
Therefore is no current method or local resource used to convey this information uniformly for all agencies that are connected to Maternal, Child, Adolescent Health. Perhaps another challenge would be to create something of this nature that can be understood and updated easily and efficiently.
not enough time or manpower

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

There is always someone in the local Health Department looking for funding opportunities.
Potential to assist our community MCAH agencies with updating and keeping current with legislation, regulations and policies.
Expand access to data through email or posting data where readily accessible. Notify agencies of availability.

The MCAH Program can work to collect this information, and perhaps convene the workgroup to share information and look at strategies to promote this. There may be other interested stakeholders that would work on this, in addition to sources to support the effort.

Additional, some counties may already have a model for something like this. Also, it is possible that this information is readily available, and may only require training or a guidebook for accessing information

There are interested people in the community that need to be tapped into the MCAH program for a different outlook

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

Budget restrictions or no funds.
Funding issues.
MCAH agencies in our area could be falling behind in current legislation regarding the MCAH population, without current updates and information
Not enough manpower available

There may not be individuals available that have knowledge of the complexity of the process, in addition to resources. Also regulations are continually changing and therefore the process will need to have methods for updating document, databases, other repositories of this type of information.

SWOT Analysis for Essential Service #7: Link women, children, and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.

Strengths *(e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)*

We have great linkages within Imperial County for women, children and youth to ensure quality systems of care.
Public Health Staff in the MCAH program are available to provide leadership in many areas related to MCAH population.
Commitment of MCAH agencies and providers.
ICCFFC Commission works to provide funding for a number of projects that link women and children to health and other agencies that provide services and care
Staff in the MCAH program are available for resource, guidance in MCAH related programs.

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

Budgetary restrictions.
Decreased resources for clinical services, financial issues on the part of families. What is the toll-free number?
No teams in place at this time to review services, linkages, quality systems, etc.
There are so many needs at localized and countywide levels that often it's difficult to prioritize without spreading resources out to thinly. Also the perception is that Imperial County make lack resources to have a system that ensures a comprehensive quality care
Lack of resources available in the County for children

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

Health promotion efforts need to increase, especially re: obesity prevention and treatment and family planning issues
Funding opportunities are always sought.
The potential exists to establish leadership for committees, and for bringing best practices to agencies
The MCAH Program can really demonstrate leadership in this area; also should look for opportunities to leverage funds through these links, such as MAH and TCM funds available.
Need for health promotion for children 5-19 yrs of age regarding obesity

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

Burn-out of providers and age of providers with limited replacement of staff for financial and/or personnel reasons
Demographic changes
Not having manpower to complete duties
Budget Constraints are threatening to limit services and quality care
Identifying the 'best' and most permissible method for linking women, children and adolescents to systems of care without violating privacy issues.
Funding and changes to regulation, in addition to lack of capacity building efforts in this area.
Budget restraints.

SWOT Analysis for Essential Service #8: Assure the capacity and competency of the public health and personal health* workforce to effectively and efficiently address maternal and child health needs.

Strengths *(e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)*

There is the potential for workforce development, in addition to working with Imperial Valley College as a resource and supporting capacity building and competency through a number of resources already available.
Communication between agnecies, recognition of need for advanced training. New opportunities for Bachelor's degree in nursing- this has a greater focus on evidence-based nursing practice and how to do research-should help for the future.
The PSC actively updates provider list and services provided. Public Health supports continuing education for MCAH staff.
We have excellent case management techniques which are incorporated into our daily routine.
There is good case management techniques utilized in our program

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

Time, available incentives for capacity, lack of distance learning opportunies, and programs that are tailored to working professionals
Public Health does not promote nursing/medical recruitment for new staff. No incentives offered to recruit new MCAH staff.
Many people leave the county for education and do not return for work. Limited placement of students does not allow for completee training
Budgetary restrictions.
Budgetary restrictions

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

Funding opportunities are always sought.
Potential to increase capacity to provide services to MCAH population.
Need opportunities for students to train in the county and outside of the county. Fresh ideas come from exposure to other areas and what is happening there. Possible links with Loma Linda, Riverside, San Diego facilities? Expand placement for students in PHD, clinics.
MCAH agencies can look at conducting a local workforce study to asses this needs. Healthcare agencies may already have assessments related to capacity and competencies of health and human services professionals. Technology can help bridge cultural and linguistic needs.

Can work to connect to institutions of higher education, in addition to tapping into binational resources
Need to educate the nursing population on the different programs of MCAH

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

Some methods may not be effective and the research driving these methods may be inconsistent with findings.
Not enough manpower to complete duties/ tasks.
Funding amounts for health care and education.
Budget constraints
Lack of funding

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

Strengths *(e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)*

Competent staff that knows and does evaluation.
Able to identify gaps in services
We are able to identify gaps in service
Some data systems are there, and information is collected that may work to help evaluate the effectiveness and accessibility of pershoal health and population based MCAH services for the County, including state-wide information and comparative results on a county-by-county basis.

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

There is little resources available for certain needs of children (counseling for obesity for older children)
Lack of information on who is doing this and how to get the data if collected
No evaluation component
No follow-through on identified gaps.
Evaluating effectiveness may be difficult in that trends change and simply methods for collecting this information change or may be limited do to changes in budgets. Also the costs and resources for this type of evaluation may not be available.

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

Funding opportunities are always sought.
Better use of information collected and expansion of access to materials.
Potential to lead the community to follow-through with evaluation of services for MCAH population
Data and information may be available for evaluating for some of the priority areas, and/or subsets or sub indicators that fall under the priority areas identified for the MCAH needs assessment
Data to be made available to the public and private sector on the health findings.

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

Lack of funding
Budget restrictions
Again budget restriction
Local capacity is limited and often that leads to justification for not taking on specific tasks, plans or projects

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

Strengths *(e.g., human, fiscal, or technological resources; social/political factors; demographic trends; past and current federal involvement/activities; state-local relationships, organizational culture, organizational structure)*

Ability to identify barriers and problems related to solutions for MCAH population; supportive of activities to improve services; available as a consult for local agencies.
New educational opportunities should lead to improved understanding of how to identify issues and act on them.
Some agencies will support innovative practies and would encourage data collection and/or research related to these practices.
Imperial County could draw support around this in that the community is unique, somewhat isolated, and individuals working with MCAH programs may be receptive to a local study

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

No participation in research in best/promising practices.
Financial and manpower limitations
Not enough local experts.
Not aware of any significant studies (local) realted to MCAH issues in the county

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

Potential for being a viable resource for the community to improve services and solutions for MCAH related health problems.
Funding opportunities are always being sought.
Budgetary restrictions
Expand links between PHD, providers, schools, college students, agencies.
Expand continuing education opportunities locally
Clarify and publicize community based MCAH issues and invite participation in problem-solving
Funding sources that may be interested in innovative ideas.

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

Budget limits and restrictions.
The desire to take on such project with the pretext that we don't have the capacity to do so.