The Maternal Child Adolescent Health

Five-Year Community Health Assessment

Butte County

July 27, 2004

Insu Hyams, PHN
Butte County Maternal Child & Adolescent Health Director
Butte County Department of Public Health

TABLE OF CONTENTS

I. Summary/Executive Report **Page 2**

II. Description of the Community Health Assessment **Page 4**

III. MCH Planning Mission Statement and Goals **Page 7**

IV. MCH Community Assessment **Page 8**

- Community Health Profile …page 8
- Community Resources Assessment … page 11
- Review of Health Indicators … page 14
- Optional Topics: Perinatal Substance Abuse & Teen Substance Abuse . . . page 21
- MCAH Resources Assessment . . . page 23
- Identification of the Problems/Unmet Needs . . . page 27

V. Priority MCH Problems **Page 30**

VI. Preliminary Problem Analysis: Perinatal Substance Abuse **Page 30**

VII. Appendices **Page 31**

- Table of 27 MCAH Health Indices . . . pages 36-38

Acknowledgements

I would like to thank many people individually for their assistance in creating this document, however the list would be *quite* long. My appreciation goes to the Butte County Public Health Nurses (PHN), the Visiting Infants and Parents' Program PHNs, and the PHN Assistants who valiantly administered the majority of the Perinatal and Child Health Surveys to parents around the county; to the student PHNs who administered the surveys to WIC parents; to partners from other agencies who also gathered survey information; and to all the parents who completed the survey. My thanks to all the community stakeholders who attended the two community health planning days and directly assisted in formulating a mission statement and prioritizing health concerns. I am in debt to Butte County Health Department's Nursing Administration which extended support and patience and also the Butte County Children's and Family Commission who funded the Visiting Infants and Parents' Program. Staff members of the State Maternal Child Adolescent Branch's consulting firm, Family Health Outcomes Project, answered over a month's worth of questions and provided good guidance. Last, but not least, I thank the clerical staff who entered survey data and performed miscellaneous tasks.

This has thus been the work of hundreds of people and a true community project. I hope it's of some use to Butte County women, children, and families and medical and program providers who respond to their health needs. - Insu Hyams *7/27/04*

I. Summary/Executive Report

The purpose of this community assessment is to provide a snapshot or description of Butte County's overall health, especially in regards to the maternal and child sub-populations. Examining both quantitative and qualitative date pinpoints specific health deficits or concerns, trends, and access-to-care problems. It can provide a baseline for comparative purposes in the future or bring data gaps to light. It is hoped this information will be useful to the community as different programs formulate plans and grants that can positively impact the health of women, children, and families.

The assessment and problem prioritization process was conducted as follows: Two community health-planning meetings were held at which providers identified health priorities. Background data on MCH health indicators was provided in two power point presentations along with preliminary results of The Perinatal and Child Health Survey developed by the Family Health Outcomes Project (FHOP) and Maternal Child Health (MCH) Directors. 280 parents from all areas of the county returned the survey; of these, 271 were adequately completed for analysis purposes. At the planning meetings, providers formulated a mission statement and one goal. Next, the MCH program capacity was assessed internally in regards to core public health functions and emerging issues. The MCH Director then formulated other goals based on MCH indicator data, parent and provider priorities, community and program capacity, and community will *as evidenced by actions*, such as coalition formation and funding procurement. The mission and goals are as follows:

Mission: The Butte County Maternal Child Health community fosters the physical and behavioral health of families through a multi-layered strategy: first, by supporting families' strengths, and second, through professional collaboration to ensure delivery of health care and education so that families can achieve optimal health outcomes.

Goals:

1. Families will become knowledgeable and empowered in accessing services to build and maintain the optimal physical and behavioral health of all family members.
2. Every baby will be born free of the effects of alcohol, drugs, and tobacco exposure.
3. Mothers who choose breastfeeding will breastfeed infants for 6-12 months.
4. Communities and families will become knowledgeable and empowered to reduce deaths and hospitalizations of children 0-19 related to home injuries and motor vehicle accidents.

Assessment Highlights:

- The top four child health issues identified by parents were: 1) drug or alcohol abuse; 2) violence; 3) teen pregnancy; and 4) mental health. Providers' top four MCH priorities were: 1) child/teen substance abuse; 2) child/teen obesity; 3) number of children in foster care; and 4) perinatal drug abuse.
- Teen self-reports of alcohol abuse, driving drunk or being driven by someone who had been drinking relate to motor vehicle accidents and to the need for teen-specific treatment programs. 29% of 11th graders reported binge drinking in the last 30 days.
- Causes of death in which Butte fell *below* the 35th ranked county were: unintentional injuries [36], motor vehicle accidents [42], suicide [42] lung cancer [43], and drug-induced deaths [48]. These all fall under preventable causes.
- The community has fared well in regards to many of the MCH goals formulated in the previous 5-year plan. The year of data was chosen to match FHOP's latest data postings.

MCH Indicator Goals in Previous 5-Year Plan and Recent Standings				
Goal #	Stated Goal	Previous Rate / % & Year	Recent Rate / % & Year	Goal Met?
1	Increase the number of pregnant women who receive early prenatal care from 72% to 90%	72% - 1998	75% - 2003	No
2	Reduce infant mortality to no more than 7/1,000 births. (Numbers fluctuate, so high value chosen for goal.)	6.7 - 1997	3.0 - 2001	Yes
	Reduce post-neonatal mortality rate to 2.5/1,000 births	3.1 -1997	1.7 – 200l	Yes
3	Reduce births to teens 10-14 years to 1/1,000 girls	0.7 -1997	0.4 - 2001	Yes
	Reduce births to teens 15-17 years to 30/1,000 girls	32.3 - 1997	15.9- 200l	Yes
	Reduce births to teens 17-19 years to 85/1,000 girls	84.1- 1997	65.1- 2001	Yes
4	Reduce child (<18 years) maltreatment to 100/1,000	141 – 1998	101– 2003	Nearly
5	Reduce average number of deaths over 5 years to children & youth 0-24 due to unintentional injuries by 25%	86% - 1991-1995	To be determined	Unknown
6	Increase # of mothers who breastfeed early to 75%	Unknown	85.8%-1999	Yes
	Increase # of mothers who breastfeed for 6 months to 50%	Unknown	Unknown	Unknown

- Birth outcomes generally are good: the percent of low weight newborns, 5%, meets the HP 2010 goal of 5%. Very low birth weight stands at less than 1%, also meeting the national goal. Pre-term birth at 11% is on a par with the state.
- An estimated 22.8% of 7th, 9th, and 11th graders are overweight and 26% are unfit.
- The rates of children regarding 1) asthma, 2) hospitalizations for mental health reasons, 3) hospitalizations for non-fatal injuries- ages 15-24, and 4) non-fatal injuries due to motor vehicle accidents were all worse than for previous years. Except for asthma among 5-18 year olds, these rates were also significantly worse than California's.
- A recent gonnorhea epidemic may raise the average number of annual cases; this has implications r.e. number of pelvic inflammatory disease cases, birth defects, and more.
- 12 % of kids 0-19 have no health insurance; 24% of those 2-11 have no dental insurance.
- Poverty, rising housing costs, and barriers to care continue to negatively impact the health of the poor and/or uninsured. 23.8% of children live below the poverty line. Access-to-care issues relate to early prenatal care, pediatric and dental care, and services at non-traditional hours. Caseloads are not expected to decrease.
- The Health Department has procured funding for three years to provide direct dental services to children 0-5 and to educate the community regarding dental health.
- The local MCH program is strong in many aspects, fulfills most core public health MCH functions, but without increased funding, meeting core functions and maintaining program quality will become increasingly less feasible.
- Perinatal substance abuse is the health problem prioritized for the MCH program.

While many health challenges have been identified, the community is actively working on a number of them and has also made strides in improving some health indicators. The county has many programs and agencies that offer assistance to multiple populations for a variety of needs. Dedicated professionals and other providers will "stay the course" through the coming years. Thus, the community has resiliency and can hopefully continue to improve the health and well-being of women, children, and families.

II. Description of the Community Health Assessment Process

A. Describe the planning group/how it was recruited/selected.

The MCH Director began by brainstorming with Public Health Nursing Administration field MCH Public Health Nurses (PHNs), the Child Abuse Prevention Council Coordinator, and members of the First Chance Coalition for Drug and Alcohol-Free Babies regarding who should be contacted and invited to two MCH community health planning events for scheduled for January and May 2004. The purpose of the events was to solicit input from professionals and para-professionals serving MCH populations in Butte County. A lengthy list of partners and stakeholders for outreach was developed.

Intensive outreach was performed in the fall of '03 and in April '04 to obtain as much partner input as possible. Professionals and staff from the following groups or agencies were invited by presentations/personal invitations made to groups, and e-mail and/or faxed announcements: pediatricians: obstetricians and certified nurse midwives (CNMs); 3 birthing hospitals; <u>CPSP Service Providers</u>; <u>4 Family Health Clinics</u>, <u>2 Indian Health Centers</u>, and 2 Children's Health Clinics; school nurses and school administration representatives; church representatives; Oroville Parish Nursing; <u>Early, Migrant, and Head Start Programs</u>; <u>Easter Seals</u>, American Lung and American Cancer Societies; <u>California Children Services</u>; <u>CHDP</u>; Butte County Office of Education – Specialized Services; <u>Healthy Start school staff from 2 schools</u>; <u>Parent Education Network</u>; <u>Northern Valley Catholic Social Services</u>; <u>County Departments of Public Health, Behavioral Health and Social Services (Foster Care Services)</u>; <u>a member of the Board of Supervisors</u>; <u>a home health agency</u>; 2 Family Resource Centers; Butte County First Five; <u>Butte County Breastfeeding Coalition</u>; Hispanic Resource Council; <u>Child Abuse Prevention Council</u>; <u>First Chance: Coalition for Drug and Alcohol-Free Babies</u>; <u>Children's Services Coordinating Council</u>; Community Health Alliance of Oroville; <u>Local Childcare Planning Council</u>; <u>Opt for Fit Kids</u>; <u>Youth for Change Program</u>; 2 homeless shelters; SEA Center for Special Needs Children; Far Northern Regional Center; <u>Valley Oaks Children's Services (R&R agency)</u>; <u>Catalyst (domestic violence shelter</u>); <u>WIC.</u>

A broad spectrum of partners attended the meetings and gave input into the process. Participants included members/staff from organizations underlined above plus representatives from: Enloe Children's Health Center; Chico Unified School District; Enloe Hospital and Feather River Hospital; the Paradise Family Resource Center; a Family Nurse Practitioner; a PHN working in a Behavioral Health program. Fifty people attended the first meeting in January and twenty-seven came to the second one in May.

B. Describe what or how partnerships/collaborations were used.

Partners assisted this assessment/planning process by 1) identifying stakeholders who should be invited to participate; 2) giving input, voicing opinions regarding topics ranging from health problems to barriers to care to attitudes and beliefs of medical, social service, and family support providers; 3) participating in a prioritization process using a prioritization tool; 4) assisting in administering parent surveys; and 5) assisting in forming a mission statement and one goal.

C. Briefly describe the planning processes.

The planning processes unfolded in overlapping parts: 1) training, 2) data retrieval and research, 3) two community health planning/assessment days for partners to garner service provider input, 4) strategizing feasible ways to obtain parent and teen input, 5) choosing a prioritization process and also information needed for that process, 6) development of a mission statement and goals, and 7) miscellaneous.

***Training**:* The MCH Director began the planning process by attending two trainings conducted by the Family Health Outcomes Project (FHOP). The first training was a 1day class called "Community Assessment I" on 2/26/03; the second all-day class, "EPI Info BC and Problem Analysis" was held on 8/23/03.

***Data retrieval and research*:** Then from September through mid-January, MCH indicator data retrieval from FHOP and research on the internet was conducted almost daily, followed by creating graphs and slides for the major presentation planned for the first community health planning day.

***Community Health Planning/Assessment Day I*:** The January meeting agenda was as follows: Introductions; "Setting the Context", i.e. a review of county demographics, and MCH State Branch directives, anticipated assessment process; identifying community assets strengths including MCH program activities; and sharing initial thoughts on improving the health of MCH populations; review of parent core survey and additional modules; group recommendations for the community assessment, which survey modules to use and how best to obtain completed surveys. Last, initial ranking of 25 health challenges was completed. (See Appendix A, page 32.)

Strategizing how to obtain parent and teen input: The MCH Director considered the following factors to determine how to obtain parent and teen input: 1) recommendations by partners on use of additional survey modules should be used, 2) number of partners willing to help administer surveys, 3) ability of PHNs and Public Health Assistants (PHAs) to obtain a significant of surveys through home visits and phone interviews (This required in-house meetings and trainings.), 4) based on feasibility, decided to train *only* supervisors in partner agencies and then relied on them to instruct their own staff on proper survey techniques, 5) availability of PHAs for data entry, 6) time and cost constraints, and last but not least, 7) availability of Healthy Kids survey results in case partners did not identify the teen module as important for planning and/or too few were willing to help obtain them.

Community Health Planning/Assessment Day II: At the May meeting, the highlights of the January meetings were reiterated, initial ranking of MCH health challenges done, preliminary results, i.e. selected frequencies, of the parent surveys shared, and review of the 2002 Healthy Kids Surveys results presented. Previously unavailable MCH indicator data were also shown by power point. After reviewing input from para/professional partners, survey information given by parents, and responses of teens garnered from school surveys, the group was then prioritized problems or challenges. (See Appendix B, page 33.)

Choosing a prioritization method: Due to time constraints, the MCH Director decided simply to use the "Health Needs/Problem Prioritization Matrix" developed by FHOP. (See Appendix C, page 34.)

Development of Mission Statement and Goals: This is described in Section IIIA.

Miscellaneous: Miscellaneous processes included participation in the development of a rural survey instrument with MCAH Action Rural Caucus volunteers and Judith Hager Balfori, MA, MPH from the MCH Branch consultant, Family Health Outcomes Project (FHOP). Healthy People 2010 was reviewed for information pertaining to the 27 MCH health indicators. Consultation with FHOP was done on an as needs basis by telephone.

D. Describe how community input was obtained

Service provider input was obtained as described above.

Parent input: The Health Department and thirteen volunteer partners disseminated and administered surveys across the county from mid-March 2004 through mid-April. Over 280 were returned; 271 were adequately completed for data entry. One mother called in and requested a survey be sent to her! Data entry was completed just before the May 4th planning day. Surveys were disseminated to: Opt for Fit Kids Program, the Adolescnet Family Life Program subcontractor, Feather River Tribal Health, Foster Care PHNs, two churches, one soccer team, one nursery school, MCH PHNs, Prenatal Care Guidance PHAs, one CPSP provider, and the Paradise Family Resource Center. Two student PHNs administered the survey to WIC parents at all 4 WIC sites. Surveys were given to men wherever we could find them – like Social Services next door! This must be a prime example of a convenience survey.

Teen input: As partners did not choose to prioritize or administer the teen survey module, Healthy Kids Survey county summaries results served as teen input.

III. MCH Planning Mission Statement and Goals

A. Briefly describe the process for developing the Mission and Goals

As described above, partners at both meetings received in-depth information detailing the health of target MCH populations, and shared information, ideas and opinions, listed health concerns and did a rough preliminary ranking, listing their pick for the 4 most important problems. At the second meeting, members individually filled out the FHOP matrix tool to formally score and rank issues. Then they created a MCH mission statement through a facilitated discussion and one goal; two large boards were used for discussion notes and a third for phrasing the mission statement multiple times until a consensus was reached.

The MCH Director wrote the goals based on the information gathered over the last year and took into account ongoing MCH programs and new recently funded programs with goals that fell within the top10 health priorities identified on the planning matrix as well as the parent's top 4 (Appendix D, page 35). The first goal was formulated with partners at Community Planning Day II. (Goals are listed below.) The second and third goals reflect parent and/or provider priorities that match well with qualitative information or quantitative indicator data (Appendix E 1-3, pages 36-38), community will, and feasibility. The fourth goal was written in light of data and MCH capacity: due to a dedicated PHN, Butte County has an ongoing safety program.

B. MCH Mission and Goals

Mission: The Butte County Maternal Child Health community fosters the physical and behavioral health of families through a multi-layered strategy: first, by supporting families' strengths, and second, through professional collaboration to ensure delivery of health care and education so that families can achieve optimal health outcomes.

Goals:

1. Families will become knowledgeable and empowered in accessing services to build and maintain the optimal physical and behavioral health of all family members.
2. Every baby will be born free of the effects of alcohol, drugs, and tobacco exposure.
3. Mothers who choose breastfeeding will continue breastfeeding until their infants are 6-12 months old.
4. Communities and families will become knowledgeable and empowered to reduce deaths and hospitalizations of children 0-19 related to home injuries and motor vehicle accidents.

IV. MCH Community Assessment

A. Community Health Profile

The Setting: Butte County is located in the Central Valley about 70 miles north of Sacramento. Semi-rural, it covers 1,640 square miles and spreads from the Sacramento River, through farmlands and semi-arid grasslands, up into the forested Sierra Nevada foothills. The economy is largely based on the service sector, retail trade, manufacturing, government entities, and financial and real estate services; agriculture now ranks behind these categories. In 2002, total population was 218,750 with a density of about 126 per square miles. Most residents live in incorporated cities; about 46% live in unincorporated county areas.

The cultural and economic hub of the county is Chico, home to California State University Chico, Enloe Hospital (a regional trauma center), the largest school districts, and the majority of small businesses. In contrast, a number of small, remote communities huddle in hard-to-access areas in the hills, some known for the underground methamphetamine culture and anti-government residents. Unfortunately, the District Attorney reports that Butte County is "famous for leading California in the number of meth lab busts."

Overall Socio-Demographic Status: Although Butte County's population is 83.3% white, it is racially and culturally diverse. Hispanics comprise 9.3% of the population, Asians 4.5%, Native Americans 1.6%, and Blacks 1.3%. U.S. Census 2000 data show that 15,558 (7.7%) of residents were born in a foreign county and 11,221 (5.5%) are non-English speaking. Nearly 24,000 (12.5%) speak a language other than English at home.

Age distribution has been stable since about 1996. In 2002, persons 0-9 years old accounted for 13% of the population; 10-19 years --14%; 20-29 years --13%; 30-39 years --14%; 40-49 years --14%; 50 and older -- 33%. The median age is 35.8.

Education Status: In 2000, Butte County had a higher percentage of high school graduates, but fewer with Bachelor degrees or higher:

Level of Education	% Butte adults	% Calif. adults
High school diploma/ >	82.3%	76.8%
Bachelor degree/ >	21.8%	26.6%

The percent of persons aged 25 and older without a high school diploma was 17.7% compared to 23.2% for California. Butte County's high school drop-out rates in 3-year averages have exceeded California's since 1993. For the years 99-00, the local average drop out rate was 5.2 versus 2.8 for the state; for 2000-2001 that average improved and dropped to 2.9 versus 2.8 for the state. In 2002, nearly 20% of births were to mothers without a high school diploma with 12.5% of these attributable to high-school-aged girls.

<u>Important factors for health planning</u>: 1) Hispanics comprise 9.3% of the population, but account for nearly 20% of the births; 2) most minorities and immigrants are on Medi-Cal, need culturally appropriate services and information, and often require translators; 3) the percent of high school drop outs and births to women without high school diplomas is significant in regards to MCH health services and health education delivery.

Social-Economic Status: Butte County has long struggled with unemployment, low wages, and poverty. Even with recent local growth and welfare reform putting more

people into the workforce, the county still lags behind the State. Per US Census 2000 data, 19.8% of Butte residents lived in poverty compared to 14.2% of Californians; 12.2% of Butte families versus 10.6% for the State; *and 23.8% of local children ages 0-18 versus 19.0%.* State Department of Finance 2001 data, show that the median household income was $31,924 versus $47,493 for the State. And in 2000, Butte County's unemployment rate was 7% compared to the State's at 4.9%.

Lower income and poor populations tend to experience barriers to health care such as few providers accepting Medi-Cal for certain health services, difficulty with transportation, or inability to speak English. These barriers impact their health by decreasing their ability to access care. For example, poor children lack good dental health care as few dentists accept young children and even fewer accept children on Medi-Cal.

Superimposed on the struggle of lower income and poor households, real estate and rental prices have soared. In 2000, the average home cost about $155,000; today it is around $250,000. Where a 2-bedroom house used to rent for $450, it now rents for $600 or more. As rents increase dramatically, poorer households have less disposable income for good nutrition, home safety devises, medications, transportation, etc.

Important factors for health planning: Poverty, rising housing costs, and barriers to care continue to negatively impact the health of the poor and/or uninsured.

Vital Statistics:
Birth rate information:
- Births have been stable over the last 5 years with a low of 2,194 and a high of 2,312. The 3-year average for 2000-2003 was 2,257. Our birth rate is generally less than the State's.
- Births to teens 15-17 have decreased from 134 (5.9%) in 1998 to 73 (3.2%) in 2002; but births togirls18-19 increased from 6.7% (n147) in 2000 to 9.3% (n210) in 2002.
- Births among ethnic groups have been stable for 2000-2002. In 2002, Caucasians accounted for 71% of births, Hispanics for 19%; Asians for 5%; Native Americans for 2%, and Blacks for 2 %, and other/unknown about 1%.

Death rate information by a 3-year average for 2000-2002:
- Infant mortality deaths by 3-year averages have significantly decreased: the average rate per 1,000 births was 8.2 for '93- '95; 7.1 for '96-'98; and 4.3 for'99-'01
- Suicides: Average annual number was 34; crude death rate was 16.0; and the State ranking was 42.
- Unintentional injuries: Average annual number was 98.3; crude death rate was 46.2; and the State ranking was 36.

Important factors for health planning: Issues central to the MCH program are 1) birth rate among teens 18-19, and 2) childhood deaths by suicide and unintentional injury.

Health Status Indicators:
Mortality rate: The overall 2003 mortality rate was 764.9 per100,000 population. The causes of death in which Butte fell *below* the 35th ranked county were all in preventable categories: unintentional injuries [36], motor vehicle accidents [42], suicide [42] lung cancer [43], and drug-induced deaths [48].

Communicable diseases: In 2000, Butte County communicable disease rates were generally lower than California's. Examples are rates/100,000 population for hepatitis

(7.5 vs. 15.1), tuberculosis (2.0 vs. 10.5), Chlamydia (166.7 vs. 251.3), and gonorrhea (13.7 vs. 58.5). However, in 2003, a gonorrhea epidemic swept through the county; case counts increased from the annual average of 25 to155 in 2003. The rate increased more than 50 times (!) and impacted the MCH workload. Women acquired 58% of the cases; some had serious outcomes: One woman delivered 5 weeks prematurely. Her infant has developmental delays, severe gastric reflux, failure to thrive, many hospitalizations, and is still followed by a PHN. Coincidentally, Chlamydia cases doubled; in 5 months, 13 pregnant women were diagnosed with the disease.

Drug and Alcohol Addiction/Abuse: Total alcohol/drug program admissions jumped from 598 in '94 to 1,175 in '95 and have stayed higher since then. In '99, total admissions were 1,145.

Immunizations: In '03, 89.2% of children entering child-care centers had completed all required immunizations. From 00–02, 91%-93% of kindergarteners were up-to-date.

Tobacco: Healthy Kids 2001 Surveys from participating districts show that about 12% of 9th graders smoke or have tried smoking. By age 21 an estimated 19% of adults smoke (Butte County Public Health Department [BCPHD] survey 2003). Per the 99-02 Fetal Infant Mortality Review (FIMR) Program of Butte and Glenn Counties Community Report, smoking or second-hand smoke was present before the death of a fetus or infant in 68 investigated cases.

Pediatric Obesity: In 2001, approximately 22.8% 5th, 7th, and 9th graders in the 4th Senate District were overweight compared to 34.3% statewide. 26.5% were unfit compared to 39.6% of kids statewide. Local CHDP data also show high percentages:

% Overweight Children 5-20 Years by Ethnicity – Butte County: 2002

Ethnic Group	≥ 85th Percentile	≥ 95th Percentile
White	15.9%	**17.4%**
Hispanic	**19.2%**	**23.9%**
Asian	12.7%	**17.4%**
Black	15.3%	15.3%
Other/unknown	16.4%	15.3%

Important factors for health planning:
The number and complexity of community health issues makes collaboration with partners and interdepartmental colleagues mandatory. Prioritization of issues requires analysis of MCH capacity, MCH indicators, community input and available resources.

Health System Indicators: According to the 2001 California Health Interview Survey (CHIS), an estimated 46,000 Butte County children 0-19 have health insurance while 6,000 (11.8%) do not. About 19,000 children 2-11 have dental insurance but 6,000 (10%) are not.

Important factors for health planning: CHDP services are essential for uninsured children. Outreach through organizations such as Migrant Head Start and the Hispanic Resource Council, the 1-800 MCH toll-free line, PHN home visits, and community health fairs are a few feasible methods to reach likely subpopulations such as migrant workers. The association between tobacco and fetal and infant deaths calls for collaboration with partners such as the American Lung Association and the Butte-Glenn Perinatal Council

B. Community resources assessment

The concerns regarding access to and availability of health care and related services were gathered by assessing MCH health indicator data and applying qualitative methods, i.e. discussion with professionals at the MCH Community Planning Day, surveying parents from a convenience sample (Appendix F), and noting PHN reports of barriers to care.

Some concerns relate to all the groups mentioned in this paragraph or for subpopulations across these groups: a) lack of services at non-traditional hours; b) lack of insurance, i.e. 19% of children and 12% of adults. This also applies to non-citizens who cannot apply for Medi-Cal; c) non-utilization of services - unless there is a dire emergency - by undocumented persons for fear of deportation; d) paucity of bilingual/biracial providers for non-English speaking minorities; and e) lack of consistent and maintained health education outreach to targeted subpopulations.

1. Concerns regarding access to health care and health-related services:

Pregnant women: Access to first trimester prenatal care is one of the primary concerns brought forward by AVSS data. In Butte County, first trimester care rates have never exceeded 76%, well below the state average and the HP 2010 goal. Women have reported being unable to get in to the provider of their choice in the first trimester. However, AVSS data indicate that Asian, Hispanic, foreign-born, and minimally educated women have higher percentages entering care late. While MCH has worked with providers, research to identify the actual cause/s for low rates of early care has not been conducted secondary to lack of resources.

Increasing gender-specific drug and alcohol treatment services has been identified as a pressing concern by the community. Touchstone, a gender-specific day treatment program, is often impacted. Skyway House's Track program provides residential drug and alcohol treatment for 14 women, but is not yet Medi-Cal approved. Even without it, the program has only one bed available at this time (7/9/04).

Dental care, so important during pregnancy, cannot be accessed by non-insured and undocumented women. If funding for Medi-Cal dental services is maintained, women covered by Medi-Cal can access treatment provided they also overcome other barriers.

Underutilization of free, evening tobacco cessation classes offered in 3 towns surprised both American Lung Association and Public Health staff. So few attended, the classes were cancelled and the few participating women funneled into mainstream classes.

Mothers: Single, working mothers often cannot get off work to take children to well-child check-ups or even for acute care at times. Providers have also observed that mothers will prioritize children's health appointments; so they may not make appointments for themselves or they may fail to show up them.

Infants: Many infants have not been able to access pediatric care because they did not have an individual Medi-Cal card. This is detailed more under "emerging issues" in the section on local MCH Program capacity.

Children/Adolescents: Children and adolescents, dependent on their parents, often face the same access barriers as parents, such as lack of insurance or transportation and others mentioned above. Some barriers are political/societal such as state regulations disallowing teens time off school to visit family planning clinics. Most services, such as immunizations, cannot be provided to teens without a parent or guardian accompanying the youth to sign consents. Therefore, another barrier to accessing care is parental neglect, evidenced in Butte by the numbers of children in foster care: in July of 2003 our rate was 13.5/1,000 children 0-19 placed in foster care, significantly worse than the State's at 8.9/1,000.

Underutilization of the OPT for Fit Kids Program occurred from January – June '04. This program, designed by a nutritionist and professor at California State University Chico, addresses overweight and unfitness in children and adolescents and engages the whole family. It was greeted enthusiastically by pediatricians and other providers and initially well used. The reasons for the downturn aren't known.

2. Concerns relating to availability of care:

Pregnant women: Both women and professionals state that per their experience, some obstetricians do not emphasize the need to get women into the office for first trimester care, and a number of them consistently see fewer than 60-70% of clients at that time.

The BCPHD tobacco cessation program has continually addressed adult smoking and provided a state model regarding underage smoking prevention. However, no sustained effort has targeted pregnant women thus far.

Mothers: Despite the fact that 60% of pregnancies are known to be unintended, a survey of physicians and clinics show there is no access to emergency contraception on weekends. For the uninsured or low-income, no such access can be had after working hours.

Infants: Locally, the MCH staff have long wished to provide PHN home visits for first-time mothers and/or fathers to assess bonding, infant development, family health issues, and need for services. Also, PHNs ideally would perform a home visit 3 or 4 days post partum to provide breastfeeding support; infants and mothers often falter with it in that first week. Due to lack of agency capacity, PHNs have to triage their home visits so outreach to promote health is not available on a broader scale.

Children/Adolescents:

Like adults, children and adolescents need care delivered in a manner appropriate to their development and social needs. Specific health problems revealed by available data that overlapped both professional and/or parental concerns highlighted current gaps in availability of care: a) adolescent and child mental health services; b) adolescent specific alcohol and drug treatment programs; c) weekend emergency contraception; and d) diagnostic services r.e. Fetal Alcohol Syndrome Disorder vs. Attention Deficit Disorder vs. other drug exposure or health disorders.

3. Community resource strengths

At the first MCH community planning day, providers and advocates identified county assets. These covered a wide range and included:

- Good interagency collaboration
- Our ability to identify health issues
- Community grants, Proposition 10
- More mid-level practitioners than previously
- Willingness of Social and Health Services to cross-train
- Staff committed to children
- High value placed on home visitation programs
- More early identification of problems and early intervention
- Continuity of some programs (ex. CHDP)
- Large number of services/programs in the county.(The challenge is to keep track of them.) Just a few examples are:
    - ❖ Butte County Safe Kids
    - ❖ Child Health & Disability Prevention (CHDP) Program
    - ❖ CPSP
    - ❖ Early Head Start (0-3) program
    - ❖ Friday Night Live
    - ❖ Growing Healthy Children
    - ❖ Kids in Safe Seats (KISS)
    - ❖ Lead poisoning prevention program
    - ❖ Strong Start (mental health program for children 0-5)
    - ❖ Sweet Success
    - ❖ Touchstone (day treatment drug and alcohol program for women)
    - ❖ WIC

Additionally, agencies, coalitions, etc. were seen as assets. These included:

- AIDS/HIV Advisory Board
- Breastfeeding Coalition
- Butte Community Jr. College
- Butte County Children's& Family Commission
- Butte County Child Abuse Prevention Council
- Butte County Family Violence Prevention
- Butte County Immunization Registry
- Butte/Glenn Child Death Review Team
- Local Childcare Planning Council
- Paradise Ridge Community Network
- First Chance Coalition for Alcohol and Drug-free Babies
- Big Brother/Big Sisters
- Boys 'n Girls Club
- Butte Glenn Perinatal Council
- Catalyst Women's Shelter
- Children's Health Alliance of Oroville
- California State University Chico
- Grandparents Raising Grandchildren
- Lactation specialists
- Oroville Family Resource Center
- Parent Teacher Associations
- Rape Crisis

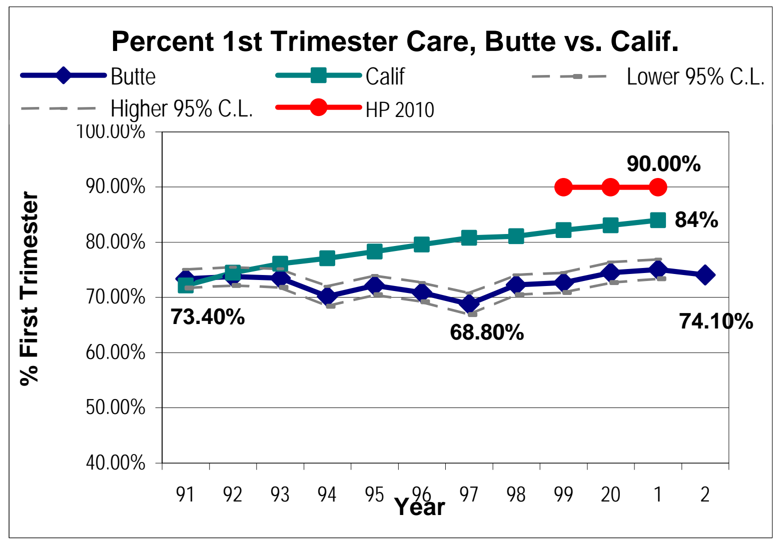
The above lists are certainly not exhaustive. Services abound in Butte County. Certainly continuing to employ case managers would be a good policy so families receive referrals to the right services and assistance in overcoming barriers. Lists of obstetrical providers and pediatricians are available on request from ihyams@buttecounty.net.

C. Review the State required MCH indicators

1) Quantitative Analysis

The indicators below (except for the last one) were reviewed because their values revealed areas in which Butte residents were worse off than state averages and/or HP 2010 goals. Butte County's MCH health indicators are shown in Appendices E1-3.

Percent of pregnant women with 1st trimester prenatal care:



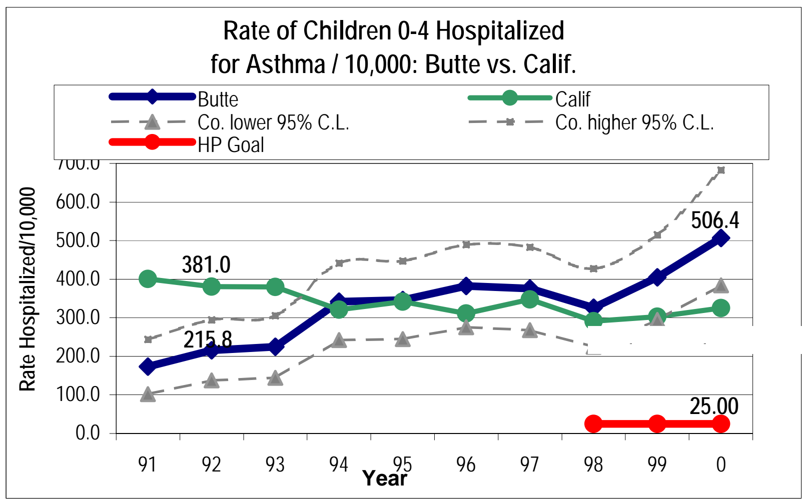
Since 1993, Butte County's first trimester prenatal care rates have been lower than the states' and the Health People (HP) 2010 goal of 90%. While the county's rate looks stable, the widening interval between the county's higher 95% confidence level and the state and HP goal show that this gap is significant.

Asian, Hispanic, young, and minimally educated women have higher percentages entering care late. In 2001, 44% of Asians entered1st trimester care, 65 % of Hispanics, and 69% of Blacks. Of minimally educated women, 72% with 12 years of school entered prenatal care early, 59% with 11 years or less, and 29% with none. 60% of young women less that 24 years old got into early care .Of 26 obstetrical providers, 17 saw 75% or more patients in the first trimester; 9 saw less than 73% early on. These numbers are consistent from 1998 until now. The problem of late entry into care will require further investigation, analysis and intervention as feasible.

Percent of Women Who Were Exclusively Breastfeeding at Hospital Discharge: From 99-02, breastfeeding initiation rates and exclusive breastfeeding at hospital discharge have been stable. Breastfeeding initiation rates only varied from 84.8% to 85.8% which exceeds the HP 2010 goal of 75%. Exclusive breastfeeding ranged from 63.7% to 68.6%. There is no data currently available regarding duration of breastfeeding in the first 12 months postpartum.

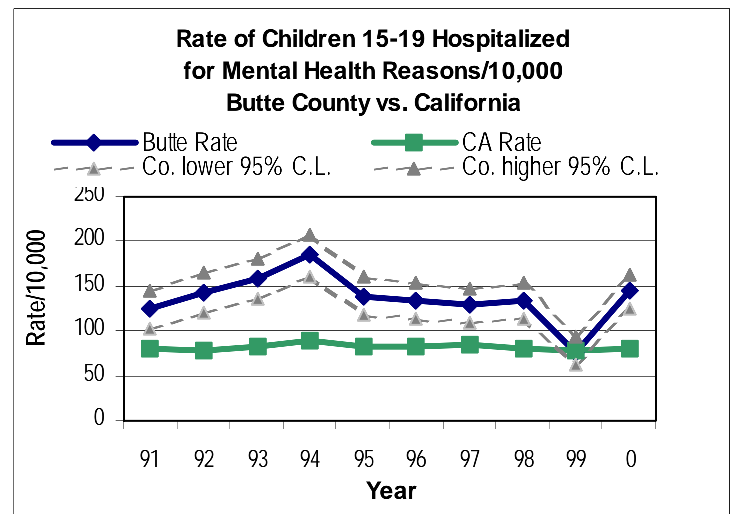
Rate of Children Hospitalized for Asthma per 10,000 (Ages 0-4)

The asthma rate among young Butte county children is emerging as a significant health problem. Although confidence levels show that data aren't highly reliable, a negative result is demonstrated by the numbers. *Before 1994, local rates were well below state rates; in 2000, the Butte County rate significantly exceeded the state's.* The steadily increasing numbers are of concern as they indicate a negative trend may be developing.



Rate of Children Hospitalized for Mental Health Reason/10,000 (Ages 15-19)

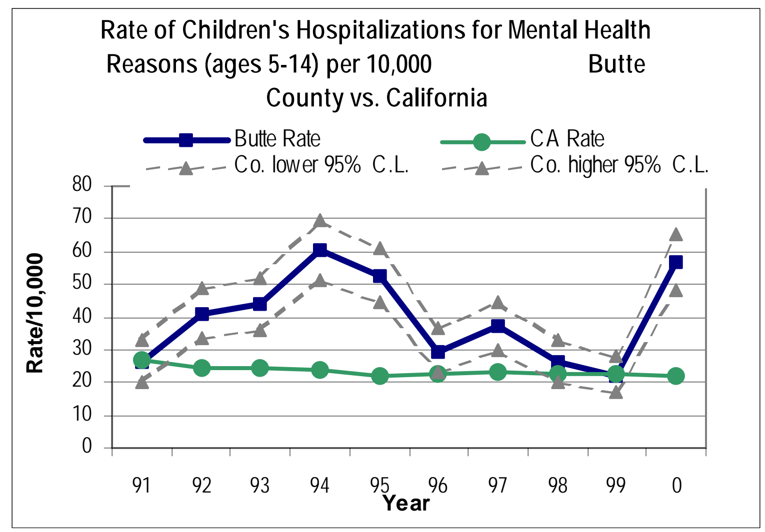
The rate of Butte County teens hospitalized for mental health reasons has been consistently and significantly higher than for California as a whole.



To the knowledge of the MCH Director, the reasons or contributing factors are unknown and/ or anecdotal. There are fewer accessible mental health services for teens and this may be contributing to the high number of admissions that perhaps could have been prevented by earlier intervention. Reasons for the rising numbers from 92-94, the subsequent drop in '95, and the off-the-curve fluctuation in '99 are also unknown. The latter could well be due to a break in maintaining record-keeping and/or reporting practices.

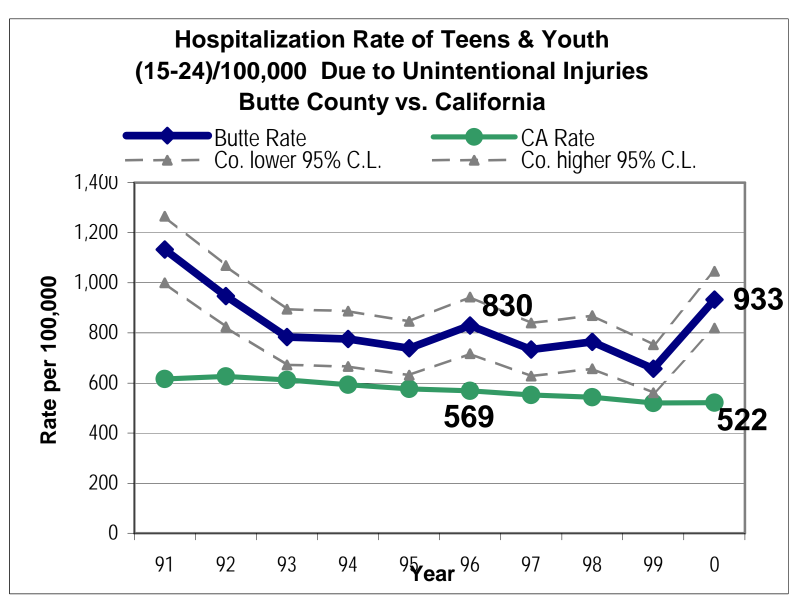
Rate of Children Hospitalized for Mental Health Reasons/10,000 (Ages 5-14)

Much of what was stated above for mental health hospitalization of 15-19 year olds is true for younger children as well. For most years in the previous decade, Butte's rate was significantly higher compared to the state's. The rate fluctuations here are more exaggerated and need further analysis, beginning with 3-year averaging. However this also will only slightly clarify a complex issue. Services for school-age and pre-teens are even fewer than for teens.



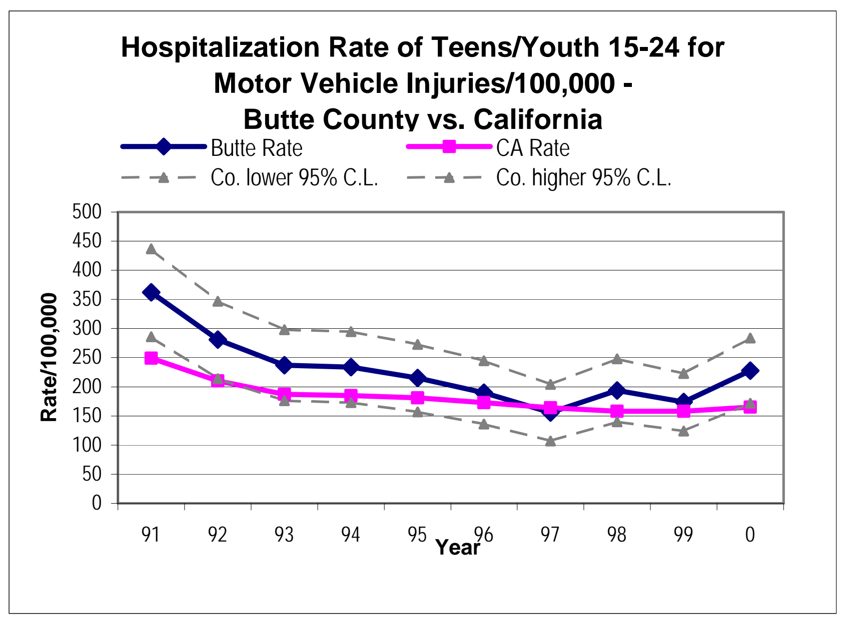
Rate of Hospitalizations All Non-Fatal Injuries by Age Group/100,000 (Ages 15-24)

Hospitalizations of 15-24 year-olds in Butte County for unintentional injuries have long been too high as seen in this graph.



Rate of Non Fatal Injuries Due to Motor Vehicle Accidents/100,000 (Ages 15-24)

Quantitatively from the graph below, it appears that Butte's rate of teen hospitalization for motor vehicle injuries are not significantly higher than the state's and may not qualify this indicator for program prioritization. However, local data limited to minors ages 15-20 demonstrate an issue notable for its persistence.



Switzers data in 3-year averages for motor vehicle injuries to children/youth from '91-'00 show a steady decrease from'93-95 (n580) to'98-00 (n490). However, the frequency among 15-20 year-olds continually accounted for two-thirds of injuries for <u>all</u> age groups. 10.2% of those were due to alcohol consumption.

Number Injuries to Children Under Age 21 by Age Group: Butte County 1991-2000									
	91-93	92-94	93-95	94-96	95-97	96-98	97-99	98-00	99-01
Total	**577**	**579**	**589**	**580**	**548**	**534**	**500**	**480**	**465**
0-4	40	34	34	34	32	33	26	34	18
5-9	63	68	72	73	65	62	57	52	40
10-14	103	102	103	101	88	84	80	83	79
15-20	***372***	***375***	***380***	***372***	***363***	***354***	***335***	***321***	***327***

2) Qualitative information

Percent of pregnant women with 1st trimester prenatal care:

Preliminary ranking (50 MCH providers)	**9th** out of 25 identified health issues.
MCH prioritization matrix (20 providers)	**10th** out of 29 identified health issues.
Prenatal & Child Health Survey (266 parents) – <u>*Convenience sampling*</u>.	**188 (98%)** of 191 answering question #34a. said it is very important to get early care! Of 161 answering question #19, 104 (86.9%) got care in 1st trimester**;** 13 (8.0%) in 2nd trimester**;** 1 (0.6%) in 3rd.
Health Kids Surveys 2001	Not applicable.
Capacity/feasibility – high, medium, low.	**Feasible**. More analysis can be done. Also, the Butte County Health Department expects to hire a new CPSP Coordinator in FY 04-05.

Percent of Women Who Were Exclusively Breastfeeding at Hospital Discharge: While the initiation rate exceeds the HP 2010 goal of 75%, local lactation consultants, home health care nurses, and PHNs have observed that <u>*duration*</u> of BF often does not exceed 3 months; also many mothers wean infants when they return to work 4 – 8 weeks later. While unconfirmed it is almost certain that Butte falls short of the HP 2010 duration goal that 50% of mothers continue breastfeeding for at least 6 months.

Women have many reasons for stopping or not initiating breastfeeding. Of 66 women who did not skip the survey question about their reason/s for not breastfeeding: *16 planned to work or attend school; 21 stated their baby didn't breastfeed very well; 6 thought bottle feeding was superior; 2 had "no" milk; 3 did not have "enough"; 1 dried up when child was sick; 1 wrote her baby was "lactose intolerant"; 1 had psoriasis; 1 was traveling; 8 were not with their infants; 1 cited embarrassment; 1 was not very informed on lactation.* <u>A qualified lactation-consultant could have addressed these barriers and assisted the mothers in overcoming them.</u>

Other reasons included contraindications such as prescription medications (n8), addiction-drug (n2) or tobacco (n1), a baby's unusual neurological condition (n1). More challenging barriers were: husband objected (n1); MD told mother not to (n6); mother had HIV (n1), mother had surgery (unspecified) (n1).

Breastfeeding (BF) – Qualitative Data Summary

Preliminary ranking (50 MCH providers)	**6th** out of 25 identified health issues.
MCH prioritization matrix (20 providers)	**10th** priority health issue out of 29. Matrix score = 816. Issue specific as breastfeeding duration.
Prenatal & Child Health Survey (266 parents) – *Convenience sampling*.	**108 (70%)** of 154 answering question 25 breastfed infants at 3 months. Of 66 who did not skip question 26, **52 (79%)** were currently breastfeeding. Parents believe in BF, but did not prioritize it
Health Kids Surveys 2001	Not applicable.
Capacity/feasibility – high, medium, low.	**Highly feasible**. BF coalition, led by MCH PHNs has long worked to increase BF services. Now has a grant to implement & strategic plan.
Comment	High rate of breastfeeding duration most likely is not representative. 50 survey participants were in WIC where BF support is strong.

Rate of Children Hospitalized for Asthma per 10,000 (Ages 0-4):

Childhood Asthma – Qualitative Data Summary

Preliminary ranking (50 MCH providers)	**Not initially chosen** by partners as a child health issue.
MCH prioritization matrix (20 providers)	**5th** priority health issue out of 29. Matrix score = 868.
Prenatal & Child Health Survey (266 parents) – *Convenience sampling*.	**Not chosen** as a health priority by parents (Question 49), although **83 (18%) of children "yes"** for asthma and 19 (4%) "yes" for having difficultly breathing on a weekly or more frequent basis.
Health Kids Surveys 2003 (approx. 8,400 students, 1/3 each of 7th, 9th, & 11th grades)	**19% of 7th grade,** **20 % of 9th grade,** and **20 % of 11th grade** respondents reported having asthma.
Capacity/feasibility – high, medium, low.	**Feasibility low.** No community push to form taskforce or coalition. No mandate, funding, or partner capacity to initiate prevention efforts.

Rate of Children Hospitalized for Mental Health Reason/10,000 (Ages 5-14)

Mental Health Hospitalizations (Ages 5-14) - Qualitative Data Summary

Preliminary ranking (50 MCH providers)	**4th** priority health issue out of 25.
MCH prioritization matrix (20 providers)	**8th** priority health issue out of 29. Matrix score = 828. Also, the **9th** priority was paucity of pediatric mental health providers.
Prenatal & Child Health Survey (266 parents) – *Convenience sampling*.	**4th** health priority chosen by parents (Question 49 – did not separate out question by children's age groups).
Health Kids Surveys 2001	**23% of 7th grade** respondents **33% of 9th grade** respondents **35% of 11th grade** respondents } reported experiencing sad and hopeless feelings in the past 12 months.
Capacity/feasibility – high, medium, low.	Low-medium. No community push to form taskforce/coalition. No mandate. Partners' capacity to initiate prevention efforts questionable.

Rate of Children Hospitalized for Mental Health Reason/10,000 (Ages 15-19)

Mental Health Hospitalizations (Ages 15-19) - Qualitative Data Summary

Preliminary ranking (50 MCH providers)	As above.
MCH prioritization matrix (20 providers)	As above.
Prenatal & Child Health Survey (266 parents) – Convenience sampling.	As above.
Health Kids Surveys 2001	**33% of 9th grade** respondents and **35% of 11th grade** respondents reported experiencing hopeless feelings in the past 12 months.
Capacity/feasibility – high, medium, low	As above.
Comment/s	Medical and service providers have long asserted that there are inadequate mental health services for children and teens.

Rate of Hospitalizations All Non-Fatal Injuries by Age Group/100,000 (Ages 15-24)

Non-Fatal Injuries (Ages 15-24) – Qualitative Data Summary

Preliminary ranking (50 MCH providers)	**16th (tied with child abuse, child neglect, and housing)** out of 25 identified health issues.
MCH prioritization matrix (20 providers)	**Not in the top 10 prioritized issues.**
Prenatal & Child Health Survey (266 parents) – Convenience sampling.	**Not chosen** as a health priority by parents (Question 49).
Health Kids Surveys 2001	As above for
Capacity/feasibility – high, medium, low.	Medium. Safety coalition in formation now under the leadership of one of the MCH PHN program coordinators.
Comment	The graph on page 13 shows one reason why the MCH program will continue to address injuries in the next five years as capacity allows.

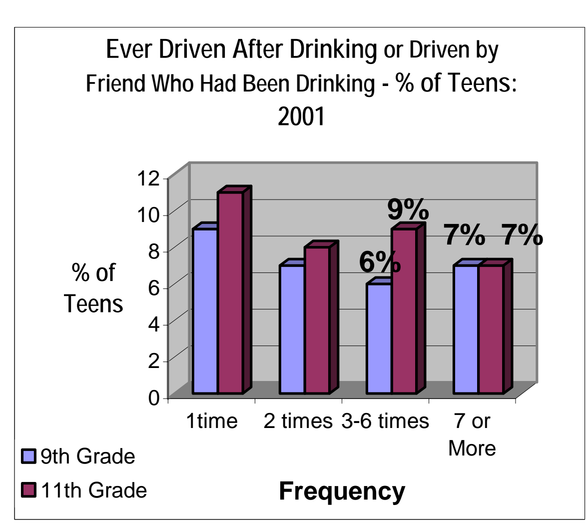
Rate of Non Fatal Injuries Due to Motor Vehicle Accidents/100,000 (Ages 15-24)

Non-Fatal Injuries (motor vehicle: ages 15-24) – Qualitative Data Summary

Preliminary ranking (50 MCH providers)	**16th** (tied with child abuse, child neglect, and housing) out of 25 identified health issues.
MCH prioritization matrix (20 providers)	**Not in the top 10 prioritized issues.**
Prenatal & child health Survey (266 parents) – Convenience sampling.	**Not chosen** as a health priority by parents (Question 49),
Health Kids Surveys 2001	See paragraph and graph at bottom of this page.
Capacity/feasibility – high, medium, low.	Medium. Safety coalition in formation now under the leadership of one of the MCH PHN program coordinators.
Comment	The table on page 14 and the graph below show several reasons why the MCH program will continue to address injuries in the next five years as capacity allows.

The adjacent graph pertains directly to motor vehicle injuries among youth showing **16% (n243) of 11th graders at high risk for a motor vehicle crash.** This carries more gravity in light of the fact that **29% (n440) of 11th graders reported binge drinking in the last 30 days.** (Healthy Kids 2001 data)

Note: "Binge drinking" was not a phrase used in the survey language. Teens were asked about consuming "5 or more drinks in a couple hours" in the last 30 days.



D. Optional Topics

Perinatal Substance Abuse

Data: There is a dearth of state and local data on perinatal substance abuse. The last prevalence study conducted by State Department of Health Services was in 1991 when birthing women in participating hospitals were tested for drugs. That study estimated that the prevalence of perinatal substance abuse was 14.1% in the northeastern section of the state (Butte was one of 12-15 counties). What local data is available hasn't been reliably tracked from year to year. Below is a sampling of the local data that has been gathered.

- At Enloe Hospital, Butte County's largest birthing hospital, 55 new mothers were urine tested for substance use in 2000 and 9 (16%) were positive.
- In 2002, at Feather River Hospital in Paradise, 11 of 36 women (31%) were positive.
- 118 children ages 0-5 were referred to the Options for Recovery program because their well-being was threatened by their parent/s' substance abuse.
- Anecdotally, social service administrators state that over 90% of foster kids are placed due to parental substance abuse. There is no state requirement that this number be documented and tracked.
- Annual admissions to drug and alcohol treatment programs doubled in the 90's and now remain at 1,100 or more.
- 29% of 11th graders reported binge drinking in the last 30 days. (Healthy Kids 2001)

Community Response:

- In April 2002, 11 community leaders including the MCH Director attended Dr. Chasnoff's 3-day training on perinatal substance abuse at the National Training Institute in Chicago. Subsequently, MCH established First Chance: the Butte Coalition for Drug and Alcohol-Free Babies and led the coalition for two years.
- In 2003-04, the coalition completed a major revision of its strategic plan, wrote a proposal and applied for a 3-year Proposition 10 grant which was funded in July '04.
- As stated above, in the spring of '04 parents and MCH service providers independently and overwhelmingly prioritized drug and alcohol abuse by children (parents and providers) and adults (providers).
- In 2004, MCH began recruiting obstetricians (OBs) and CNMs. 3 OBs and 4 CNMs now use the 4Ps+, Chasnoff's science-based substance abuse verbal screening tool.

Capacity: Butte County has a gender-specific day treatment program with therapeutic child care which was established over 10 years ago. Prior to this year, there were no residential treatment programs. Now, there is a facility with 14 beds that accepts pregnant women, case manages them through their birth and allows mothers to keep their infants with them during recovery and transition. However, it is already full and the program will most like be impacted much of the time. The First Chance Coalition has developed a referral and feedback system for OB providers, providing them with needed support so they can "hand off" clients knowing the women will get proper follow-up.

Analysis: The coalition needs to assure that data will be gathered from appropriate partners in a consistent, trackable manner and analyzed by qualified professionals for future planning. However, even without reliable data, the problem is acute, prioritized by the community, beginning to be innovatively addressed, and targets a crucial, discrete MCH subpopulation. As such, it is also a priority issue for the MCH program.

Teen Substance Abuse

Data: The following are from Healthy Kid's Surveys conducted throughout the county:

Selected Drug and Alcohol Measures by Gender and Grade 2001						
	Percent		Percent		Percent	
Selected Measure	%F	%M	%F	% M	%F	%M
1 full drink in past 30 days	14	12	34	26	42	43
Smoke marijuana in the past 30 days	4	5	17	18	22	27
5/> drinks in a couple of hours in past 30 days	6	4	18	15	25	33
Perception that frequent alcohol use is extremely harmful	75	71	67	59	75	61
Perception that frequent marijuana use is extremely harmful	85	81	70	66	68	57

Community Response and Capacity:

- As stated above, both parents and MCH service providers consider this to be high priority.
- Various school districts have drug and alcohol prevention programs with unique features to each participating district. These are grant funded, so not all districts have a program and programs are often not continuous.
- There are no teen specific drug and alcohol programs or groups available through the Behavioral Health Department at this time.
- One counseling firm offers teen day-treatment and counseling for private pay or private insurance clients.
- Alcoholic Anonymous only convenes an Ala-Teen co-dependency group.
- There is no community council or taskforce dedicated to working on this issue.

Analysis: While this issue is pressing, the MCH program does not have the capacity to address it at this time, but stands ready to advocate for and collaborate on this problem.

E. Assessment of MCAH Capacity

Part I. Capacity Assessment				
Assess MCH capacity in each of the areas below:	Rate capacity in each area by checking a number: **4 = strong, 3 = adequate 2 = inadequate, 1= weak** Strong → Weak			
A. Organizational relationship <u>within</u> Health Department	4	3	2	1
Summary of Opportunities: The MCH Director is not a supervisor and has no direct participation in the Health Department's (HD) overall strategic planning. However, the Director of Nurses and 2 of 3 PHN Supervisors have all had years of experience working in MCH. The MCH Director does attend supervisor meetings where input can be offered.				
Summary of Challenges: An ongoing difficulty is measuring outcomes for MCH PHN field nurses' home visiting program. The HD Director expects outcome measures and without them MCH will not be as valued as programs that do. Our Visiting Infants and Parents (VIP) program <u>is</u> working towards establishing these. It is difficult to justify increasing staff as there are no guidelines from the State Department of Health Services recommending a minimum number of PHNs/1,000 births.				
B. Cultural competency	4	3	2	1
Summary of Opportunities: MCH staff include 2 bilingual/bicultural Spanish speaking PHNs and 2 PHAs. We also have two bicultural, bilingual Hmong PHAs. While their time is limited, virtually all MCH services can be provided to these largest of Butte County's ethnic minority groups.				
Summary of Challenges: The Supervisors of MCH PHNs and about half the staff have received cultural sensitivity training. Some newer PHNs may not have had such training previously, but they are able to consult with supervisors and bilingual/bicultural staff.				
C. Resources	4	3	2	1
Summary of Opportunities: The MCH Director, VIP Program Coordinator, former CPSP Coordinator, and the Director of Nurses have all been successful in obtaining major and lesser community grants to improve or augment MCH services in Butte County.				
Summary of Challenges: Ongoing base funding for the county MCH program has not increased since before 1990. Any increases have been previously kept by the State. Base funding with matching federal dollars (FFP) once paid for the MCH Director <u>and</u> staff, operating expenses, etc. Today, it only covers the Director and CPSP Coordinator positions with FFP draw-down. Currently, Target Case Management federal funding covers field PHN positions. However, this only pays for services for Medi-Cal clients. No monies to hire a part-time health educator to help with outreach ranging from Safely Surrendered Babies to smoking during pregnancy to preconception care.				
D. Coordination/Collaboration with other <u>Agencies/CBOs</u>	4	3	2	1
Summary of Opportunities; MCH is well known to other agencies and they send many referrals. PHNs are valued in the community and known for the caliber of their work. MCH staff has and continues to work well with numerous community partners. We are their ally in advocating for shared clients: Our AFLP contractor and CHDP Director are well aware that on the state level, MCH Directors and the MCH Branch both worked hard to save their programs from the State budget axe. The MCH Director and VIP Coordinator have both held pertinent trainings that were well-attended.				
Summary of Challenges: With staff and budget cuts, MCH and other agencies will find it increasingly difficult to give time to coalition/collaborative work as they cover their own core functions. Braiding funding may be even more difficult. Agencies and programs will be competing for some of the same grants; our challenge will be to continue to support and complement one another's work.				

Core Public Health/ MCH Functions	Rate capacity in each area by checking a number: **4 = strong, 3 = adequate** **2 = inadequate, 1= weak** Strong → Weak
1. Monitor health status	4 3 2 1
Summary of Opportunities: The MCH Director monitors the health of the community through tracking MCH indicator data, consulting peers within the HD, collaboration with hospital labor and delivery units, and periodic contact with CPSP program providers, obstetrical, and pediatric providers.	
Summary of Challenges: Inadequate funding to hire or contract for epidemiological /data analysis /program evaluation services. Due to time and budget constraints, the MCH Director does not monitor the community health status at regular intervals.	
2. Diagnosis & investigate community problems	4 3 2 1
Summary of Opportunities: The MCH Director uses AVSS data (and now other sources identified by FHOP) for quantitative information, but gathering qualitative information is often necessary to identify a problem. So, the MCH Director *listens* when PHNs, providers, or the public describe health problem or a barrier to care. Also when clients experience barriers at another agency, MCH usually works with their supervisors to problem-solve. Lastly, FHOP trainings have been helpful.	
Summary of Challenges: Due to the necessity of triaging the workload, the MCH Director hasn't used or implemented what is learned at FHOP trainings in a timely manner – and sometimes not at all.	
3. Inform, educate, empower people	4 3 2 1
Summary of Opportunities: We generated newspaper articles on breastfeeding in the workplace and the potential demise of the MCH program when blue-lined, e.g. eliminated in a budget proposal by former Governor Davis. Small community grants funded the development of a professional television ad on preconception care that was aired for two-weeks on local cable channels; and augmentation of Prop 10 New Parent Kits with a resource booklet was similarly funded. We now utilize MCH PHAs to staff health fairs who can answer general questions about MCH resources in the community and provide appropriate flyers or brochures or items such as poison control stickers.	
Summary of Challenges: Educating the community at large is frankly hamstrung by lack of funding for a health educator, health education materials, or development of professional quality materials.	
4. Mobilize community partnerships	4 3 2 1
Summary of Opportunities: Large grants obtained for Breastfeeding Coalition and First Chance Coalition. Safety partners now have car-seat fitting stations at numerous sites. Grass-roots advocacy effort to save MCH from the state budget axe.	
Summary of Challenges: As stated above staff and budget cuts make it increasingly difficult for partners to prioritize collaborative work as they take more clients and cover their own core functions.	
5. Develop policies and plans	4 3 2 1
Summary of Opportunities Many: Collaborative – SB2669 Committee: Planned a strategy to select and fund a community leadership team to attend the Training Institute/Chasnoff's program in Chicago r.e. perinatally drug/alcohol-exposed infants. First Chance Coalition: developed specific, feasible long and short-term strategies to decrease the number of drug/alcohol exposed newborns. The Perinatal Council, lead by the CPSP Coordinator, obtained funding to develop a pregnancy passport (prenatal care history card) and introduce it to providers. It is now used by 8 CNMs and 1 obstetrician. Sample domestic violence referral policy written for providers. Internally developed procedures for PHA's to implement PCG program saving phone outreach from budget cuts.	
Summary of Challenges: Inability to impact a problem like provider Medi-Cal reimbursement rates. No time on important MCH issues such as promoting preconception care with local clinics, college student health centers, and providers and non-availability of emergency contraception on weekends.	

6. Link women and children to services	4	3	2	1
Summary of Opportunities: MCH provides client linkage via: 1. home visits, 2. PCG phone service, 3. 1-800 toll-free line, 4. answering "Nurse-of-the-day" calls, 5. providing information and brochures to providers and partners, 6. participating in community health fairs, 7. coordinating and/or conducting trainings for providers and social service eligibility workers, 8. case management, 9. occasionally transporting clients to services, 10. internally exchanging newest resource changes with peers.				
Summary of Challenges: Impacted Medi-Cal services, especially dental care. At times can't obtain services for the uninsured, medically indigent, or undocumented. Undocumented clients unwilling to utilize CHDP or other programs for fear of deportation. Delays at social services due to impacted programs. Programs constantly change or end. Staff turnover in agencies affects quality of services.				
7. Evaluate effectiveness, access and quality of population based services	4	3	2	1
Summary of Opportunities: Quantitative: 1. PHN client outcomes measured by the Life Skills Progression tool for VIP Program. 2. MCH indicators monitored via AVSS, 3. Numbers of adequately immunized children from kindergarten retrospective studies. Qualitative: 1) subjective tool used by PHNs not on VIP team, 2) documented cases of barriers to care.				
Summary of Challenges: No spare time to do more than cursory review of available data (AVSS, parent survey data) or to really utilize training (FHOP).				
8. Research for insights/solutions	4	3	2	1
Summary of Opportunities: Any original research has been qualitative. 1. Utilized PHAs for basic community research such as surveying for clinics/private providers r.e. emergency contraception services; 2. Teamed with partners: HD and other agency staff surveyed parents for MCH 5-year plan; 3. Previously, surveyed providers and partners for various purposes.				
Summary of Challenges: 1. Due to small budget, we cannot hire staff or contract out for research; we do not have epidemiologist on staff for research. 2. No spare time to do more than cursory review of available data (AVSS, parent survey data) or to really utilize training (FHOP).				

Part II. Capacity Assessment

List emerging issues/policies in the public or private health care sectors that impact the local MCH program	II. Briefly describe MCH impact and response
1. Infants denied care by Medi-Cal providers because they did not have Medi-Cal cards.	Infants were not receiving essential post-natal care. The MCH Director informed a Social Services Supervisor of the infant "short-cut" to Medi-Cal. With assistance from the CHDP Director, and VIP Coordinator, a training conference was conducted for providers, Social Services, CPSP providers, PHNs, advocates, medical billers. Social Services now has a mechanism for infant "short cut".CCS and hospitals will be able to bill Medi-Cal for services previously denied.
2. Legislative efforts for universal health care	Legislation and community response followed by MCH Director. Informing local representatives and others as permitted by HD.
3. Lack of knowledge: Safely Surrendered Babies law	Distributed information at Butte College and CSUC health fairs. Plan presentation to 51 CSUC dorm advisors. Developed display board and wallet cards.Presentations: Prospect School and Oroville Family Resource Center to 20 teens. E-mailed Safe Arms School classroom curriculum to high school educators. Helpcentral.org listing.

List ongoing issues/policies in the public or private health care sectors that impact the local MCH program	Briefly describe MCH impact and response
1. Perinatal Substance Abuse	Pregnant substance abusers not identified for intervention. MCH established and coordinated the 1st Chance Coalition. A private treatment provider and partner now offers gender-specific,residential program for pregnant women;6 obstetric providers now screen.
2. Reports of some obstetricians not scheduling prenatal office visits until the 2nd trimester.	74% of pregnant women enter prenatal care early. In '01-'02, the CPSP Coordinator met with all obstetric providers in their offices and promoted 1st trimester care, at least 10 prenatal visits, and the use of a pregnancy passport. Early-entry to care rates haven't improved.
3. Mental health services for depression during pregnancy and post-partum insufficient and hard-to-access.	Depressed pregnant/post-partum women not receiving needed treatment. In '02, CPSP Coordinator and partners held a post partum depression conference featuring Dr. Shoshana Bennett to educate professionals. Informal discussions between the HD and Behavioral Health were conducted. In '01, BH was reorganized to address multiple service gaps. MCH situation described remains unchanged.

List Collaboratives / Networks that MCH convenes	For its major planning body or bodies, provide a full description of membership or include roster/representation in an appendix. For others, summarize membership categories, e.g., child advocates, social services representatives, etc.
1. Breastfeeding Coalition	See Appendix F
2. Butte-Glenn Perinatal Council	See Appendix F
3. Butte-Glenn Child Death Review Team	See Appendix -F
4. 0-3 Home Visitors Workgroup	See Appendix -F
5. Safe Kids Coalition	See Appendix -F
6. The First Chance Coalition: 02-04	See Appendix H1- 4
List Collaboratives / Networks in which MCH participates as member.	**Summarize membership (see above)**
1. Child Abuse Prevention Council	See Appendix G
2. Hispanic Resource Council	See Appendix G
3. Paradise Ridge Community Network	See Appendix G
4. Children's Coordinating Council	See Appendix G
(If applies) Briefly highlight any research activities MCH is involved in and how the findings have been used to increase MCH capacity or affect policies.	
1. Collecting 4Ps+ verbal screening data from obstetric offices. Objective: provide 1.prevalence estimate of drug-use during pregnancy, 2.provider feedback, 3. information for writing grants.	

F. Identification of the Problems/Unmet Needs of the Local MCH Population

1. Synthesis of findings regarding community health and resources assessments, overview MCH health indicators, and analysis MCH program capacity.

   Background context: Butte County's population is 83.3% white, yet ethnically diversified, mostly by Asians, Native Americans, Blacks, and Hispanics. Children 0-19 account for 27% of the population and 23% of them live in poverty. Nearly 20% of all residents live in poverty. Unemployment stands at 7% and the median household income is $15,570 less than the state median, while home and rental prices have dramatically increased.

   Birth information: Birth rates have been stable in 2000-2003 at about 2,257 a year, as have births to ethnic groups, the largest being Hispanic with 19 % of births and other groups with 2-5% each. In 2002, births to 15-17 year-olds decreased to 3.2 % from 5.9% in '98; but births to 17-19 year-olds increased from 6.7% in '00 to 9.3% in '02.

   Death information: The 2003 mortality rate was 764.9/100,000. Looking at annual averages for '00-'02, Butte ranked <u>below</u> 35 other counties for death caused by unintentional injuries, suicides, motor vehicle accidents, lung cancer, and drug-induced deaths. On the positive side, infant mortality rates decreased from a three-year average of 8.2 for '93-'95 to 4.3 for '99-'01.

   Alcohol, drugs, and tobacco: Alcohol and drug admissions have exceeded 1,100 annually since '95. By 9th grade over 10% of children smoke or have tried smoking. In 2003 a Butte County Health Department convenience survey showed that about 24% of adult participants smoke.

   Overweight: 2002 Pediatric Nutrition Surveillance data reveal that too many children ages 5-20 are obese (≥95th percentile): 23.9% of Hispanics. 17.5% of Caucasians and Asians, and 15.3% of Blacks and others. Also, too many are at risk for obesity (≥85th percentile): again the largest group is Hispanic at 19.2%.

   Health Insurance: 6,000 children (19%) under age 20 lack health insurance and 6,000 children (10%) ages 2-11 have no dental coverage.

   Communicable disease: the most notable local change occurred in 2003 when an epidemic of gonorrhea occurred. The annual number of cases, around 25, exploded to 155, increasing the rate more than 50 times. 58% of the cases were in females and numbers may never subside to pre-outbreak levels.

   Community assets: committed providers who collaborate well; improved early identification of problems and intervention; increased number of mid-level practitioners; abundance of services; working coalitions; and funded health grants.

   MCH Program Capacity: The Health Department's Nursing Administration strongly supports the MCH program. The staff has demonstrated excellent collaboration with other agencies and is culturally competent. In core public health functions, staff performs strongly in mobilizing partnerships, developing policies and plans, and linking women and children to services. Despite fiscal and time constraints, monitoring and diagnosing health problems is adequate as is evaluating access to and quality of services. However, more funding is required to fulfill health education/community empowerment and research functions.

2001 or 2002 MCH health indicators (rates causing concern are underlined): About 2,250 births occur annually. Butte County's fertility and teen birth rates are lower than California's. 20% of births are to females without a high school diploma. 71% are white; 19% are Hispanic. 54% are paid for by Medi-Cal. The birth rate for teens 15-17 at 15.9 per1,000 females is significantly better than both the state rate and the Healthy People 2010 goal. However, the percent of teens giving birth to more than l child increased lately to 4% locally.

Birth outcomes to Butte County parents are good: the percent of low weight newborns, 5%, is significantly better than the state's and meets the HP 2010 goal of 5%. Very low birth weight stands at less than 1%, meeting the national goal. The percentage of pre-term births of 11% is on a par with the state, but worse than the HP 2010 goal of 8%. Prenatal care values are well below HP 2010 goals: entry into first trimester care stood at 75% (HP 2010 – 90%) and trailed California by 10%; proportion of women receiving adequate prenatal care (Kotelchuck) was poor at 45% (HP 2010 – 90%) yet significantly better than the state at 41%.

The perinatal, neonatal, post-neonatal, and infant death rates have improved over the last decade and in 2001 were either significantly better than the state's and HP 2010 goals or about the same. Regarding children's death rates, data is insufficient to make any such comparisons due to small numbers.

Insurance and overweight indicator values were about the same as California's; poverty, and chlamydia had insufficient data for comparison. A positive note was that 76% of 2-11 year olds had been to a dentist in the last year, besting the state at 73%. The rate of domestic violence calls at 6.82 per 1,000 population was significantly better that the state's at 7.83; however this may or may not indicate a decrease in domestic violence. Violence shelter demand is still high. Unfortunately, Butte County's rate of placing children in foster care is abysmal at 13.51/1,000, significantly worse than the state at 8.9.

The rates of children regarding 1) asthma, 2) hospitalizations for mental health reasons, 3) hospitalizations for non-fatal injuries (ages 15-24), and 4) non-fatal injuries due to motor vehicle accidents were all worse than for previous years. Except for asthma among 5-18 year olds, these rates were also significantly worse than California's. Other issues of grave concern among parents and providers were 1) perinatal substance abuse and 2) youth and teen substance abuse.

Concerns/unmet needs: Concerns about access to health care, paucity of or gaps in services, and under-utilization of programs include the following:

- access to services during non-traditional hours
- access to first trimester prenatal care, early pediatric care for infants, and dental care for children
- paucity of adolescent and child mental health services, adolescent specific alcohol and drug treatment programs, gender-specific drug and alcohol residential treatment beds for women, and PHNs available to visit new parents
- lack of tobacco education programs specifically targeting pregnant women and lack of emergency contraceptive services on week-ends
- under-utilization of free, evening tobacco cessation classes by pregnant women per the American Lung Association and low use of the OPT for Fit Kids program for overweight/unfit children according to the program director.

Major Findings:

- Butte County's poorest state rankings in causes of death are all in preventable categories: unintentional injuries, motor vehicle accidents, suicide, drug abuse. Both parents and providers prioritized drug and alcohol abuse as their number one health challenge. Community will and capacity to work with drug/alcohol abuse is high.
- Poverty, unemployment, rising costs of living, and barriers to care will continue to stress the health of the poor, uninsured, and undocumented at persistent levels. Demand for services is not expected to decrease.
- Asthma among children 0-4 is an emerging health issue. If a negative trend is established this could impact the number of emergency room visits, child hospitalizations, and parent workdays lost. MCH providers ranked asthma as the 5th highest problem. Community capacity for prevention efforts is low.
- A recent gonnorhea epidemic may raise the average number of annual cases; this has implications regarding the annual number of pelvic inflammatory disease cases, newborns with birth defects, and other sequellae.
- The problem of late entry into first trimester care will require further inquiry, analysis, and intervention as feasible.
- Local data on breastfeeding duration rates for 6 to 12 months is not available. Providers want to establish breastfeeding for 6-12 months as the healthy "norm" for the county. Providers ranked it as 10th on their concerns list. Community and MCH capacity to address this issue is high.
- Hospitalization rates of teens 15-19 for mental health reasons significantly exceed state levels 7 out of 10 years ('91-'00). The community hasn't built capacity to meet this need. Parents ranked mental health as children's 4th highest health problem; service providers ranked it as 8th. Capacity to meet treatment needs for teens is low.
- Hospitalization rates of teens 15-19 for all non-fatal injuries exceed state levels and motor vehicle caused injuries persist in high numbers. The Health Department and its partners have some limited capacity to begin to address these concerns.
- Teen self-reports of alcohol abuse, driving drunk or being driven by someone who had been drinking relates to motor vehicle accidents and to the need for teen-specific treatment programs. Substance abuse cited as the #1 issue by parents and providers.
- 11.8 percent of children and teens 0-19 have no health insurance and 10% of children 2-11 have no dental insurance.
- Children's dental health was the 5th priority in providers' first ranking of problems. Unfortunately, it was left off the parent survey! The Health Department has procured funding for three years to provide direct dental services for children 0-5 and build a program.
- The numbers of minorities, immigrants, and under-educated significantly impact delivery of MCH services and modality of health education; these need to be culturally and literacy-level appropriate.
- The local MCH program is strong in many aspects, fulfills most core public health MCH functions, but cannot meet health education and research functions with its current budget. Without increased funding, meeting core functions and maintaining program quality will become increasingly less feasible.

V. Priority MCH Problems

Final problems list:

1. Families will become knowledgeable and empowered in accessing services.
2. All pregnant women will be verbally screened for drug, alcohol, and tobacco use, and if positive, offered appropriate referrals, follow-up, and placed in treatment if needed.
3. Mothers will be able to access a lactation support program to increase their duration of breastfeeding.
4. Hospitalizations of children 0-19 related to injuries should be reduced.

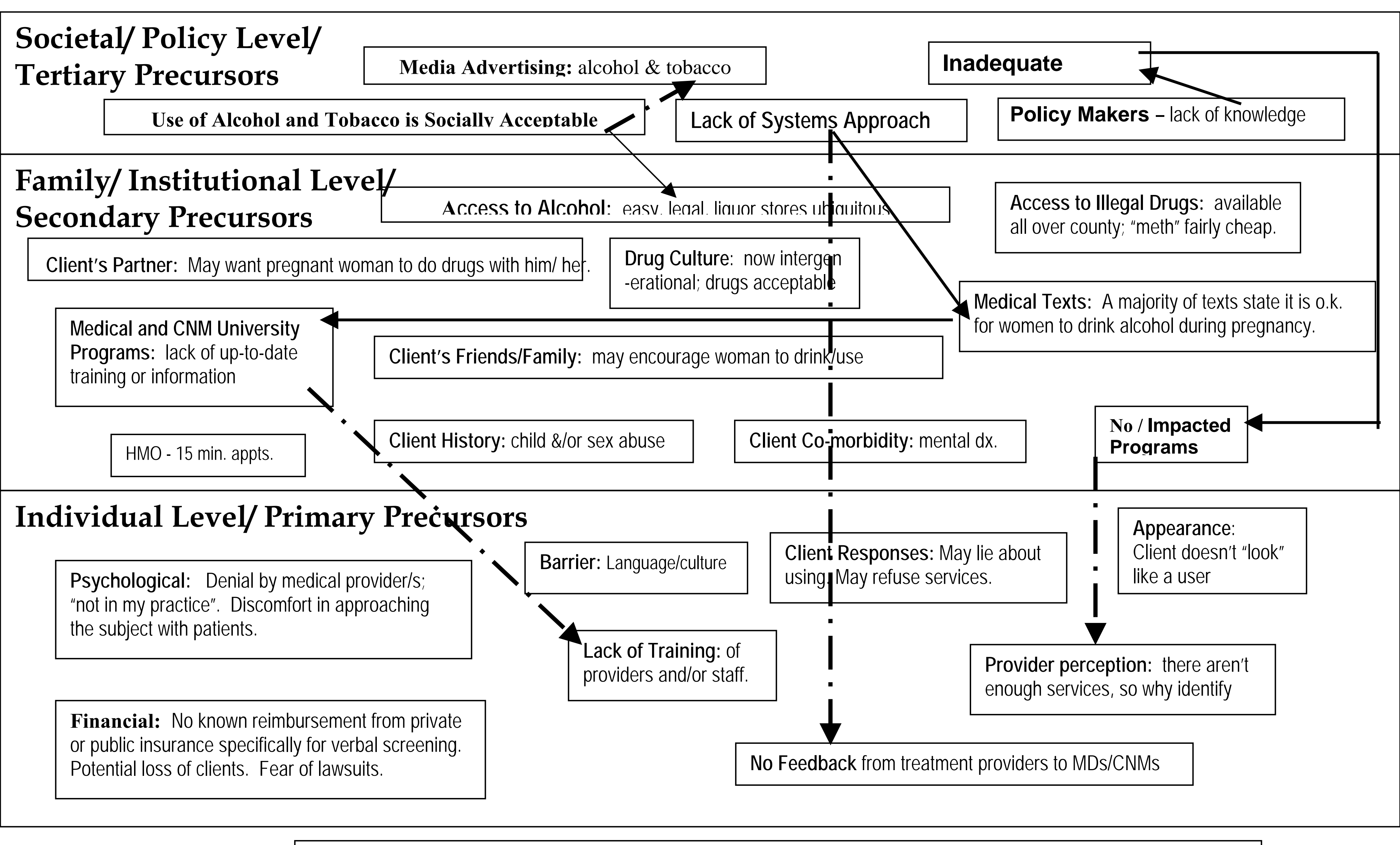
Brief description of process and rationale used to set priorities:

1. Two community planning meetings conducted. Provider priorities identified and mission statement and goals formulated.
2. Perinatal and child health surveys administered to parents around the county. Parental priorities identified.
3. MCH program capacity assessed in regards to both parent and provider priorities.
4. Community capacity assessed in regards to both parent and provider priorities.
5. All of the above considered in light of a) established need, b) community will as evidenced by actions, e.g. coalitions, funding procurement, etc., and c) feasibility of MCH partners addressing that need.

VI. Preliminary Problem Analysis for Perinatal Substance Abuse

Problem Statement: Pregnant substance abusing women are not being identified by obstetrical providers or referred for treatment resulting in an unknown number of births of substance-exposed children.

Preliminary Problem Analysis Diagram: See below. Note: heavy dotted lines indicate areas of action for First Chance: Butte Coalition for Drug & Alcohol-Free Babies.



Targeted Indicator : **Unidentified and Untreated Perinatal Substance Abuse**

Consequences: Continued maternal drug abuse causing: prematurity, intrauterine growth retardation, abruptio placentae, low birth weight, still birth, SIDS, neonatal seizures, long term cognitive, behavioral & academic problems

Data/Information Needed: First Chance: the Butte Coalition for Alcohol and Drug-Free Babies would ideally like to establish the prevalence of perinatal substance abuse in the county and also a "ball-park" sense of the impact on community program loads primarily for use in planning strategies and writing grants. At this time, there is no plan developed for data gathering. The following is a list of ideas devised thus far:

- A one-to-three month meconium study on all newborns of Butte County residents. In fact, the study design is virtually completed and supported by the Health Officer. The coalition is looking for possible funding.
- A survey of community partners regarding how many of their new referrals over a 6-month period are identified by providers or family as substance exposed in-utero or documented as "suspected" cases. Programs range from California Children's Services, to Early Head Start, to special education programs, PHN caseloads, etc.
- A survey of all women's treatment programs of number of pregnant women served in a 6-12 month period and their outcomes at 3, 6, and 12 months.
- Develop an ongoing data system to be used by treatment providers county-wide, both public and private.
- Obtain from hospitals SB2669 data on number of tests run on infants and number of positives on a regular basis.
- Systematize collection and reporting of the data provided by 4Ps+ verbal screening forms.

A literature review has already been completed by a nurse in the Options for Recovery Program who reported findings to the SB2669 subcommittee of the Butte County Child Abuse Prevention Council. Based on her reports, the subcommittee worked with Enloe Hospital on a grant that later funded sending a team of community leaders to Chicago for training in perinatal substance abuse by Dr. Ira Chasnoff.

For the MCH program, further compilation and analysis of data generated by the Perinatal and Child Health Survey will be performed by the MCH Director fiscal year '04-'05. AVSS data pertinent to entry into first trimester care will also be reviewed in detail.

VII. APPENDICES

See following pages.

Community Health Issues Ranking by Weighted Score*

Issue	1st	2nd	3rd	4th	5th	weighted score*
Substance Abuse: Drugs, Alcohol, Tobacco	40	8	18	8	10	**84**
Dental Health	10	28	6	6	0	**50**
Mental Health	15	24	9	6	2	**56**
Childhood Obesity / Nutrition	15	8	21	8	5	**57**
Breastfeeding	5	12	6	8	1	32
Early Prenatal Care	10	0	0	6	0	16
Preconception Care / Unintended Pregnancy	5	4	3	2	0	14
Non-intentional Injuries (0-5)	0	0	3	0	1	4
Health Literacy & Education & Parenting Ed. includes: belief that health care = sick care only, outreach to fathers; family relationship building (not just child focused) relationship building (not just child focused)	30	12	21	2	2	**67**
Teen & Foster Kids Outreach, Health Education	0	0	4	0	1	5
Collaborative Processes; knowledge of programs	5	0	3	0	1	9
Too few pediatricians and pediatric dentists	5	12	3	4	5	29
Too few mental health providers	5	0	6	0	1	11
More bilingual services & staff	0	12	0	0	0	12
Health Insurance for All	5	4	0	2	0	11
Child Care & Respite Care	0	0	0	4	0	4
Home Visitation Services: Newborns, Families	10	0	3	2	1	16
Poverty	10	0	0	0	1	11
Transportation	10	8	3	2	2	25
Housing	0	4	0	0	0	4
Child Abuse	0	0	0	4	0	4
Child Neglect	0	4	0	0	0	4
Family Violence	10	0	0	2	2	14
Community Safety: crime/parks/activities	0	4	0	0	2	6
Negative attitude r.e. outlying areas and residents (includes professionals)	5	0	0	0	0	5

** 1st rank -5 points; 2nd – 4 points; 3rd-3 points; 4th – 2 points; 5th – 1 point*

MCAH Community Health Priorities Matrix Results

Prob	Topic	Individual Participant Score Results																				Grand Totals	Ave. Score	Top 10
1	1st trim.care	25	46	38	24	38	23	27	53	34	23	56	45	43	30	51	24	26	17	20	27	670	33.5	
2	adeq. prenatal care	31	43	38	45		28	27	56	38	38	55	51	46	36	57	31	29	17	31	27	567	38.11	
3	preterm births	50	47	45	50	48	31	26	45	37	45	45	53	36	27	52	53	39	17	34	29	809	40.45	
4	low birthwt.	52	51	47	41		28	54	42	40	50	48	0	35	49	53	54	41	17	38	29	769	40.47	
5	BF duration	48	35	35	44	40	35	47	46	32	61	53	45	46	49	38	55	24	20	42	21	**816**	40.8	**10**
6	obesity - child & teen	54	49	44	50	48	44	54	48	57	56	62	49	46	52	53	47	46	31	46	34	**970**	48.5	**2**
~~7~~	~~teen deaths (15-19)~~	repea	below																			repeat	repeat	repeat
~~8~~	~~obesity - child & teen~~	repea	above																			repeat	repeat	repeat
9	dental- child	48	44	36	45	46	34	52	45	42	49	47	0	40	35	46	38	37	45	27	49	805	42.36	
10	dental - preg women	48	38	35	37	40	32	51	46	29	45	51	0	40	23	48	41		45	29	49	727	38.26	
11	asthma - child	45	45	44	46	45	41	54	50	55	47	50	0	49	53	61	46		45	41	51	**868**	45.68	**5**
12	mental health - child	36	40	37	28	38	40	45	37	56	50	38	53	43	34	44	40	39	35	42	53	**828**	41.4	**8**
13	non-fatal injuries (0-19)	33	39	40	27	49	33	42	36	37	46	48	0	46	0	37	34		27	0	41	615	32.37	
14	MVAs (0-19)	36	46	40	53		27	52	45	41	44	48	0	46	0	37	50		27	0	37	629	34.94	
15	child deaths (0-14)	41	45	50	49	46	40	53	41	42	44	54	0	33	33	41	37	14	38	0	41	742	37.1	
16	teen deaths (15-19)	40	44	45	47	40	46	56	44	44	50	55	48	42	0	47	34	43	40	36	50	**851**	42.55	**7**
17	child/teen drug abuse	52	50	47	54	42	40	58	50	56	49	48	50	48	53	52	42	46	41	45	48	**971**	48.55	**1**
18	perinatal drug abuse	55	49	47	44	50	34	58	54	48	42	49	45	48	0	51	43	47	40	52	35	**891**	46.89	**4**
19	domestic violence	48	42	45	42	44	40	46	47	44	44	45	56	37	40	45	38		43	46	35	792	43.53	
20	# children foster care	46	49	45	53	48	39	53	53	42	45	53	46	46	48	55	40		39	54	53	**907**	47.74	**3**
21	% children poverty	34	42	44	36	48	38	49	43	44	43	42	40	42	48	46	38	47	31	41	56	**852**	42.6	**6**
22	% child no health insurance	32	42	48	43	42	32	55	51	49	45	41	0	39	0	40	34	41	31	38	56	759	37.95	
23	children no dental insurance	46	40	40	42	52	34	52	42	44	54		0	43	47	41	43	41	30	45	38	774	43	
24	not enough pediatricians	41	32	50	32	33	41	50	46	23	37		30	39	41	45	32		26	44	47	689	38.27	
25	too few pediatric dentists	49	33	44	40	56	34	54	48	23	47	46	30	38	39	53	38		26	31	47	776	40.84	
26	not enough pediatric mental health providers	36	38	45	57	57	33	52	49	26	47	40	30	49	0	47	47	38	40	31	55	**817**	43	**9**
27	health literacy+education	41	34	43	41	43	33	50	35	32	39	41		51	44	50	33		26	43	34	713	39.61	
28	parent ed & support grps.	44	38	48	31	43	35	48	45	33	37	45	33	47	35	38	36		27	38	37	738	38.84	
29	transportation	33	33	50	35	42	29	45	37	32	37	39	23	33	27	37	38		27	39	36	672	35.37	
30	improve collaborative processes	37	39	57	29	50	29	47	41	34	18	33	24	36	0	45	42	43	30	22	37	693	36.47	
31	tobacco cessation	46	39	45	61	56	36	58	44		29	51	40	0	0	59	42		30	56	53	745	41.38	

Health Needs/Problem Priortization Matrix

Criterion #1: Significant number of people affected (1)	Criterion #4: Problem is amenable to effective intervention (3)
Criterion #2: Severity or cost of consequences (3)	Criterion #5: Timely data is available to measure the problem (2)
Criterion #3: Problem is getting worse (2)	Criterion #6: Resources are available to address the problem (2)

Health Indicator		Prioritization Criteria In the line below C1, C2, etc., record weights as follows: **1=Important; 2=Very Important; 3=Most Important** Multiply weight by score for each problem and all criteria.												Total Scores
		C 1 (1)		C 2 (3)		C 3 (2)		C 4 (3)		C 5 (2)		C6 (2)		

MCH Prioritization Matrix		
Rank	Problem	Score
No. 1	child/teen drug abuse	971
No. 2	obesity - child & teen	970
No. 3	# children foster care	907
No. 4	perinatal drug abuse	891
No. 5	asthma - child	868
No. 6	% children poverty	852
No. 7	teen deaths (15-19)	851
No. 8	mental health - child	828
No. 9	too few pediatric mental health providers	817
No.10	BF duration	816

Top 4 Parent-Identified Child Health Issues
1. Drug/Alcohol Abuse
2. Violence
3. Teen Pregnancy
4. Mental Health/Emotional Problems

Top 4 Initial Ranking by Community Partners
1. Drug/Alcohol/Tobacco Abuse
2. Health Literacy & Education & & Parenting Education
3. Childhood Obesity / Nutrition
4. Mental Health/Emotional Problems

County	Indicator # Description	Yr. of Data	County Value Numer.	Denom.	Rate or %	HP Goals	State Value
Butte	**1** Fertility Rates per 1,000 Females (Ages 15 to 44)	2001	2266	43203	52.450061	none	70.8
Butte	**2** Teen Birth Rate per 1,000 Females (Ages 10 to 14)	2001	3	7100	0.4225352	none	0.61
	(Ages 15 to 17)		72	4520	15.929204	43	24.4
	(Ages 18 to 19)		194	2978	65.144392	none	76.6
Butte	**3** Percent Low Birth Weight (Live Births)	2001	121	2314	5%	5%	6%
Butte	**4** Percent Very Low Birth Weight (Live Births)	2001	11	2314	0%	1%	1%
Butte	**5** Percent Preterm Births (< 37 Wks Gestation)	2001	247	2314	11%	8%	10%
Butte	**6** Percent of Births Occurring within 24 Months of Previous Birth (Entire pop.by Age)	HOLD					
Butte	**7** Percent of Teen Births to Women Who Were Already Mothers	2001	63	1412	4%	none	3%
Butte	**8** Perinatal Death Rate	2001	15	2314	6.4822	4.1	5.7
Butte	**9** Neonatal Death Rate per 1,000 Live Births (Birth to < 28 days)	2001	6	2314	2.5929127	2.9	3.61 '99-'0
Butte	**10** Post-Neonatal Death Rate per 1,000 Live Births (> 28 Days to 1 Year)	2001	4	2314	1.7286085	1.2	3.61'99-'01
Butte	**11** Infant Death Rate per 1,000 Live Births (Birth to 1 Year)	2001	7	2314	3.0250648	4.5	3.61'99-'01
Butte	**12** Death Rate per 100,000 (Ages 1 to 14)	2001	7	39097	17.904187	none	16.6
	(Ages 15 to 19)		12	15383	78	39.8	59.1
Butte	**13** Percent Prenatal Care in First Trimester (Live Births)	2001	1737	2314	75%	90%	84%
Butte	**14** Proportion of Women (Age 15 to 44) with Adequate Prenatal Care(Kotelchuck)	2001	1047	2314	45%	90%	41%
Butte	**15** Percent of Women Who Were Breastfeeding at Time of Hospital Discharge	1999	1450	2314	63%	none	42%
Butte	**16** Percent of Children and Adolescents (Ages 0 to 19) without Health Insurance	2001	6000	51000	12%	(1-1) 100%	12%
Butte	**17** Percent of Children (Ages 2 to 11) without Dental Insurance	2001	6000	25000	24%	none	23%
Butte	**18** Percent of Children (Ages 2 to 11)Who Have Been to the Dentist in Past Year	2001	19000	25000	76%	(21-10)56%	73%
Butte	**19** Percent of Children and Adolescents Who Are Overweight (Ages 5 -11)	2002	341	1925	18%	(19-3a) 5%	16%
	(Ages 12-19)	2002	187	985	19%	(19-3b) 5%	21%
Butte	**20** Rate of Children Hospitalized for Asthma per 10,000 (Ages 0 to 4)	2000	66	13034	50.636796	(24-2A) 25	32.5
	(Ages 5 to 18)		29	40084	7.2348069	(1-9a) 17.3	109
Butte	**21** Rate per 1,000 Females (Ages 15 to 19) with a Reported Case of Chlamydia	2002	107	7625	14.032787	none	22
Butte	**22** Rate of Children Hospitalized for Mental Health Reason/10,000 (Ages 5 to 14)	2000	160	28140	56.858564	none	21.76
	(Ages 15 to 19)		215	14892	144.37282	none	80.79
Butte	**23** Rate of Hospitalizations All Non-Fatal Injuries by Age Group/100,000(0 to 14)	2000	114	41174	276.87376	none	249.5
	(Ages 15 to 24)		262	28086	932.84911	none	705
Butte	**24** Rate of Non-Fatal Injuries Due to Motor Vehicle Accidents/100,000 (0 to 14)	2000	23	41174	55.860494	none	39.2
	(Ages 15 to 24)		64	28086	227.87	none	165.4
Butte	**25** Number of Children Living in Foster Care for Selected Month (July) per 1,000	2003	714	52838	13.513002	none	8.9309
Butte	**26** Percent of Children (Ages 0 to 19) Living in Poverty	2000	10946	47956	23%	none	(0-17yrs)18%
Butte	**27** Number of Domestic Violence Related Calls for Assistance in Year per 1,000	2001	1105	161943	6.8233885	none	7.83%
Butte	**28** Abstinence Rate or Issues regarding Perinatal Substance Abuse	1991			est. 14%	(16-17)	94%
Butte	**29** Rates or Issues regarding Youth & Teen Substance Abuse	03/'04				(26-11d)	20%

Status Compared to: State	Healthy People	Past Years	If qualitative analysis,method?	If you selected "Qualitative - Other Method," please describe your process:
Significantly Better	No Healthy People Objectives for this	About the Same		
Significantly Better	No Healthy People Objectives for this	Better	Qualitative - Focus Groups	With AVSS data, 2 community planning days for professionals- matrix tool used
Significantly Better	Significantly Better	Better	Qualitative - Focus Groups	With AVSS data, 2 community planning days for professionals- matrix tool used
Cannot Tell/Insufficient Dat	No Healthy People Objectives for this	Cannot Tell/Insufficient Dat	Qualitative - Focus Groups	With AVSS data, 2 community planning days for professionals- matrix tool used
Significantly Better	About the Same	About the Same	Qualitative - Focus Groups	With AVSS data, 2 community planning days for professionals- matrix tool used
Cannot Tell/Insufficient Dat	Cannot Tell/Insufficient Data	About the Same	Qualitative - Focus Groups	With AVSS data, 2 community planning days for professionals- matrix tool used
About the Same	Significantly Worse	About the Same	Qualitative - Focus Groups	With AVSS data, 2 community planning days for professionals- matrix tool used
About the Same	No Healthy People Objectives for this	Worse	Qualitative - Focus Groups	With AVSS data, 2 community planning days for professionals- matrix tool used
About the Same	About the Same	About the Same		
Significantly Better	About the Same	Better		COMMENT: While numbers are small, confidence intervals look solid
About the Same	About the Same	About the Same		COMMENT: While numbers are small, confidence intervals look solid
Significantly Better	Significantly Better	Better		COMMENT: While numbers are small, confidence intervals look solid
Cannot Tell/Insufficient Dat	No Healthy People Objectives for this	Cannot Tell/Insufficient Data		COMMENT:HP goals go by ages 1-4, 5-9, 10-14.Can't make comparison to 0-14 group.
Cannot Tell/Insufficient Dat	Cannot Tell/Insufficient Data	Cannot Tell/Insufficient Data		
Significantly Worse	Significantly Worse	About the Same	Qualitative - Surveys	With AVSS data, used > 270 surveys- convenience sampling & matrix tool
Significantly Better	Significantly Worse	About the Same		
Significantly Better	No Healthy People Objectives for this	Cannot Tell/Insufficient D	Qualitative - Focus Groups	Butte-63% & CA- 42% r.e. exclusive BF; r.e. BF initiation Butte>90% , HP - 75%
About the Same	Significantly Worse	Cannot Tell/Insufficient D	Qualitative - Surveys	also > 270 surveys- convenience sampling.
About the Same	No Healthy People Objectives for this	Cannot Tell/Insufficient D	Qualitative - Focus Groups	2 community planning days for professionals- matrix tool used
Significantly Better	No Healthy People Objectives for this	Cannot Tell/Insufficient D	Qualitative - Surveys	used > 270 completed surveys- convenience sampling
Cannot Tell/Insufficient Dat	Cannot Tell/Insufficient Data	Cannot Tell/Insufficient D	Qualitative - Focus Groups	2 community planning days for professionals- matrix tool used
Cannot Tell/Insufficient Dat	Cannot Tell/Insufficient Data	Cannot Tell/Insufficient D	Qualitative - Focus Groups	2 community planning days for professionals- matrix tool used
Significantly Worse	Significantly Worse	Worse	Qualitative - Surveys	> 270 surveys- convenience sampling: & 2 professional planning days: matrix tool
Significantly Better	Significantly Better	Worse	Qualitative - Surveys	> 270 surveys- convenience sampling: & 2 professional planning days: matrix tool
Cannot Tell/Insufficient Dat	No Healthy People Objectives for this	Cannot Tell/Insufficient Data		
Significantly Worse	No Healthy People Objectives for this	Worse	Qualitative - Surveys	> 270 surveys- convenience sampling: & 2 professional planning days: matrix tool
Significantly Worse	No Healthy People Objectives for this	Worse	Qualitative - Surveys	> 270 surveys- convenience sampling: & 2 professional planning days: matrix tool
About the Same	No Healthy People Objectives for this	About the Same	Qualitative - Surveys	> 270 surveys- convenience sampling: & 2 professional planning days: matrix tool
Significantly Worse	No Healthy People Objectives for this	Worse	Qualitative - Surveys	> 270 surveys- convenience sampling: & 2 professional planning days: matrix tool
About the Same	No Healthy People Objectives for this	Worse	Qualitative - Surveys	> 270 surveys- convenience sampling: & 2 professional planning days: matrix tool
Significantly Worse	No Healthy People Objectives for this	Worse	Qualitative - Surveys	> 270 surveys- convenience sampling: & 2 professional planning days: matrix tool
Significantly Worse	No Healthy People Objectives for this	Cannot Tell/Insufficien	Qualitative - Focus Groups	2 community planning days for professionals- matrix tool used
Cannot Tell/Insufficient Dat	No Healthy People Objectives for this	Cannot Tell/Insufficient D	Qualitative - Surveys	> 270 surveys- convenience sampling: & 2 professional planning days: matrix tool
Significantly Better	No Healthy People Objectives for this	Cannot Tell/Insufficien	Qualitative - Surveys	> 270 surveys- convenience sampling: & 2 professional planning days: matrix tool
	Cannot Tell/Insufficient Data	Cannot Tell/Insufficient D	Qualitative - Focus Groups	2 professional planning days: initial brainstormed prioritization & matrix tool
	Cannot Tell/Insufficient Data	Cannot Tell/Insufficient D	Qualitative - Surveys	Healthy Kids Survey & 270 completed parent surveys-convenience sampling

priority county?	If yes, describe the reasoning process used in determining this indicator as a priority
No	
No	
No	
No	
No	
No	
No	
No	
No	
No	
No	
No	
No	
No	
No	COMMENT: Community did not prioritize, but **MCH may still address as capacity / resources allow.**
No	
Yes	HD has 3-yr Prop. 10 BF grant. Strong BF Coalition.Helps obesity prevention. Pediatricians more receptive to BF.
No	Comment: Butte Co. CHDP just received a 3-yr. Prop 10 grant to address pediatric dental care services gap.
No	
No	
No	3-yr obesity grant through CSUC about to expire. Local study preliminary results show much higher incidence of
No	childhood obesity in Butte County than PEDNS / CHDP data. **PHNs will work with OPT for Fit Kids Program.**
No	
No	
No	
No	Professionals& parents id'd child mental health service gap. Recent teen suicides & matricide of newborn reinforce
No	the urgency of problem. 0-5 mental health services grant ending.**MCH to continue C.D.R.T. activity re suicides.**
No	
No	
No	
No	From 1993-1999, state rates were not significantly lower than Butte's. MCH will continue to monitor.
No	
No	
No	
Yes	Initial prioritization& matrix tool - prob in top 4;Prop 10 gave start up funds 3 yrs ago.Community prioritizes! Is at core of MCH
No	Parents' 1st choice as # 1, 2, & 3 most important prob. Healthy Kids Survey: 16% 11th graders binged alcohol >3Xs in 30 days

APPENDIX F – page 39 -

List Collaboratives / Networks that MCH **convenes**	For its major planning body or bodies, provide a full description of membership or include roster/representation in an appendix. For others, summarize membership categories, e.g., child advocates, social services representatives, etc.
1. The Butte County Breastfeeding Coalition	Enloe Hospital, private mom, a doula, Dr Asarian- pediatrician, CPSP providers, Feather River Hospital, WIC
2. The Butte-Glenn Perinatal Council	Glenn County Public Health, WIC, Butte & Glenn County Social Services, CPSP providers, Dr. Reed (retired), Enloe Hospital, Planned Parenthood, Butte County Department of Employment and Social Services
3. The Butte-Glenn Child Death Review Team	Calif. Highway Patrol; Behavioral Health; Butte and Glenn County District Attorneys and Sheriffs; Butte County Fire Dept; Chico, Oroville, Paradise, and Gridley City Police Depts.; Butte and Glenn County Child Protective Services; Butte County Office of Education; Behavioral Health; Enloe Children's Center and Emergency Room
4. 0-3 Home Visitors Workgroup	Parent Education Network, Child Abuse Prevention Council, Far Northern Regional Center, Valley Oaks Children's Services, Youth for Change, Butte County Office of Education, Rowell Family Empowerment Center, Head Start, Early Head Start, Home Health Care Management, Touchstone Perinatal Services, OPT for Fit Kids, Northern Valley Catholic Social Services, Northern Valley Indian Health, Butte County Behavioral Health, Butte County 1st Five
5. Safe Kids Coalition	Enloe Medical Center, Butte County Assoc. of Governments, Head Start, Chico & Oroville Fire Depts., Calif. Dept. of Forestry/Butte County Fire, City of Paradise Public Works, Glenn County Health Services, Lake Oroville Bicyclists Organization, First Responder Paramedics, Oroville Hospital, Calif. Highway Patrol, Dr. Resk, County Pathologist, Northern Valley Indian Health, Feather River Tribal Health, Home Health Care Management, Child Abuse Prevention Council, Butte County Office of Education, No. Valley Catholic Soc. Services.
6. The First Chance Coalition:April 02 - June 04	**See Appendix H 1-3**

List Collaboratives / Networks in which MCH participates as a member.	Summarize membership
1. Child Abuse Prevention Council	Butte County Department of Behavioral Health, Butte County Department of Employment and Social Services, Butte County District Attorney's Office, Butte County Public Health, Catalyst (Domestic Violence Women's Shelter), Enloe Children's Health Center, Anne Gile-pediatric psychotherapist, Grandparents as Parents, Lassen Foundation, Local Child Care Planning Council, Northern Valley Catholic Social Services, Options for Recovery Program, Parent Education Network, Valley Oaks Children's Services
2. Hispanic Resource Council	American Lung Association, Big Brothers Big Sisters, Butte County Probation / Victim Witness, Butte County Public Health, Butte-Glenn Community College, CA Rural Legal Assistance, Inc., CA Highway Patrol, CA Mini-Corp Program, CAL. Human Development Corp., CAL WORKS Division of Butte County Social Services, Chico Housing Improvement Program, Chico Police Department, Chico Unified School District, Community Collaborative for Youth, Costco, Del Norte Clinics, Enloe Hospital, Far Northern Regional Center, Glenn County HRA, Girl Scouts of Sierra Cascade, Healthy/Even Start, Home Health Care Management, Latinas Activas, Legal Services of Northern California, Migrant Head Start, Migrant Education, Northern Valley Catholic Social Services, Parent Education Network, Planned Parenthood, SEA Center, Valley Oaks Children Center, Wells Fargo Bank-North Branch, Women's Health Specialists
3. Paradise Ridge Community Network	Boys 'n Girls Club, Butte County Head Start, Butte County Office of Education, Butte County Health Department, Center for Tolerance and Non-violence, Community Action Agency, Feather River Hospital, First Christian Church, Friends of the Library, Grandparents as Parents, Paradise Community Foundation, Paradise Ridge Family Resource Center, Paradise Parish Nursing Program, Paradise Unified School District, Private Industry Council, Skyway House, United Methodist Church, WIC, Youth for Change
4. Children's Coordinating Council	Butte County Supervisor Mary Anne Houx, Butte County Probation, Butte County Courts, Chapman School- Even Start Program, Valley Oak Children Services, Local Child Care Planning Council, Youth for Change, Child Abuse Prevention Council, Parent Education Network, Butte County Office of Education, Butte College, CSUC, Independent Living Services of Northern California, Catalyst (domestic violence women's shelter), Northern Valley Catholic Social Services, Feather River Tribal Health, Northern Valley Indian Health, HelpCentral.org (community listing of services), Butte County Departments of Behavioral Health, Public Health, and Employment/Social Services.

APPENDIX H-1 - page 41 -

First Chance Members Listing
March 2004

Name	Agency	Address	e-mail	Phone	Fax	√ Active Member	√ E-mail only	√ Take me off listing
Ables, Kasey	Feather River Tribal Health			532-6811 ext. 284			??	
Ainsworth, Ron, M.D.	NA	771 Buschmann Road, Suite AA Paradise 95969		877-8640	877-4717	XX		
Balch, Gloria	Valley Oaks Children's Services	289 Rio Lindo Chico, CA 95926		895 3572	895-1119	XX		
Bixler, Rohani	Catalyst	P.O. Box 4184 Chico, CA 95927		343-7845	343-3960	XX		
Brayton, Suzanne	Touchstone	1390 E. Lassen Chico 95926		345-4155	899-2017		??	??
Connoy, Ed, MSW	Oroville Hospital	2767 Olive Highway Oroville 95966		534-1172	538-3212	XX		
Cooper, MaryAnn	Feather River Hospital	5974 Pentz Rd, Paradise 95969		876-7902	876-9732	XX		
Cragar, Patricia Director	Butte Co.Dept Employment & Social Services	202 Mira Loma Dr. #63 Oroville 95965		538-7891	534-5745	XX		
Deadmond, Janet R.N.C	Oroville Hospital	2767 Olive Hwy. Oroville 95966		532-8445	532-8414		??	

Name	Agency	Address	e-mail	Phone	Fax	√ *Member*	√ E-mail only	√ Take me off listing
Donnelson, Sharon	Feather River Tribal Health	2145 5th Ave. Oroville 95965		534-5394	533-1113		??	??
Eagan, Virginia	Touchstone Enloe	1390 E. Lassen Ave Chico 95927		332-6268	899-2017	XX		
Gardner, Janelle RNC, PhD	CSU Chico School of Nursing	14979 Woodland Park, Dr Forest Ranch 95942		898-6429 or home 342-6159		XX		
Grams, Cathi	Children's Services	DESS Administration 202 Mira Loma Dr. Oroville, CA 95965		538-2070	538-5745	XX		
Guerra, Tracy	Enloe Childrens Health Center	277 Cohasset Road Chico 95926		332-6026	899-2045	XX		
Higgins, Tommy	Skyway House	6373 Oak Way Paradise 95969		876-9436	872-5563		??	
Huffmon, Linda	Behavioral Health	P.O. Box 233 Chico 95927		891-0661	891-0661	XX		
Hyams, Insu PHN	Butte County Public Health	202 Mira Loma Dr., #35 Oroville, CA 95965		538-7585	538-7297	XX		
Krauss, Shirley	Cherokee House	59 Crystal Pines Rd Cherokee, CA 95965		534-8061	533-2628			??
Lehman, Justine	Northern Valley Catholic Social Social Services	10 Independence Circle, Chico, CA 95973		345-1600 ext 126	345-1685	XX		

APPENDIX H 3 - page 43 -

Name	Agency	Address	e-mail	Phone	Fax	√ Member	√ E-mail only	√ Take me off listing
Liddiard, Don	Butte County Behavioral Health			891-2784	891-2809	??	??	
Lindauer, Barbara	Touchstone	1390 East Lassen Ave. Chico, CA 95973		332-6230	899-2017	XX		
Luz, Brad Ph.D.	Butte Co. Behavioral Health			891-2850	895-6549	XX		
Marcotte ,Dolores	Touchstone	1390 East Lassen Ave. Chico 95926		332-6204	899-2017	XX		
Morrison, Sibyl	Enloe Diabetes, Nutrition & Pregnancy	888 Lakeside Village Commons, Chico, CA 95928		332-6802	899-2039	XX		
Murdock, Phyllis	Public Health Director	Public Health: Admin. 202 Mira Loma Drive Oroville, CA 59565		538-7583	538-2164	XX		
Neal, Eric M.D.	Oroville Hospital	2809 Olive Highway, Suite 330 Oroville 95966		533-0774	533-3568	XX		
Nelson, Chris PHN	Public Health /Behavioral Health	695 Oleander Ave Chico 95926		891-2778	879-3309	XX		
Pierce, Leah	Feather River Hospital	5974 Pentz Rd. Paradise 95969		876-7902	876-7932	XX		
Porter, Elizabeth	Skyway House	6373 Oak Way Paradise 95969		876-7499	872-5563	XX		

Name	Agency	Address	e-mail	Phone	Fax	√ Member	√ E-mail only	√ Take me off listing
Ramsey, Mike D.A.	Butte County District Attorney	25 County Center Drive, Oroville 95965	mramsey@buttecounty.net	538-7411	538-7928		XX	
Rueggar, Margie	Child Abuse Prevention Council	2070 Talbert Drive Chico, CA 95928	margie@parented.org	893-0391 ext. 3037	893-4075	XX		
Vicki Shively	Northern Valley Indian Health	207 North Butte Street Willows, CA 95988	Vicki@snowcrest.net	934-5431	934-2372		??	
Stevens, Darrell W.	Butte County Superior Court	655 Oleander Avenue Chico 95926	Dstevens@cmc.net	879-3312	895-6509	XX		
Todd, Joy	Touchstone	1390 East Lassen Chico 95926	wandawave@yahoo.com	332-6090	899-2017	XX		
Tonjes, Sandra	Children's Service Div.	78 Table Mountain Blvd. Oroville, CA 95965	STonjes@dsw.ncen.org	538-7896	534-5921	XX		
Weeber, Tracy R.N.	Enloe Hospital	1531 Esplanade Chico 95926	Tracy.weeber@enloe.org	332-7427/ 332-3431 work - cell	899-5705	XX		
Yocum, Teresa	Feather River Hospital	5974 Pentz Road Paradise, CA 95969	yocumtl@ah.org	893-9361 ext. 7310	876-7932	XX		