California Department of Public Health (CDPH)

Maternal, Child and Adolescent Health (MCAH) Program

Scope of Work (SOW)

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

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

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

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

* [The Ten Essential Services of Public Health](http://www.cdc.gov/nphpsp/essentialServices.html)
* [The Spectrum of Prevention](http://www.preventioninstitute.org/component/taxonomy/term/list/94/127.html)
* [Life Course Perspective](http://mchb.hrsa.gov/lifecourseresources.htm)
* [The Social-Ecological Model](http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html)
* [Social Determinants of Health](http://www.cdc.gov/socialdeterminants/)
* [Strengthening Families](http://www.cssp.org/reform/strengthening-families)

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

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

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

| **Goal 1: Women/Maternal Domain: Improve access to and utilization of comprehensive, quality health and social services**  **The shaded and/or highlighted areas represent required activities.** | | | |
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| **Short and/or Intermediate Objective(s)** | **Intervention Activities to Meet Objectives (Describe the steps of the intervention)** | **Evaluation/Performance Measures**  **Process, Short and/or Intermediate Measures**  **(Report on these measures in the Annual Report)** | |
| **Process Description and Measures** | **Short and/or Intermediate Outcome**  **Measure(s)** |
| **Objective 1.1**  **All women of reproductive age, pregnant women, infants, children, adolescents and children and youth with special health care needs (CYSHCN) will have access to needed and preventive, medical, dental, and social services by:**   * Targeting outreach services to identify pregnant women, women of reproductive age, infants, children and adolescents and their families who are eligible for Medi-Cal assistance or other publicly provided health care programs and assist them in applying for these benefits2 * Decreasing Medi-Cal eligible women, children, post-partum women without insurance1 | **Assessment**  **1.1a**   1. Identify and monitor the health status of women of reproductive age, pregnant women, infants, children, adolescents, and CYSHCN, including the social determinants of health and access/barriers to the provision of:  * Preventive, medical, dental, and social services | **1.1a**   1. This deliverable will be fulfilled by completing and submitting your Community Profile with your Agreement Funding Application each year | **1.1a**  Nothing is entered here. |
| 1. Review data books and monitor trends over time, geographic areas and population group disparities | 1. Briefly describe process for monitoring and interpreting data |  |
| 1. Annually, share your data with key local health department leadership | 1. Report the date data shared with the key health department leadership. Briefly describe their response, if significant. |  |
|  | Participate in collaboratives, coalitions, community organizations, etc., to review data and develop policies and products to address social determinants of health and disparities. | Report the total number of collaboratives with MCAH staff participation.  Submit online Collaborative Surveys that document participation, objectives, activities and accomplishments of MCAH –related collaboratives. | List policies or products developed to improve infrastructure that address MCAH priorities. |
|  | **Policy Development**  **1.1c**   1. Review, revise and enact protocols or policies that facilitate access to Medi-Cal, California Children’s Services (CCS), Covered CA, and Women, Infants, and Children (WIC) | **1.1c**   1. List types of protocols or policies developed or revised to facilitate access to health care services. | **1.1c**   1. List formal and informal agreements in place including Memoranda of Understanding with Medi-Cal Managed Care Plans (MCP) or other organizations that address the needs of mothers and infants |
|  | 1. Develop and implement protocols to ensure all clients in MCAH programs are enrolled in a health insurance plan, linked to a provider, and complete an annual visit. Protocols include the following key components:  * Assist clients to enroll in health insurance * Link clients to a health care provider for a preventive and/or medical visit * Develop a tracking mechanism to verify that the client enrolled in health insurance, completed a preventive or well medical visit | 1. Briefly describe the key components of the protocols developed to ensure all clients in MCAH programs are enrolled in insurance or a health plan, linked to a provider and complete an annual preventative and/or medical visit. | 1. Describe and summarize the impact of protocols or policy and systems changes that facilitate access to Medi-Cal, CCS, Covered CA, and WIC. |
|  | **Assurance**  **1.1d**  Develop staff knowledge and public health competencies for MCAH related issues | **1.1d**  Summarize staff knowledge and competencies gained | **1.1d**  Nothing is entered here |
|  | **1.1e**  Conduct activities to facilitate referrals to Medi-Cal, Covered CA, CCS, and other low cost/no-cost health insurance programs for health care coverage2 | **1.1e**  Describe activities to ensure referrals to health insurance, programs and preventive visits | **1.1e**  Report the number of referrals to Medi-Cal, Covered CA, CCS, or other low/no-cost health insurance or programs. |
|  | **1.1f**  Provide a toll-free or “no-cost to the calling party” telephone information service and other appropriate methods of communication, e.g., local MCAH Program web page to the local community**2** to facilitate linkage of MCAH population to services | **1.1f**  Describe the methods of communication, including the, cultural and linguistic challenges and solutions to linking the MCAH population to services | **1.1f**  Report the following:   * Number of calls to the toll-free or “no-cost to the calling party” telephone information service * The number of web hits to the appropriate local MCAH Program webpage |

| **Goal 1.2: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for reproductive age women.** | | | |
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| **Short and/or Intermediate Objective(s)** | **Intervention Activities to Meet Objectives (Describe the steps of the intervention)** | **Evaluation/Performance Measures**  **Process, Short and/or Intermediate Measures**  **(Report on these measures in the Annual Report)** | |
| **Process Description and Measures** | **Short and/or Intermediate Outcome**  **Measure(s)** |
| **REQUIRED LOCAL OBJECTIVE: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ is required to develop at least one specific short and/or intermediate SMART outcome objective(s) to address access to needed preventive services. *Number each locally developed objective as follows: 1.2, 1.2a, 1.2b, 1.2c, 1.2d, etc.*** | | | |
| **Objective 1.2**  **Insert a local objective to address increasing access to and utilization of preventive health services1 for reproductive age women**  Examples of focus areas can include but are not limited to:   * Well-women visit * Mental health * Substance use * Chronic disease * Preconception/ Interconception care * Birth Intervals-Spacing * Unintended/mistimed pregnancy * Family planning * Intimate partner/domestic violence | **1.2a**  List evidence-based or informed activities to meet the Objective(s) here.  Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development and Assurance | **1.2a**  Develop process measures for applicable intervention activities here | **1.2a**  Develop short and/or intermediate outcome related performance measures for the objectives and activities here |

| **Goal 1.3: WOMEN/MATERNAL DOMAIN: All pregnant women will have access to early, adequate, and high quality perinatal care with a special emphasis on low-income and Medi-Cal eligible women.** | | | |
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| **Short and/or Intermediate Objective(s)** | **Intervention Activities to Meet Objectives (Describe the steps of the intervention)** | **Evaluation/Performance Measures**  **Process, Short and/or Intermediate Measures**  **(Report on these measures in the Annual Report)** | |
| **Process Description and Measures** | **Short and/or Intermediate Outcome**  **Measure(s)** |
| **Objective 1.3**  **All women will have access to quality maternal and early perinatal care, including CPSP services for Medi-Cal eligible women by:**   * Increasing first trimester prenatal care initiation1 * Increasing postpartum visit1 * Increasing access to providers that can provide the appropriate services and level of care for reproductive age women1 | **Assurance**  **1.3a**   1. Develop MCAH staff knowledge of the system of maternal and perinatal care | **1.3a**  Report the following:   1. List of trainings received by staff on perinatal care, such as roundtables, regional meetings, collaborative work | **1.3a**  Provide the number and describe the outcomes of:   * Roundtable meetings * Regional meetings * Other maternal and perinatal meetings |
| 1. Develop a comprehensive resource and referral guide of available health and social services | 1. Submit resource and referral guide |  |
| 1. Attend the yearly CPSP statewide meeting | 1. Date and attendance at the CPSP yearly meeting |  |
|  | 1. Conduct local activities to facilitate increased access to early and quality perinatal care | 1. List activities implemented to increase access of women to early and quality perinatal care. Identify barriers and opportunities to improve access to early and quality perinatal care |  |

| **Goal 1.3: WOMEN/MATERNAL DOMAIN: All pregnant women will have access to early, adequate, and high quality perinatal care with a special emphasis on low-income and Medi-Cal eligible women.** | | | |
| --- | --- | --- | --- |
| **Short and/or Intermediate Objective(s)** | **Intervention Activities to Meet Objectives (Describe the steps of the intervention)** | **Evaluation/Performance Measures**  **Process, Short and/or Intermediate Measures**  **(Report on these measures in the Annual Report)** | |
| **Process Description and Measures** | **Short and/or Intermediate Outcome**  **Measure(s)** |
|  | **1.3b**  Outreach to perinatal providers, including Medi-Cal Managed Care   1. Enroll in CPSP (Fee-for- Service and FQHC/RHC/IHC providers) | **1.3b**   1. Enroll FFS and FQHC/RHC/IHC providers   Identify the MCP liaison(s). | **1.3b**  Nothing is entered here |
|  | 1. Identify and work with MCP liaisons to provide CPSP comparable services | 1. Work with MCP(s) to provide CPSP comparable services |  |
|  | 1. Assist MCP providers to provide CPSP comparable services | 1. Work with MCP providers to provide CPSP comparable services |  |
|  | **1.3c**  Coordinate perinatal activities between MCAH and the Regional Perinatal Programs of California (RPPC) to improve maternal and perinatal systems of care, including coordinated post-partum referral systems for high-risk mothers and infants upon hospital discharge | **1.3c**  List number of meetings attended to facilitate coordination of activities between RPPC and MCAH and briefly describe outcomes | **1.3c**  Nothing is entered here. |
|  | **1.3d**  Conduct technical assistance and face-to-face quality assurance/quality improvement (QA/QI) activities with CPSP providers or managed care providers in collaboration with MCP(s) liaison to ensure that CPSP services are implemented and protocols are in place | **1.3d**  Report the number of CPSP provider technical assistance activities conducted by phone or email  Report the number of QA/QI face-to-face site visits conducted with:   * Enrolled CPSP providers * MCPs providers (with MCP liaison(s)) * Number of chart reviews   List common problems or barriers and successful interventions | **1.3d**  Describe the results of technical assistance provided by phone or email  Describe the results of QA/QI activities that were conducted with:   * Enrolled CPSP providers * MCPs providers (with MCP liaison(s)) * Summary of findings from the chart reviews |

| **Goal 1.4: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for pregnant women.** | | | |
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| | **Short and/or Intermediate Objective(s)** | **Intervention Activities to Meet Objectives (Describe the steps of the intervention)** | **Evaluation/Performance Measures**  **Process, Short and/or Intermediate Measures**  **(Report on these measures in the Annual Report)** | | | --- | --- | --- | --- | | **Process Description and Measures** | **Short and/or Intermediate Outcome**  **Measure(s)** |   **REQUIRED LOCAL OBJECTIVE: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ is required to develop at least one specific short and/or intermediate SMART outcome objective(s) to address access to needed preventive services. *Number each locally developed objective as follows: 1.4, 1.4a, 1.4b, 1.4c, 1.4d, etc.*** | | | |
| **Objective 1.4**  **Insert a local objective to address increasing access to and utilization of health services1 for pregnant women**  Examples of focus areas can include but are not limited to:   * Immunization (Tdap) * Zika virus in pregnancy * Maternal mental health * Substance use including Opioid, Marijuana use Chronic disease * Partner/family violence * Interconception care/ Birth Intervals-Spacing * Family Planning | **1.4**  List evidence-based or informed activities to meet the Objective(s) here.  Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development and Assurance | **1.4**  Develop process measures for applicable intervention activities here | **1.4**  Develop short and/or intermediate outcome related performance measures for the objectives and activities here. |

| **Goal 2: CHILD/CYSHCN DOMAIN: Improve the cognitive, physical, and emotional development of all children, including children and youth with special health care needs.**  **The shaded and bolded areas represent required activities.** | | | |
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| **Short and/or Intermediate Objective(s)** | **Intervention Activities to Meet Objectives (Describe the steps of the intervention)** | **Evaluation/Performance Measures**  **Process, Short and/or Intermediate Measures**  **(Report on these measures in the Annual Report)** | |
| **Process Description and Measures** | **Short and/or Intermediate Outcome**  **Measure(s)** |
| **Objective 2.1**  **Provide developmental screening for all children1 in MCAH programs**   * All children, including CYSHCN, receive a yearly preventive medical visit * Increase the rate of developmental screening for children ages 0-5 years according to AAP guidelines – 9 months, 18 months and 30 months | **Child Objective**  **2.1a**  Promote the [American Academy of Pediatrics](https://www.aap.org/en-us/Pages/Default.aspx) (AAP) developmental screening guidelines. | **2.1a** | **2.1a** |
| **The following bolded activities, i, ii, are required:**   1. **Promote regular preventive medical visits for all children, including CYSHCN, in MCAH Home Visiting and Case Management programs, per Bright Futures/AAP,** | **Required**  **Describe or report the following for MCAH programs:**   1. **Activities to promote the yearly preventive medical visit** | **Required**  **Describe or report the following for children in MCAH programs**   1. **Number of children, including CYSHCN, receiving a yearly preventive medical visit** |
| 1. **Adopt protocols/policies, including a QA/QI process, to screen, refer, and link all children in MCAH Home Visiting or Case Management Programs** | 1. **Describe protocols/policies including QA/QI process to screen, refer and link all children in MCAH programs** | 1. **Number of children in MCAH programs receiving developmental screening**  * **Number of children with positive screens that complete a follow-up visit with their primary care provider** * **Number of children with positive screens linked to services** * **Number of calls received for referrals and linkages to services** |
|  | ***CYSHCN Objective(s)***  ***At least one activity is required. Choose from activities 2.1.b-2.1. (highlight your choices in yellow):*** | ***Report the following based on the activities you chose to implement in the second column (highlight your choices in yellow):*** | ***Describe the following based on the activities you chose to implement in the second column***  ***(highlight your choices in yellow):*** |
| **2.1b**  Promote the use of [Birth to 5; Watch Me Thrive](http://www.acf.hhs.gov/programs/ecd/child-health-development/watch-me-thrive), Learn the Signs, Act Early or other screening materials consistent with AAP guidelines | **2.1b**  Number of providers or provider systems receiving information about Birth to 5, Learn the Signs, Act Early or other screening materials | **2.1b**  Nothing is entered here |
|  | **2.1c**  Participate in [Help Me Grow](http://www.helpmegrownational.org/) (HMG) or programs that promote the core components of HMG | **2.1c**  Describe participation in HMG or HMG like programs | **2.1c**  Outcomes of participation in HMG or HMG like programs. Describe results of work to implement HMG core components |
|  | **2.1d**  Increase understanding of the specific barriers to referral and evaluation by early intervention or pediatric specialists (including mental/behavioral health) | **2.1d**  Describe barriers to referral and evaluation by early intervention or pediatric specialists | **2.1d**  Nothing is entered here |
|  | **2.1e**  Plan and implement a family engagement project to improve local efforts to serve children and youth with special health care needs (e.g., convene a family advisory group to assess how CYSHCN are served in local home visiting or case management programs) | **2.1e**  Describe project activities, goals, and outcomes such as number of family members engaged, number of community meetings, and other process measures specific to the planned project | **2.1e**  Nothing is entered here |
|  | **2.1f**  Work with health plans (HPs), including MCPs, to identify and address barriers to screening, referral, linkage and to assist the HPs in increasing developmental screenings for their members, per AAP guidelines, through education, provider feedback, incentives, quality improvement, or other methods | **2.1f**  Describe barriers and strategies to increase screening, referral and linkage   * Number of HPs requiring screenings per AAP guidelines | **2.1f**  Nothing is entered here |
|  | **2.1g**  Identify methods to measure and monitor rates of developmental and other types of childhood screening, referrals, and successful linkages to care in your jurisdiction | **2.1g**  If applicable, provide data on developmental and other screening rates, referrals, and successful linkages to care for the target population | **2.1g**  Nothing is entered here |
|  | **2.1h**  Based on local needs, develop strategies to promote awareness of and address childhood adversity and trauma, including Adverse Childhood Experiences (ACEs), and build family and community resilience | **2.1h**  Provide a description, and data if applicable, on process measures and outcomes relevant to the planned activities | **2.1h**  Nothing is entered here |
|  | **2.1i**  Outreach and education to providers to promote developmental screening, referral and linkages | **2.1i**  Describe type of outreach/education performed and results of outreach to providers | **2.1i**  Nothing is entered here |
|  | **2.1j**  Provide care coordination for CYSHCN, especially non-CCS eligible children or children enrolled in CCS in need of services not covered by CCS | **2.1j**  Describe activities for care coordination provided | **2.1j**  List the number of children receiving care coordination |

| **Goal 2: CHILD/CYSHCN DOMAIN: Improve the cognitive, physical, and emotional development of all children, including children and youth with special health care needs.**  **The shaded and bolded areas represent required activities.** | | | |
| --- | --- | --- | --- |
| **Short and/or Intermediate Objective(s)** | **Intervention Activities to Meet Objectives (Describe the steps of the intervention)** | **Evaluation/Performance Measures**  **Process, Short and/or Intermediate Measures**  **(Report on these measures in the Annual Report)** | |
| **Process Description and Measures** | **Short and/or Intermediate Outcome**  **Measure(s)** |
| **OPTIONAL LOCAL OBJECTIVE: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. *Number each locally developed objective as follows: 2.2, 2.2a, 2.2b, 2.2c, etc.*** | | | |
| **Objective 2.2**  Provide a local objective that improves the, cognitive, physical, and emotional development of all children, including children and youth with special health care needs.  Examples of focus areas can include but are not limited to:   * Reducing unintentional injuries1 * Reducing child abuse and neglect1 | **2.2**  List evidence-based or informed activities to meet the objective(s) here.  Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development and Assurance | **2.2**  Develop process measures for applicable intervention activities here | **2.2**  Develop short and/or intermediate outcome related performance measures for the objectives and activities here |

| **Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality by reducing the rate of SIDS/SUID deaths**  **The shaded area represents required activities.** | | | |
| --- | --- | --- | --- |
| **Short and/or Intermediate Objective(s)** | **Intervention Activities to Meet Objectives (Describe the steps of the intervention)** | **Evaluation/Performance Measures**  **Process, Short and/or Intermediate Measures**  **(Report on these measures in the Annual Report)** | |
| **Process Description and Measures** | **Short and/or Intermediate Outcome Measure(s)** |
| **Objective 3.1**  **All parents/caregivers experiencing a sudden and unexpected death will be offered grief and bereavement support services** | **Assurance**  **3.1a**  Establish contact with parents/caregivers of infants with presumed SIDS death to provide grief and bereavement support services**3**  Provide grief and support materials to parents | **3.1a**  (Insert number) of parents/caregivers who experience a presumed SIDS death and the number who are contacted for grief and bereavement support services. | **3.1a**  Nothing is entered here |
|  | **3.1b**  Contact local coroner office to ensure timely reporting and referral of parents of all babies who die suddenly and unexpectedly regardless of circumstances of death | **3.1b**  Report the coroner’s notifications received  Briefly describe barriers and opportunities for success | **3.1b**  Nothing is entered here |
| **Objective 3.2.**  **All professionals, para-professionals, staff, and community members will receive information and education on SIDS risk reduction practices and infant safe sleep** | **3.2a**  Disseminate AAP guidelines on infant safe sleep and SIDS risk reduction to providers, pediatricians, CPSP providers, parents,community members and other caregivers of infants | **3.2a**  Numbers receiving AAP guidelines on infant safe sleep:   * + Providers   + Pediatricians * CPSP providers * Child care providers * Other – list | **3.2a**  Nothing is entered here |

| **Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality by reducing the rate of SIDS/SUID deaths**  **The shaded area represents required activities.** | | | | |
| --- | --- | --- | --- | --- |
| **Short and/or Intermediate Objective(s)** | **Intervention Activities to Meet Objectives (Describe the steps of the intervention)** | **Evaluation/Performance Measures**  **Process, Short and/or Intermediate Measures**  **(Report on these measures in the Annual Report)** | | |
| **Process Description and Measures** | **Short and/or Intermediate Outcome Measure(s)** | |
|  | **3.2b**  Attend the SIDS Annual Conference/SIDS training(s), SIDS Coordinators’ meeting and other conferences/trainings related to infant health3. | **3.2b**  Provide staff member name and date of attendance at SIDS Annual Conference/SIDS training(s) and other conference/trainings related to infant health. | | **3.2b**  Describe results of staff trainings related to infant health. |

| **Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality by reducing the rate of SIDS/SUID deaths**  **The shaded area represents required activities.** | | | |
| --- | --- | --- | --- |
| **Short and/or Intermediate Objective(s)** | **Intervention Activities to Meet Objectives (Describe the steps of the intervention)** | **Evaluation/Performance Measures**  **Process, Short and/or Intermediate Measures**  **(Report on these measures in the Annual Report)** | |
| **Process Description and Measures** | **Short and/or Intermediate Outcome**  **Measure(s)** |
| **REQUIRED LOCAL OBJECTIVE: Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ must provide at least one specific short and/or intermediate SMART outcome objective(s) to address SIDS/SUID. *Number each locally developed objective as follows: 3.3, 3.3a, 3.3b, 3.3c., etc.*** | | | |
| **Objective 3.3**  Provide objective(s) that reduce the risk of SIDS/SUIDS.  Examples of focus areas can include but are not limited to:   * Child care providers, i.e. babysitters, grandparents, formal day care * Hospitals * Clinics, FQHC, RCH, IHC | **3.3**  List evidence-based or informed activities to meet outcome objectives here.  Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development and Assurance | **3.3**  Develop process measures for applicable intervention activities here | **3.3**  Develop short and/or intermediate outcome related performance measures for the objectives and activities here |

| **Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality**  **The shaded area represents required activities.** | | | |
| --- | --- | --- | --- |
| **Short and/or Intermediate Objective(s)** | **Intervention Activities to Meet Objectives (Describe the steps of the intervention)** | **Evaluation/Performance Measures**  **Process, Short and/or Intermediate Measures**  **(Report on these measures in the Annual Report)** | |
| **Process Description and Measures** | **Short and/or Intermediate Outcome**  **Measure(s)** |
| **REQUIRED LOCAL OBJECTIVE: Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ must provide at least one specific short and/or intermediate SMART outcome objective(s) to address perinatal/infant health. *Number each locally developed objective as follows: 3.4, 3.4a, 3.4b, 3.4c., etc.*** | | | |
| **Objective 3.4**  Insert a local objective that improves infant health by:   * Reducing pre-term births and infant mortality1 * Increase infant safe sleep practices1 * Increase breastfeeding initiation and duration1   Examples of focus areas can include but not limited to:   * Breastfeeding initiation and duration * Prematurity/Low birth weight * Perinatal substance use * Access to enhanced perinatal (neonatal) services * Birth intervals/Birth Spacing | **3.4**  List activities to improve perinatal/infant health here  Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development and Assurance | **3.4**  Develop process measures for applicable intervention activities here | **3.4**  Develop short and/or intermediate outcome related performance measures for the objectives and activities here. |

| **Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality** | | | |
| --- | --- | --- | --- |
| **Short and/or Intermediate Objective(s)** | **Intervention Activities to Meet Objectives (Describe the steps of the intervention)** | **Evaluation/Performance Measures**  **Process, Short and/or Intermediate Measures**  **(Report on these measures in the Annual Report)** | |
| **Process Description and Measures** | **Short and/or Intermediate Outcome**  **Measure(s)** |
| **For FIMR LHJs only complete**  **Objective 3.5**  **Reduce preventable fetal, neonatal and post-neonatal and infant deaths.** | **For FIMR LHJs only complete Assessment**  **3.5a**  Complete the review of at least \_\_ cases, which is approximately \_\_% of all fetal, neonatal, and post-neonatal deaths. | **For FIMR LHJs only complete Assessment**  **3.5a**  Develop a process for sample.  Submit number of cases reviewed as specified in the Annual Report table. | **For FIMR LHJs only complete Assessment**  **3.5a**  Submit annual local summary report of findings and recommendations (periodicity to be determined by consulting with MCAH). |
|  | **Assurance**  **3.5b**  Establish, facilitate, and maintain a Case Review Team (CRT) to review selected cases, identify contributing factors to fetal, neonatal, and post-neonatal deaths, and make recommendations to address these factors. | **3.5b**  Submit FIMR Tracking Log and FIMR Committee Membership forms for CRT and CAT with the Annual Report. | **3.5b and c**  Nothing is entered here |
|  | **3.5c**  Establish, facilitate, and maintain a Community Action Team (CAT) to recommend and implement community, policy, and/or systems changes that address review findings. |  |  |

| **Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality** | | | |
| --- | --- | --- | --- |
| **Short and/or Intermediate Objective(s)** | **Intervention Activities to Meet Objectives (Describe the steps of the intervention)** | **Evaluation/Performance Measures**  **Process, Short and/or Intermediate Measures**  **(Report on these measures in the Annual Report)** | |
| **Process Description and Measures** | **Short and/or Intermediate Outcome**  **Measure(s)** |
| **REQUIRED LOCAL OBJECTIVE for FIMR LHJs Only: Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ must provide at least one specific short and/or intermediate SMART outcome objective(s) to address perinatal/infant health. *Number each locally developed objective as follows: 3.6, 3.6a, 3.6b, 3.6c, etc.*** | | | |
| **Objective 3.6**  Insert a local objective that addresses reducing the number of preventable, fetal, neonatal, post-neonatal, and infant deaths.  Examples of focus areas can include but are not limited to:   * Prematurity/Low birth weight * Perinatal substance use * Access to enhanced perinatal (neonatal) services * Birth intervals/Birth Spacing | **3.6**  Based on CRT recommendations, identify and implement at least one evidence based or informed intervention involving policy, systems, or community norm changes here | **3.6**  Develop process measures for applicable intervention activities here | **3.6**  Develop short and/or intermediate outcome-related performance measures for the objectives and activities here |

| **Goal 4: CROSSCUTTING DOMAIN: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy weight.** | | | |
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| **Short and/or Intermediate Objective(s)** | **Intervention Activities to Meet Objectives (Describe the steps of the intervention)** | **Evaluation/Performance Measures**  **Process, Short and/or Intermediate Measures**  **(Report on these measures in the Annual Report)** | |
| **Process Description and Measures** | **Short and/or Intermediate Outcome**  **Measure(s)** |
| **OPTIONAL LOCAL OBJECTIVE: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. *Number each locally developed objective as follows: 4.1, 4.1a, 4.1b, 4.1c, etc.*** | | | |
| **Objective 4.1**  Insert a local objective that addresses the proportions of children, adolescents and women of reproductive age who maintain a healthy weigh by:   * Increasing consumption of a healthy diet1 * Increasing physical activity1   Examples of focus areas can include but are not limited to:   * Overweight/obesity in children * Physical activity * Recommended weight gain during pregnancy * Recommended intake of folic acid * Food security * Access to WIC services | List evidence-based or informed activities to meet the objective(s) here.  Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development and Assurance | Develop process measures for applicable intervention activities here | Develop short and/or intermediate outcome related performance measures for the objectives and activities here |

| **Goal 5: ADOLESCENT DOMAIN: Promote and enhance adolescent strengths, skills, and supports to improve adolescent health.** | | | |
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| **Short and/or Intermediate Objective(s)** | **Intervention Activities to Meet Objectives (Describe the steps of the intervention)** | **Evaluation/Performance Measures**  **Process, Short and/or Intermediate Measures**  **(Report on these measures in the Annual Report)** | |
| **Process Description and Measures** | **Short and/or Intermediate Outcome**  **Measure(s)** |
| **OPTIONAL LOCAL OBJECTIVE: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. *Number each locally developed objective as follows: 5.1, 5.1a, 5.1b, 5.1c, etc.*** | | | |
| **Objective 5.1**  Insert a local objective that promotes and enhances adolescents strengths, skills and supports improve health by:   * Decreasing teen pregnancies1 * Reducing teen dating violence, bullying and harassment 1   Examples of focus areas can include but not limited to:   * Adolescent sexual health, including contraception, preconception health, STIs * Racial ethnic disparities in adolescent birth rates * Adolescent injuries * Adolescent violence * Adolescent mental health * Development of a Positive Youth Development framework * Reducing suicides | **5.1**  List evidence-based or informed activities to meet the objective(s) here  Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development, and Assurance | **5.1**  Develop process measures for applicable intervention activities here | **5.1**  Develop short and/or intermediate outcome related performance measures for the objectives and activities here |