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

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

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

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

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

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

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

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

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

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

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

The shaded and/or highlighted areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
Objective 1.1 **All women of reproductive age, pregnant women, infants, children, adolescents and children and youth with special health care needs (CYSHCN) will have access to needed and preventive, medical, dental, and social services by:** • Targeting outreach services to identify pregnant women, women of reproductive age, infants, children and adolescents and their families who are eligible for Medi-Cal assistance or other publicly provided health care programs and assist them in applying for these benefits[2] • Decreasing Medi-Cal eligible women, children, post-partum women without insurance[1]	**Assessment** **1.1a** i. Identify and monitor the health status of women of reproductive age, pregnant women, infants, children, adolescents, and CYSHCN, including the social determinants of health and access/barriers to the provision of: • Preventive, medical, dental, and social services ii. Review data books and monitor trends over time, geographic areas and population group disparities iii. Annually, share your data with key local health department leadership	**1.1a** i. This deliverable will be fulfilled by completing and submitting your Community Profile with your Agreement Funding Application each year ii. Briefly describe process for monitoring and interpreting data iii. Report the date data shared with the key health department leadership. Briefly describe their response, if significant.	**1.1a** Nothing is entered here.

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

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

The shaded and/or highlighted areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
	ii. Develop and implement protocols to ensure all clients in MCAH programs are enrolled in a health insurance plan, linked to a provider, and complete an annual visit. Protocols include the following key components: • Assist clients to enroll in health insurance • Link clients to a health care provider for a preventive and/or medical visit • Develop a tracking mechanism to verify that the client enrolled in health insurance, completed a preventive or well medical visit	ii. Briefly describe the key components of the protocols developed to ensure all clients in MCAH programs are enrolled in insurance or a health plan, linked to a provider and complete an annual preventative and/or medical visit.	ii. Describe and summarize the impact of protocols or policy and systems changes that facilitate access to Medi-Cal, CCS, Covered CA, and WIC.
	Assurance **1.1d** Develop staff knowledge and public health competencies for MCAH related issues	**1.1d** Summarize staff knowledge and competencies gained	**1.1d** Nothing is entered here

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

The shaded and/or highlighted areas represent required activities.

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

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Goal 1.2: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for reproductive age 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)
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 By June 30, 2021, all pregnant and postpartum women (up to 1 year postpartum) who are clients of the FNU will be screened for PMADs, and those who screen positive will be referred for appropriate follow-up care.	**1.2a** Perform the following activities: • Assess pregnant and postpartum women for PMADs using the Edinburgh Postnatal Depression Scale (EPDS) at least once while the case is open. If the woman is seen both in the antenatal period and the postpartum (PP) period the case manager will assess for PMADs both antenatal and PP. • Clients who score greater than or equal to 10 on the EPDS are offered a referral to a local service provider with expertise in this area and education on PMADs. The client's primary Health Care Provider (HCP) is notified if the client gives permission and a Release of Information is signed. A follow-up home visit is scheduled within one month or earlier at the discretion of the MCAH case manager. • If the client appears to be severely depressed or there is a positive answer to questions related to harming	**1.2a** Briefly describe or report: • Currently existing and newly created resources and support groups for PMADs • Identified access to care issues • Rationale for interventions, recommendations and strategies/policies developed • Referral process developed and implemented • CQI/QA process developed • Collaboratives/ partnerships formed • Resource referral list/brochure/website	**1.2a** • Numerator: Number of pregnant and postpartum women seen by FNU screened for PMADs Denominator: Number of pregnant and postpartum women seen by FNU • Numerator: Number of pregnant and postpartum women seen by FNU who screened positive for PMADs and referred to appropriate follow-up care Denominator: Number of pregnant and postpartum women seen by FNU who screened positive for PMADs **Report the following:** Numerators (Outcome Measures): • PMAD Info and resources not received – No EPDS done • PMAD Info and resources received – No EPDS done • PMAD Info and resources received – EPDS <10

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Goal 1.2: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for reproductive age 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)
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.*			
	herself or her child/ren (Question #10 on the EPDS), 9-1-1 or the Behavioral Wellness 24 hour Crisis Response and Service Access line will be contacted for immediate Mental Health Assessment. • The infant is to be assessed for developmental delays and signs of poor maternal-infant attachment. • Documentation in the PHN Database care plan includes the Health Indicator “PMAD”; the assessment of medical/mental needs and familial/social support status; the intervention and education; referrals given; continued case management needs; goals; and outcomes.		• PMAD Info and resources received – EPDS <10 – Declined referral • PMAD Info and resources received – EPCS <10 – Referred and on wait-list • PMAD Info and resources received – Referred and receiving services • PMAD Info and resources received – EPDS >/= 10 or Positive Question #10 – Referred and on wait-list • PMAD Info and resources received - EPDS >/= 10 or Positive Question #10 – Referred and receiving services • PMAD Info and resources received - EPDS >/= 10 or Positive Question #10 – Declined referral • PMAD Info and resources received – No EPDS d/t language barrier • PMAD Info and resources received – No EPDS d/t language barrier – Referred and receiving services

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Goal 1.2: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for reproductive age 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)
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.*			
			• PMAD Info and resources received – No EPDS d/t language barrier – Referred and on wait-list • PMAD Info and resources received – No EPDS d/t language barrier – Declined referral Denominator: Number of pregnant and postpartum women seen by FNU • Brief description of outcomes of the CQI/QA process, including methods of measurements and results

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

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

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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)
	MCP(s) liaison to ensure that CPSP services are implemented and protocols are in place	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	with: • Enrolled CPSP providers • MCPs providers (with MCP liaison(s)) • Summary of findings from the chart reviews

[1] 2016-2020 Title V State Priorities
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Goal 1.4: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for pregnant 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)**
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.*			
Ongoing PHD Field Nursing Measure **Objective 1.4** By June 30, 2021, all Medi-Cal eligible pregnant and postpartum women who are clients in the Field Nursing Unit (FNU) will be enrolled in Medi-Cal and have timely access* to care. ***Timely access to care for:** • **Eligible pregnant women = Within 1 month from initial referral.** • **Eligible postpartum women = Within 2 months of obtaining insurance**	**Ongoing PHD Field Nursing Measure** **1.4** MCAH staff will: • Assess each MCAH program client for eligibility for Medi-Cal. • Refer to the "Medi-Cal Eligibility and Covered CA website: https://www.coveredca.com/ • California Department of Health Care Services: Presumptive Eligibility for Pregnant Women: http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/PE.aspx • Refer unenrolled but potentially eligible clients for application assistance and assist as necessary • Follow-up with referred clients to determine if they become enrolled • Encourage enrolled clients to complete an appointment with a health care provider and follow-up to assure completion Develop and implement a Continuous Quality Improvement/Quality Assurance (CQI/QA) process to monitor implementation of policies/processes, a regular	**Ongoing PHD Field Nursing Measure** **1.4** • Describe access to care issues identified • Describe rationale for interventions, recommendations and strategies developed • Briefly describe barriers, challenges and solutions to enrollment in Medi-Cal and follow-up to see a provider • Briefly describe the CQI/QA process developed	**Ongoing PHD Field Nursing Measure** **1.4** • Numerator: Number of pregnant women in the MCAH FNU who are enrolled or are in the process of applying for Medi-Cal have a scheduled appointment with a provider within one month of the initial referral Denominator: All pregnant women in the MCAH FNU program eligible for Medi-Cal • Numerator: Number of postpartum women in the MCAH FNU who enrolled in Medi-Cal and have a scheduled appointment with a provider within 2 months of obtaining insurance Denominator: All postpartum women in the MCAH FNU program eligible for Medi-Cal • Describe referral process developed • Describe the outcome of the CQI/QA process including methods of measurements and results Health Indicators:

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Goal 1.4: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for pregnant 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)
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.*			
	feedback mechanism to continually improve the process and a plan to evaluate the impact		-Lack of Insurance/Care: Pregnant – all ages -Lack of Insurance/Care: Postpartum – all ages -Currently has insurance and timely access to care -Currently has insurance and NO access to care Health Indicator Outcomes: -Currently has insurance and timely access to care obtained -Currently has insurance, timely access to care not obtained -Obtained Insurance and timely access to care obtained -Obtained Insurance, timely access to care not obtained -Insurance application in process at closure, timely access to care obtained -Insurance application in process at closure, timely access to care not obtained -Insurance not obtained, timely access to care not obtained -Unable to locate for status of referral

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Goal 1.4: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for pregnant 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)
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.*			
Ongoing PHD Field Nursing Measure **Objective 1.5** By June 30, 2021, 85% of clients with a risk factor/history of Domestic Violence (DV) and/or current DV receiving MCAH Field Nursing Unit (FNU) home visits will receive information, referral and follow-up care or assistance. **1.6** By June 30, 2021, 35% of clients with a risk factor/history of Domestic Violence (DV) and/or current DV will have a verbal or written safety plan.	**Ongoing PHD Field Nursing Measure** **1.5 & 1.6** Perform the following activities: Field Nursing Unit home visit interventions include: • Assess family for history of and/or current issues with DV. • FNU staff will input information re: individual cases into the PHN Database under health indicator status. • Local information on DV resources will be current. Field Nursing Unit home visit interventions include: • Assist client in planning for a safe exit from home if needed. • Ask that the client specify what her plan is at a subsequent home visit.	**Ongoing PHD Field Nursing Measure** **1.5 & 1.6** Briefly describe: • Assessment, intervention, referral process, provider access and barriers to obtaining domestic violence resources. Discuss documentation of health indicators • Field nursing assistance for safety planning and health indicators.	**Ongoing PHD Field Nursing Measure** **1.5** • Numerator: Number of clients with a risk factor/history/current DV receiving a brief intervention, referral and follow-up care or assistance Denominator: Number of MCAH FNU home visiting clients with a risk factor/history of Domestic Violence (DV) and/or current DV **1.6 Report the following:** Numerators (Outcome Measures): • Referral for DV Resources received and acknowledged • Referral for DV Resources received: Clt/Family receiving services • Referral for DV Resources received and acknowledged – Verbalized Safety Plan • Referral for DV received • Declined treatment referral • Not found (2 attempted home visits with a note left at the door and 1 phone call attempt made) • Declined FNU Services Denominator: Number of FNU clients

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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.*			
			with risk/history/current DV
Ongoing PHD Field Nursing Measure **Objective 1.7** By June 30, 2021, 100% of FNU clients seen in the antepartum and immediate (2mo) postpartum period that have a diagnosis of GDM will be given information on GDM and on the importance of self-care using the GDM PHN toolkit and will follow diet, monitoring and scheduled appointments as assessed by the PHN.	**Ongoing PHD Field Nursing Measure** **1.7** Perform the following activities: • The MCAH Field Nursing Unit will provide GDM education that promotes self-management of diet, weight, and blood sugar to clients with a diagnosis of GDM in the antepartum and/or postpartum period. • Utilize the GDM PHN Toolkit.	**Ongoing PHD Field Nursing Measure** **1.7** • Briefly describe the process of FNU home visitation to promote diet, weight and blood sugar utilizing the GDM PHN toolkit on clients seen with a diagnosis of GDM or Type II DM in the antepartum or postpartum period. • Number of FNU clients with diagnosis of GDM that were referred to the FNU for GDM education. • Number receiving materials	**Ongoing PHD Field Nursing Measure** **1.7** Of the Clients given information (Numerators): • Number following diet, monitoring and scheduled appointments • Number not following diet, monitoring and schedule appointments • Number declined • Number Unable to locate Denominator: Number of FNU GDM clients

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

The shaded and bolded areas represent required activities.

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

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

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

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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)
	advisory group to assess how CYSHCN are served in local home visiting or case management programs)	planned project	
	2.1f Work with health plans (HPs), including MCPs, to identify and address barriers to screening, referral, linkage and to assist the HPs in increasing developmental screenings for their members, per AAP guidelines, through education, provider feedback, incentives, quality improvement, or other methods	**2.1f** Describe barriers and strategies to increase screening, referral and linkage • Number of HPs requiring screenings per AAP guidelines	**2.1f** Nothing is entered here
	2.1g Identify methods to measure and monitor rates of developmental and other types of childhood screening, referrals, and successful linkages to care in your jurisdiction	**2.1g** If applicable, provide data on developmental and other screening rates, referrals, and successful linkages to care for the target population	**2.1g** Nothing is entered here
	2.1h Based on local needs, develop strategies to promote awareness of and address childhood adversity and trauma, including Adverse Childhood Experiences (ACEs), and build family and	**2.1h** Provide a description, and data if applicable, on process measures and outcomes relevant to the planned activities **See Obj. 2.4**	**2.1h** Nothing is entered here **See Obj. 2.4**

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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)
	community resilience **See Obj. 2.4**		
	2.1i Outreach and education to providers to promote developmental screening, referral and linkages	**2.1i** Describe type of outreach/education performed and results of outreach to providers	**2.1i** Nothing is entered here
	2.1j Provide care coordination for CYSHCN, especially non-CCS eligible children or children enrolled in CCS in need of services not covered by CCS	**2.1j** Describe activities for care coordination provided	**2.1j** List the number of children receiving care coordination

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Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<u>OPTIONAL LOCAL OBJECTIVE</u>: 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.***			
Ongoing PHD Field Nursing Measure **Objective 2.2** By June 30, 2021, all eligible children and adolescents ages 0-18 who are clients of the Field Nursing Unit (FNU) will be enrolled in health insurance. **Objective 2.3** By June 30, 2021 all children and adolescents ages 0-18 who are clients of the FNU will have a scheduled appointment or are aware of the next well child visit based on Bright Futures periodicity schedule.	**Ongoing PHD Field Nursing Measure** **2.2 and 2.3** MCAH staff develops and implements policies to: • Assess each child ages 0-18 who are clients of the FNU to determine if they are enrolled in health insurance within a two month period • Refer unenrolled but potentially eligible children for application assistance or directly provide application assistance for appropriate insurance type • Follow-up with referred children to determine if they become enrolled and incentive by offering low cost health promotion equipment. • Determine and educate families on upcoming/next well child visit per Bright Futures Schedule. • Develop and implement a Continuous Quality Improvement/Quality Assurance (CQI/QA) process to monitor	**Ongoing PHD Field Nursing Measure** **2.2 and 2.3** • Describe access to care issues identified • Describe rationale for interventions, recommendations and strategies/policies developed • Describe policies implemented • Briefly describe referral process developed and implemented • Briefly describe the CQI/QA process developed	**Ongoing PHD Field Nursing Measure** **2.2 and 2.3** • <u>Numerator</u>: Number of eligible children and adolescents who are clients of the FNU who enroll in health insurance within two months <u>Denominator</u>: All eligible children and adolescents seen by FNU • Describe the outcome of the CQI/QA process including methods of measurements and results <u>Health Indicator outcomes</u> -Obtained Insurance within 2 months -Obtained insurance after 2 month -Unable to locate for status of referral -Insurance not obtained

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Short and/or Intermediate Objective(s)	**Intervention Activities to Meet Objectives (Describe the steps of the intervention)**	**Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)**	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
<u>OPTIONAL LOCAL OBJECTIVE</u>: 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.***			
	implementation of policies/processes, a regular feedback mechanism to continually improve the process and a plan to evaluate the impact		
Ongoing PHD Field Nursing Measure **Objective 2.4** By June 30, 2021, all Head of Household (HOH) in the MCAH FNU will be screened for ACES and those with scores $\geq$ 4 will be referred to parenting classes and/or community support.	**Ongoing PHD Field Nursing Measure** **2.4** • All HOH will be offered an ACES screening and NEAR@Home visit. • List of updated parenting classes and community resources are available to MCAH staff	**Ongoing PHD Field Nursing Measure** **2.4** • Discuss the ACE screening and NEAR@Home process • Describe the process for educating staff about NEAR science, screenings, and when to refer clients • Describe the process of integrating the policy related to ACES screening and referrals • Describe QA process	**Ongoing PHD Field Nursing Measure** **2.4** <u>Numerator</u>: Number of clients with ACES score $\geq$ 4 referred to parenting classes and/or community support <u>Denominator</u>: Total number of clients with ACES score $\geq$ 4 score

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

The shaded area represents required activities.

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

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The shaded area represents required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
	3.2b Attend the SIDS Annual Conference/SIDS training(s), SIDS Coordinators' meeting and other conferences/trainings related to infant health[3].	**3.2b** Provide staff member name and date of attendance at SIDS Annual Conference/SIDS training(s) and other conference/trainings related to infant health.	**3.2b** Describe results of staff trainings related to infant health.

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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 By June 30, 2020 develop and implement a community awareness campaign targeting the Hispanic and Mixtec communities aimed at increasing awareness of safe sleep practices and SIDS risk reduction.	**3.3** • Outreach to organizations to partner with such as Promotores de Salud, SBCEO, First 5, and/or local agricultural businesses (ex: Driscoll Farms Health Center) • Develop materials with pictures of safe sleep for those with limited written language skills • SIDS coordinator and/or MCAH field nursing unit staff provide infant safe sleep education and SIDS risk reduction to Hispanic and Mixtec community members • Develop and implement a Continuous Quality Improvement/Quality Assurance (CQI/QA) process to monitor implementation of SIDS and safe sleep education and a feedback mechanism to evaluate the impact	**3.3** Briefly describe: • Community partnerships, linkages, and outreach • Number of parents receiving education about infant safe sleep practices and SIDS risk reduction • Presentations given • Materials developed • Evaluation tool developed • Results of the evaluations • Barriers, challenges, and opportunities to improve infant safe sleep practices • The CQI/QA process developed	**3.3** Numerator: Number of parents demonstrating increased knowledge and intention to follow infant safe sleep practices and SIDS risk reduction Denominator: Total number of parents educated • Briefly describe the results of evaluation • Describe the outcomes of the CQI/QA process including methods of measurements and results

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

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Short and/or Intermediate Objective(s)	**Intervention Activities to Meet Objectives (Describe the steps of the intervention)**	**Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)**	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
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 By June 30, 2021, 75% of FNU clients with a risk factor for Drugs/ETOH/ other Substance will receive a referral for treatment as confirmed in the care plan.	**3.4** Perform the following activities: • Develop and implement policies to screen all pregnant and postpartum women in the FNU for Perinatal Substance Use (PSU) • Refer women who screen positive for PSU to the appropriate provider who will best meet their individual needs • Develop and implement a CQI/QA process to monitor implementation of policies/processes, a regular feedback mechanism to continually improve the process and evaluate the impact • Collaborate with providers, community organizations, and support groups to establish a referral resource network • Develop and implement processes that link women who screen positive for PSU to appropriate resources	**3.4** Briefly describe or report: • Currently existing and newly created resources and support groups for PSU prevention • Identified access to care issues • Rationale for interventions, recommendations and strategies/policies developed • Referral process developed and implemented • CQI/QA process developed • Collaboratives/ partnerships formed • Resource referral list/brochure/website	**3.4** • Numerator: Number of FNU clients with a risk factor for Drugs/ETOH/other Substance that received a referral for treatment Denominator: Number of FNU clients with a risk factor for Drugs/ETOH/other Substance **Report the following:** Numerators (Outcome Measures): • Acknowledges referrals -no further use • Acknowledges referrals -unknown outcome • Acknowledges referrals -continues to use • Maintaining tx services • Began outpt tx • Began inpt tx • Began SA tx- Poor Compliance • Decld-rpt no use • Not Found: • Declined FNS Denominator: Number of FNU clients with a risk factor for Drugs/ETOH/ other Substance

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

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Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
			• Brief description of outcomes of the CQI/QA process, including methods of measurements and results

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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.** **SBC does not participate in FIMR.**	**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.		

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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)**
<u>REQUIRED LOCAL OBJECTIVE for FIMR LHJs Only:</u> Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ must provide at least one specific short and/or intermediate SMART outcome objective(s) to address perinatal/infant health. *Number each locally developed objective as follows: 3.6, 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 **SBC does not participate in FIMR.**	**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

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

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<u>OPTIONAL LOCAL OBJECTIVE:</u> 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.*			
Ongoing PHD Field Nursing Measure **Objective 4.1** By June 30, 2021, 80% of MCAH FNU breastfeeding clients will continue to breastfeed at closure of case.	**Ongoing PHD Field Nursing Measure** **4.1** Perform the following activities: • Identify and monitor trends on breastfeeding in SBC. • Work with community organizations to influence policy and address disparities. • Field Nursing Unit staff will attend at least one training on breastfeeding. • Assessment of breastfeeding for all postpartum mothers. • Support of breastfeeding and/or assistance is given as needed by FNU staff. • Encourage mothers to exclusively breastfeed on all pregnant and postpartum visits. • Provide referrals for WIC, Lactation Consultants and • Peer Counseling as needed. • FNU staff input information re: individual cases into the PHN Database under health indicator status. • Documentation of breastfeeding	**Ongoing PHD Field Nursing Measure** **4.1** Briefly describe • Breastfeeding trends in Santa Barbara County. • Describe MCAH staff participation in the Breastfeeding Coalition. • Describe breastfeeding training for Field Nursing Unit staff. • Describe Field Nursing Unit breastfeeding interventions and referrals to WIC and Lactation Services. • List three successful strategies used to sustain exclusive BF? • Describe barriers to BF	**Ongoing PHD Field Nursing Measure** **4.1** <u>Numerators</u>: • No problems – Breastfeeding adequate, no supplementation • No problems – Breastfeeding adequate with supplementation • No problems – No longer breastfeeding • Breastfeeding support – Breastfeeding adequate, no supplementation • Breastfeeding support – Breastfeeding adequate, supplementation • Breastfeeding support – No longer breastfeeding • Referral for breastfeeding consultation received – Breastfeeding adequate, no supplementation • Referral for breastfeeding consultation received – Breastfeeding adequate, supplementation <u>Denominator</u>: All breastfeeding clients in the MCAH FNU.

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

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)
	support given assessed on individual chart reviews. • All documentation is reviewed by the Supervising PHNs.		

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

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 • Not addressed in this SOW. • MCAH Director collaborates with AFLP Manager, CalPREP and MOU with Teen Services grantee in North County for referrals.	**5.1**	**5.1**	**5.1**

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