

San Benito County
MATERNAL, CHILD AND ADOLESCENT PROGRAM (MCAH)
FIVE YEAR NEEDS ASSESSMENT FOR 2005-2009

I. SUMMARY/EXECUTIVE REPORT

This is the third MCAH Community Assessment conducted by the San Benito County Health & Human Services Agency, Public Health Division, Maternal, Child and Adolescent Health Program. The first assessment developed broad goals for the fledging MCAH program. An action plan was prepared in 1995 with refinement of objectives in 1996. The second assessment involved community input from collaborative agencies, organizations and businesses as well as 1267 residents (\pm 2% of the population). The purposes of the current assessment are to report the health status of a dynamic community over the past five years and to report the MCAH program accomplishments relative to the 1999-2004 plan. The MCAH Community Assessment is also a State and local program requirement, a core public health function and an essential practice for service planning and resource allocation. Data has been collected from an extensive array of sources by the planning team for the required and the optional indicators selected by the MCAH team and community partners and collaborators. The planning team, with the assistance of the public health epidemiologist and FHOP staff reviewed and analyzed the data. The mission for this assessment has been to obtain as much precise information from as many relevant sources as possible, in order to prepare a report that will be used by the community for making San Benito County a healthier community in which healthy people live.

In August of 2002, the core team developed an initial plan and schedule for the assessment process. The plan included identification of key staff, community resources, partners, local data and sources, deliverable products, and funding. The team met again in October and December 2002, January and February 2003. The MCAH staff met in August and December 2002, February and May 2003. The MCAH Director attended FHOP training in October 2003. The preparation of the Community Assessment reports was revitalized in March 2004 with critical staffing changes. Information gathered through interviews, staff and community meetings; reading and research will be combined with the results from community surveys to be conducted in the Fall of 2004 and additional meetings with community partners for prioritizing indicators and planning action for the next five years. The results will be reported in the published San Benito County Health Status Report of 2005.

The MCAH mission revised in 1999 and reviewed in the current assessment process, *All San Benito children and their families will reside in a safe, healthy and nurturing environment, enjoy equal access to resources and realize their unique potential with a strong sense of responsibility to self and community*, is still relevant today. The goals are consistent with the State and Federal programs and still provide the core elements of the local program.

The team would like to thank the FHOP staff for their considerable assistance in preparing the data. There were no surprises; San Benito County is for the most part a very healthy place to live. The County measures as well as or better than the State on all but four of the indicators and has reached the 2010 goals on six. Access to care and care resources continues to be problems. Major challenges are the data: small numbers, combining of this county with other larger counties and, the availability of data on such issues as asthma and domestic violence. The analysis of the indicators reaffirms that the priority needs continue to be prenatal care, insurance coverage, health care resources, preventive dental care, childhood obesity, substance abuse and domestic violence.

II. DESCRIPTION OF THE MCAH COMMUNITY ASSESSMENT PROCESS

The planning team began in 2002 and included the Directors of MCAH, Public Health Nursing, and Health Education. Other members of the MCAH, CHDP and public health staffs were included to add expertise and/or knowledge in specific areas. These members included the epidemiologist (in training), deputy director of vital statistics, perinatal services coordinator, and childcare health linkages coordinator. These personnel resources brought together the best knowledge and skills available. There are no funds to hire professionals in the field. The members of the team accepted these tasks in addition to their regular duties and assignments. The process is an enormous undertaking due to the minimal staffing afforded this rural community. The only way to meet the deadline was to begin early and borrow resources where possible.

It was felt that valuable information could be obtained from routine and targeted interactions with our community partners and collaborators. MCAH staff meetings were designed to guide these interactions and have input from all staff members. Economic conditions, staff shortages and increased workload demands precluded additional meetings and reduced the number of regular meetings. Personal interviews of agency leadership, consensus discussions in community collaboratives and assessments conducted by other agencies have been used to obtain information from a broad spectrum of the community.

The planning team began in August of 2002. The team developed an initial plan and schedule for conducting the assessment. The plan included identification of key staff, community resources, partners, local data and sources, deliverable products, and funding. The team met again in October and December. The October meeting focused on data sources and how best to access local information. At the December meeting the team reviewed community health reports from several California counties and selected the features, categories and priority indicators for our report to be published by January 2005 with funding yet to be identified. The focus of the meeting in January 2003 was data sources for the categories and indicators of the report and a plan to seek input from partners.

In February 2003 input was sought from the directors of the mental health and substance abuse programs. They were asked: 1) what were appropriate indicators of community needs in their fields, 2) what goals should the community set to work toward meeting the needs, 3) what sample questions would they propose for the community survey of the residents perceptions of the needs and solutions and 4) were there particular target groups they would like to have surveyed. Similar information was obtained in April 2003, by interview, from an environmental health specialist.

The MCAH program staff also held meetings to involve staff in the process. The staff meeting in August 2002 announced the formation of the planning team, discussed the purpose of the assessment, solicited ideas for target populations and survey questions and set the preliminary timeline. In December 2002 the program staff viewed a presentation covering the State and local MCAH plans, the local mission and goals, the community assessment process, and staff roles. All staff members were asked to return in February 2003 with a list of groups, providers, coalitions, and businesses to survey, and sample questions – what do you need to know to better meet the needs of clients. The February meeting collected the information brought by the staff members and discussed how the information would contribute to program planning. At the May 2003 meeting the staff focused on Public Health indicators, identifying MCAH needs and participated in an exercise on indicator selection and prioritization.

The preparation of the Community Assessment was revitalized in February 2004 with critical staffing changes precipitated by the resignation of the MCAH Director. Using the Guidelines & Indicator Lists for MCAH jurisdictions now available, the planning team expanded and resumed meeting in March 2004.

In addition to the information attained as described above, further input will be obtained in the first half of the 2004-2005 FY. Meetings and surveys will be conducted for broad participation in prioritizing key indicators, comparing San Benito to the indicators and making recommendations for action. The results will be analyzed and reported in the San Benito County Health Status Report of 2005. It is expected that several smaller reports will be prepared to highlight different aspects of the community assessment for targeted groups with appropriate language, cultural and literacy considerations. If funding allows, at least some of the reports will be published in Spanish.

III. MCAH PLANNING MISSION STATEMENT AND GOALS:

The first Community Health Status Report for San Benito County, published in 1999 has been a valuable resource for the MCAH program, the Public Health Division, community partners and others. The information it contains has been used to guide planning, write grants, orient new staff, inform government leadership and local business about important matters in our community and respond to inquiries from current and prospective residents. The planning team for the current Community Assessment began the process by deciding on the format and content for the next report. The mission for this portion of the process was to achieve a product that was: more accurate, more appealing to a wide range of readers, published in English and Spanish, provided a comparison to national standards not just report the current status of the community and inspired participation in the recommended actions for change and improvement by ordinary citizens, community leaders and policy makers. Emphasis was given to key quality of life indicators in the areas of healthy living, public safety and societal issues.

The MCAH staff reviewed the mission and goals for the local program in the initial and recent meetings for the process. The consensus is that the words in these statements remain fresh and relevant as guides for the work of the local MCAH program.

Mission: *All San Benito County children and their families will reside in a safe, healthy and nurturing environment; enjoy equal access to resources and realize their unique potential with a strong sense of responsibility to self and community.*

Goals:

- ❖ All pregnant women, newborns, children and adolescents will have access to preventive and primary care services in an environment promoting optimal health, well-being and committed to excellence.
- ❖ All children will live in a community that promotes optimal health, growth and development.
- ❖ Agencies and practitioners serving children and families, including MCAH staff, shall engage in collaborative and countywide planning and quality assurance efforts to ensure provision of a comprehensive community-based, integrated health care system.

IV. MCAH COMMUNITY ASSESSMENT

A. COMMUNITY HEALTH PROFILE

A.1: **Geographic Features:** San Benito County is located 50 miles south of San Jose in the southern end of the Santa Clara Valley. It is a landlocked area 1,396 square miles – 893,440 acres of valleys, hills and mountains. It is bordered on the south and west by Monterey County, on the east by Fresno and Merced counties, on the north by Santa Clara and Santa Cruz counties. Lying forty-five miles east of the Pacific Ocean on California's Central Coast, San Benito enjoys a temperate climate boasting 333 days of sunshine and temperatures averaging in the high 60s. The mild climate with 10 to 12 inches of annual rainfall, the coastal marine layer fog and well-water irrigation supports the agricultural sector in the flat northern valleys. The top producing crops are lettuce, wine grapes and bell peppers. The southern area is semi-arid, sparsely populated (35% of the residents) and dedicated to cattle production. The majority (65%) of the residents live in the larger of the two incorporated cities of the County, Hollister. The 6 square miles of Hollister and its immediate surroundings is the single suburban residential and business center for the County.

A.2: **Population Demographics:** With an estimated population of 53,234, (2000 Census), (56,300 2003, DOF) San Benito County is ranked 43rd in population among California counties. From 1990 to 2000 San Benito grew 45% from 36,697 to 53, 234 residents. One of the fastest growing counties in the 1990s, San Benito continues to grow at approximately 4% per year. Total households have grown from 11,422 to 15,885 nearly 39%. Housing stock was keeping pace until stringent growth control measures were enacted in the beginning of the new century. By 2001 four thousand four hundred and eighty-six housing units were built, an increase of 36% (12,230 in 1990 to 16,716 in 2001). As of May 2004, a total of 197 single-family dwellings have been built since January 1, 2002. Availability of seasonal family farm worker units (individual) is currently at 67. The number of unaccompanied adult seasonal farm worker units (sleeping beds), no children, is 286. Rent must be paid at both county seasonal farm worker-housing facilities. There are 16 mobile home units used for year round transitional shelter (homeless), no rent is required however it is strongly encouraged that families utilizing the shelter units contribute to a voluntary rent savings account. The funds in the account are released to the families upon departure from the transitional shelter. The seasonal farm worker population for the County is estimated at 3,920. In 2000, San Benito County's population was evenly divided by gender, with 49.4% females and 50.6% males. By race, White constituted 46% of the population a 5% drop from 1990. There has been no change in the Latino/Hispanic population since 1990, 47.9%. The largest growth has occurred among other ethnic groups – Native Americans, Pacific Islanders and Asians, (Indian, Chinese, Filipino, Japanese, Korean, Vietnamese). These groups grew from 1.5% of the population in 1990 to 3.6% in 2000. The numbers of African-Americans also grew from 0.5% to 1.1% of the population. Just over 65% of the residents are in married-couple families. Of the total households by type, 81% are families, 46% with children under 18 years.

Female heads of household comprise 10.5% of the household types, but only 6.2% of these have children less than 18 years of age. However, 15.3% of children live in single-parent households. Nineteen percent of the households are occupied by individuals 65 years and over. The number of persons per household, 3.32 is higher than for the USA, California and nearby Santa Clara County at 2.59, 2.87 and 2.92 respectively. The average family size is slightly higher at 3.64.

Table 1: San Benito County Population Demographics - 2000

Age	Number (%)	Race/Ethnicity	Number (%)	Gender	Number (%)
<5	4,705 (8.8)	White	24,513 (46.0)	Female	26,293 (49.4)
5-9	5,015 (9.4)	Hispanic	25,516 (47.9)	Male	26,941 (50.6)
10-14	4,766 (9.0)	African-American	573 (1.1)		
15-19	4,152 (7.8)	Asian	1,277 (2.4)		
20-24	3,213 (6.0)	Other PI	99 (0.3)		
25-34	7,782 (14.6)	Native American	616 (1.2)		
35-44	8,994 (16.9)	Some other race	(1.1)		
45-54	6,612 (12.4)				
55-59	2,192 (4.1)				
60-64	1,488 (2.8)				
65-74	2,379 (4.5)				
75-84	1,473 (2.8)				
>85	463 (0.9)				

(Source US Census Bureau, Census 2000)

The total population under 44 years of age constitutes 72.6% of the population. The median age in 1990 was 30 years and in 2000 is 31.4 years. Children less than 5 years of age are 8.8% of the population and young people between 6 and 20 years of age are 26.2. The proportion of women of childbearing age, 15-44 years, is 22.4% of the total population. This remains a very young community. Slightly more than fifty percent of the births in San Benito County are born to Mexico-born mothers. In 2001, the percent of births all mothers in San Benito with no high school degree was 29.3%. While the percent of births to Hispanic mothers in the county with no high school degree was much higher at 43.4%, it was lower than for California at 51.0%. For all women these percentages are 5- 10 % higher than California and have remained much the same over the decade of the 1990s. The percent of births with the primary payer being Medi-Cal in the year 2000 was 35.7 % for all women and 50 % for Hispanic mothers. These percentages rose from similar levels in 1989 to nearly 50% for all women in 1992 remaining high until 1996 when they declined to current levels. San Benito is very close to the State levels in California on this indicator of poverty.

San Benito County ranks 46th out of 58 counties in poverty and 48th in child poverty. The proportion of all people living in poverty was 12.9% in 1990 and now stands at 13.3%. County estimates for people under age 18 in poverty fluctuated from a low of 15.3% in 1999 to a high of 17.9% in 1997. The population under age 18 below 200% of poverty constitutes 34% of the population. According to Project Lean there are currently 17% of children 0-18 years of age in poverty in the County. Even as the demand for charitable food assistance increased by 23 percent in 2002, there were high levels of underutilization of food assistance programs.

SAN BENITO COUNTY FOOD ASSISTANCE	# Eligible	# Eligible Not Served	% Eligible Not Served	County Rank
Food Stamp Program	5,734	3,230	56%	20
Women, Infants Children (WIC)	2,376	487	20%	35
National School Lunch Program	3,940	1,416	36%	12
School Breakfast Program	3,940	3,585	91%	2
Summer Food Service Program	3,940	3,088	78%	32
Child Care Food Program-centers	N/A	N/A	N/A	N/A
Child Care Food Program -homes	N/A	N/A	N/A	N/A

In 2000 the total number of children under 18 years of age in group homes was ninety-two, 58.7 % males and 41.3% females. The Juvenile Hall facility is certified for 20 incarcerated youth has capacity for 28 beds, with males out numbering females at a seven to one ratio... Since 2000 the hall is frequently at capacity. The number of children living in foster care for selected month (July) per 1000 residents was 6.84% in 2000. The ethnicity of children in foster care is reflective of the ethnicity in the Community as a whole.

A.3: **Social-Economic Status:** In 1999 San Benito County ranked 40th for personal income, \$1,148.7 and 36th for per capita income, \$22,402. The average earnings per job in 1999 were \$30,551. The 2000 average annual income per household was \$57,348 compared to the 1990 average annual income per household of \$44,193. The per capita income in 1990 was \$ 13,933 and in 2000 \$ 20,932. Agricultural field workers earn significantly less.

Unemployment rate for 2000 was 7.9% lower than the 1990 rate of 11.5%. Between January 2001 and January 2002, the unemployment rate increased again from 9.2% to 11.7%. Job growth for all industries was 1,490 from 1999 to 2000. There has been a loss of farm jobs and a gain in all other sectors of employment over the decade. Agriculture remains the third largest labor force after professional and retail.

A.4: **Education Status:** In 1990 the median years of school was 12.7. School enrollment in grades K through 12 for the academic year totaled 8,509 students. The same population saw an increase in enrollment figures for the 2002 to 2003 academic year to a total of 11,678 students. The graduation rate for the 2002 to 2003 academic year was 91.7%, with 433 students in the senior class. The 4 year derived dropout rate in 2001-02 for grades 9-12 was 5.2 for San Benito High School, 5.3 for the county as a whole as compared to 10.9 for California. Residents are now also afforded the opportunity for continued education at the Community College satellite campus located in the county seat of Hollister, which opened in the mid 1990's. Enrollment figures at the satellite location in the academic year 2000 totaled 1,575 students. There is wide disparity in education between migrant farmworkers and their families and the residents of the community. Nearly 14% of children 5 to 15 years have difficulty speaking English. ESL programs have been slashed. In the 1992 through 1993 school year, English as a second language classes accounted for 19.8% of enrollment. In the academic years 2002 through 2003, ESL enrollment peaked at 20.4%.

A.5: **Migration Trends:** commuters, home buys At least 16,000 residents commute to work each day outside the county. Forty-four percent commute 20-90 minutes away. Some school personnel estimate that 60% of the children come from families where both parents are employed and commute out of town. Farm work is very seasonal and dependent upon the end of the rainy season. The beginning of the growing season can vary from as early as January to as late as March. The season

typically ends by the first of November. The numbers of workers increases to a height of 12,000 in June, July and August, and then begins to drop again. Many farm workers are permanent residents "migrating" from the fields to the cannery, service and light industries when the growing season ends.

A.6: **Housing:** In 2000 total housing units were 16,499. Housing vacancy rates were very low at 3.7% for all housing types, 1.0% for homeowner vacancy and 2.7% for rentals. The homeownership rate was comparable to State and National rates at 69.9%. Rental units constitute 30.1% of the occupied housing units. The median value of owner-occupied housing units is now at \$375,000 up from \$284,000 just two years ago. This is slightly under the price of same unit in California and about half the value of the same unit in Santa Clara County. For some 36.9% of the residents their gross rent was 30% or more of their household income in 1999. There are 134 housing units for families and singles for seasonal, recreational or occasional use. According to the US Census for 1990 there were 2,162 agricultural workers in the labor force. The HRSA Migrant Workers report of 2000 estimates 5,690 migrant and seasonal farm workers in the labor force an increase of 163%. There are fifteen large, private camps and many smaller ones that open and close with the peak seasons. The workers must pay rent for the space they use although many of these facilities are very substandard.

A.7: **Vital Statistics:** There has been a steady climb in total number of births in San Benito County since 1990 from 732 to 876 in 2000 a 19.7% increase. The crude birth rate was 19.8 per 1000 people in 1990 and 16.9 in 2000. This is a decline of 14.6%. The general fertility rate was 84.1 in 2000. Medi-Cal births in 1990 represented 49.4% of all births and accounted for 48.3% in the year 2000. The Crude death rate in 2000 was 5.2 per 1,000 people as compared to 6.4 in 1992. Of interest is San Benito's ranking due to causes of death: The County ranks in the first quartile (1992-1994) for deaths due to all causes, firearm injuries, homicide, suicide, all cancers, cerebrovascular disease and drug related. The County ranked in the third quartile in the same years for deaths due to motor vehicle crashes and unintentional injuries. This was relative unchanged in 1999-2000 with these exceptions: homicide, and unintentional injuries second quartile. The County had improved in coronary heart disease from the second to the first quartile but declined in cerebrovascular disease and drug related deaths to the second quartile. On the new indicator, deaths due to diabetes San Benito ranks 29th in 2000 a decline from 23rd rank just one year earlier.

Infant deaths per 1000 live births in the year 2000 were 3.1, a decrease from 8.12 for the aggregate years 1990 through 1992. Perinatal death rate was at 0.0005 for aggregate years 1999 through the end of 2000. The statistical significance of these statements must be tempered by the reality of small numbers in this rural county where a single occurrence can have a profound effect on the quantitative data.

A.8: **Health Issues:** A review of the required indicators and summary prepared by FHOP shows that the county overall is doing about the same at the state or better on all but four indicators. These are:

- 1) the proportion of women with adequate prenatal care,
- 2) children and adolescents without health insurance and
- 3) children without dental insurance and
- 4) children who have been to the dentist in the past year.

The County has met or exceeds the Healthy People 2010 goals on six indicators:

- 1) very low birth weight,
- 2) perinatal death rate
- 3) infant death rate,
- 4) breastfeeding,
- 5) children who have been to the dentist in the past year and,
- 6) domestic violence related calls. Many of these indicators must be viewed with caution, as the numbers are very small with wide confidence intervals.

Other issues include the difficulty in collecting the data, whether it is representative of the entire county or only the City of Hollister, the combining of San Benito

population statistics with neighboring Monterey County which has approximately eight times as many residents, and having only one year of data for the indicator. Other sources of data are included in this assessment, as available, to address known health problems such as childhood obesity and diabetes. Further review and discussion of the indicators is found in section C.

Community Health Profile – Key Findings:

- San Benito County, a mid-sized jurisdiction of 53,234 residents (2000), continues to grow at an average of 4% per year. It is largely rural and agricultural with one population center that is also the governmental and business center. About 1/3 of the residents are recent arrivals and commute to jobs in the surrounding counties and cities.
- Housing growth has been frozen for the past 3-4 years. The cost of housing has soared. The household size has seen dramatic increases. Vacancy rates are very low in all types of units.
- The ethnic diversity is increasing but the numbers remain very small. This could present significant problems in delivering health care services when the immigrants are monolingual in languages other than English or Spanish. The community remains majority white or Hispanic.
- Thirty-five percent of the population is children under the age of 18 years, the largest in the state. Women in the childbearing years of 15-44 comprise 22.4% of the total population. The median age is 31.4 years. This is a young community necessitating a strong MCAH program.
- The county ranks 46th out of 58 counties in poverty and 48th in child poverty. The proportion of all people living in poverty stands at 13.3%. For children under age 18 years the proportion is 17.9% and children below 200% of the federal poverty standard constitute 34% of the population. Agricultural field workers earn at the lowest rate in spite of the fact that agriculture is the most important economic sector of the county.
- In spite of the poverty, especially for children there is an underutilization of food assistance and medical and dental insurance programs.
- There are several educational issues. There is wide disparity between migrant farm workers and their families and other residents of the community. Twenty-five percent of the births are to Hispanic women without a high school education. ESL enrollment is around 20%. Graduation rates and alternative educational opportunities are improving.
- Thirty-three percent of the residents commute to work each day outside the county and 44% percent of those commute up to 90 minutes. The number of children in licensed childcare is not proportionally representative. Some children may be cared for in family homes but others may be alone and responsible for themselves for several hours a day.
- On the standard measures for health San Benito is doing well for the most part. However, the rates of childhood obesity, dental caries, and diabetes are causes for great concern.
- Community infrastructure already severely strained over the past two decades will not be addressed in the current economic situation. Problems of health, health care, violence, drug abuse and crime are likely to climb over the next 3-5 years.

ii. **Assessment of Community Assets**

MAPP

Due to time constraints, changes in key personnel in local and community wide agencies and coalitions, and the rural nature of our community, the MAPP tool has not been utilized for this assessment process. We believe there is a potential for the use of this tool in the future, however until State and local budgets have been approved and personnel are firmly ensconced, we will postpone implementation of the MAPP tool.

Resource Guide

Our partner coalitions and agencies have been invaluable in identifying local resources and have published a pocket guide for distribution to the community at large. The guide was sponsored by Healthy Mothers, Healthy Babies Coalition; San Benito County Local Child Care Planning Council; San Benito County Health and Human Services Agency, Public Health Services, the umbrella agency housing MCAH. The guide is a bilingual publication with community resources grouped into like categories and current phone numbers supplied for each resource. Categories include: Crisis and Emergency Services, Transportation, Special Needs Children, Substance Abuse Prevention-Alcohol and Drug Treatment, Legal Services, Public Health Services, Housing and Emergency Housing, Law Enforcement, Legal Services, Breastfeeding Information and Support, Child Care/Daycare, Child Safety, Counseling/Support Services, Dental Health Care, Education-Academic/Vocational, Education-Parent and Family, Employment Resources, Family Violence Prevention, Financial Support, Food-Nutrition/Supplemental Programs, Foster Care, Health Care, and Hospitals. The guide also provides links for relay services for the hearing impaired, CDC, U.S. Citizenship and Immigration Services, and the toll free MCAH information and referral phone number.

The guide contains a wealth of information and folds into the size of a credit card that increases the convenience of retention. It will be reviewed and periodically updated to ensure accurate information is transmitted to community members.

B. COMMUNITY RESOURCES ASSESSMENT.

Scope of health and social services

The health and social services "system" in San Benito County is composed of a combination of county, non-profit and for-profit entities. The County entity is the San Benito County Health & Human Services Agency. It is comprised of three divisions: Social Services, Benefits and the Public Health Division. Public Health is comprised of Preventive Health and Nursing Services, Environment Health and Health Education. San Benito has one 49-bed district hospital with two clinics, one FQHC (look alike) clinic, one urgent care center, and two small for-profit clinics.

The sources of obstetrical delivery are the district hospital and hospitals in the region. Any delivery either with anticipated complications is scheduled at Good Samaritan Hospital in San Jose, fifty miles to the north. Complications that occur during the delivery or in the newborn are transferred by air to Good Samaritan Hospital. The CPSP clients begin their care at the FQHC, are transferred to local obstetricians and are delivered at the district hospital. A significant number of private insurance deliveries occur outside the County.

San Benito is a fee-for-service County. A managed care entity tried to enter the County some years ago but failed and created a very negative atmosphere for any future managed care entity. Low-income residents have four insurance options: Medi-Cal, County Medical Services Program (CMSP) an adult Medi-Cal program for 34 of California's rural counties, Healthy Families, AIM and CHDP's Gateway. There are about 100 physicians representing 30 fields of medicine. Very few physicians or dentists accept patients with Medi-Cal or CMSP citing low payment, high paperwork, late payment, and high frustration. There are more Healthy Families providers and more satisfaction with it on the part of both providers and the insured. Occasionally California Kids becomes available and public health facilitates the enrollment of as many families as possible before the window closes. The only providers for this program are in Salinas, twenty-five miles to the south. These programs offer a convoluted array of benefits, paying for part of needed treatment but not for all of it and each program has a different menu of benefits.

Adequacy of health and social services

This section will present a brief overview of available information. Further measure of adequacy and satisfaction with what is available will take place with the community surveys over the next several months.

Barriers

- Lack of health insurance
- Lack of providers accepting insurance available to low-income residents
- Lack of provider staff with bilingual, bicultural staff; Indian dialects

- Specialty care outside of the County
- Lack of transportation/adequate transportation services
- Lack of knowledge about the available transportation
- Lack of familiarity with region for accessing specialty services
- Inability to pay “administrative fee”
- Rude, inefficient reception and long waits
- Lack of knowledge about what services one should seek
- Lack of knowledge about what services are available and how to access them
- Fear of costs if care is sought
- Bureaucratic obstacles

Gaps

- Mental/emotional health services
- Substance abuse services/perinatal substance abuse services
- Local health care providers
- Local specialists
- Local residential care services/shelters
- Bilingual services
- Community-based support services, Alanon, Alateen, NA, grief, special needs parents, Tobacco Cessation, etc.
- Community policing
- Gang prevention and diversion
- Positive youth services – health and recreation
- All day Head Start and other preschool programs
- Nutrition services for obesity prevention and management
- Bilingual nutrition services
- Substance abuse screening of pregnant women, parents
- Support services for children
- Foster care homes
- Local treatment/outpatient facilities for mental health, substance abuse, special needs
- Arts, sports, and physical activity for all incomes, working families.
- Funding, funding, funding.
- Staffing for programs.
- Women’s health care programs, bilingual with outreach

These are some of the problems that are known from incidents in the community or from comments by staff of local services and clients; others have surfaced through MCAH participation in the Child Welfare Redesign process. Other surveys have been conducted, such as CMSP, which target the adult population not specifically the maternal, child and adolescent populations. Participation in the community groups is also a source of information. However, the voice of the community is extremely important and that will be collected with intercept surveys in the fall. Items addressing the barriers, gaps and perhaps, solutions are at the heart of this survey. This report will be expanded with the results of the survey and the community prioritization.

C. REVIEW OF THE STATE REQUIRED MCAH INDICATORS.

Quantitative Analysis:

- (i) The proportion of women receiving adequate prenatal care defined as entry into care in the first trimester with continued care through out, stands at 576, with the State proportion at 933. The resulting rate of adequate prenatal care in this county at 0.62% indicates significant improvement is needed in this area.
- (ii) Proportionately children without dental insurance was at 1900, State comparisons at 7500, with a resulting rate of 25%.

Qualitative Analysis:

- (i) Factors affecting adequate prenatal care are addressed in depth in the capacity-rating tool, (see appendix) and will be summarized here. Fragmentation of care and lack of medical providers that accept Medi-Cal insurance in a county where approximately half of the births are Medi-Cal funded is an issue MCAH will continue to negotiate with providers. The Stork’s Nest program, rejuvenated in July 2002 has enrolled over 300 women. The majority of the clients are also enrolled in CPSP. This group has a higher

rate of early entry into prenatal care that the population as a whole. Other data drawn from this source is included in several of the indicators in this section. Immigrant populations may not comprehend standards of care, and are often fearful to seek assistance from "the government". Many pregnant women work in the service industry or are field workers and lack the benefit of paid leave for obstetrical visits. They may be in danger of losing their jobs if time off is taken. Transportation remains an issue as well; existing County Transit stops are few and far between, necessitating long walks, often on unpaved shoulders of busy roads, to the nearest bus stop or office/clinic. MCAH will continue outreach efforts to educate immigrants, the general public, and employers on the health benefits as well as the cost savings associated with consistent prenatal care. Expansion of the County Transit system will be a slow process as our infrastructure continually lags behind the rapid population growth. MCAH will continue to advocate on all levels of county government to maintain and expand the services required for a healthy community. Public Health (DNS) is a member of the Hollister City Traffic Safety Commission. The County does not have a similar body. Matters of concern about traffic, road and street conditions, pedestrian and bicycle access and safety are brought to this body for action. A representative of the Council of Governments is also a member of the Commission and relays issues to the COG Board. In addition, COG is the fiscal agent for a number of funds that can be used for improvements and the local Commission has identified ways to use these funds in areas of population growth and mixed City/County roadways.

- (ii) CHDP gateway figures have indicated under utilization of insurance. MCAH as well as collaborative partners such as the Healthy Mothers Healthy Babies and the Dental Coalition, continually engage in outreach and education efforts to mediate this disparity. The loss of support staff to assist the public in completing lengthy applications has most certainly had an impact on the number of applications submitted. Insurance does not necessarily equate to access, as only 5 of more than 30 dentists practicing in the County will accept Denti-Cal insurance. There are a total of eight CPSP physicians in the County, with one additional physician from neighboring Santa Clara County who comes to Hollister on a regular basis.

Currently a total of 6 physicians are Child Health and Disability Providers (CHDP), up from 4 in 1999. The last private practice physician to accept Medi-Cal in the community closed her practice to Medi-Cal reimbursement in 2004, all Medi-Cal insured individuals must seek care at either the San Benito Health Foundation (FQHC look alike), or the District hospital sponsored Hazel Hawkins Clinic.

D. OPTIONAL TOPICS

- 1) The percent of children who report at least 20 minutes of physical activity 3 or more days per week. A summary of the 2000 through 2001 school year indicates that only 17% of children tested in grade 5 met all six of the fitness standards, 35.4% of 7th grade children met the six fitness standards, and 32.8% of children in grade 9 met all six fitness standards.
- 2) San Benito County currently ranks 6th in the state for number of children less than 6 years of age enrolled in a web based electronic immunization registry. Our CASA vaccination rates in the year 2000, stood at 72% as compared to the State at 66.6%. The latest CASA, 2004, is now at 82.24% for those up to date at 24 months and an additional 14.95% up to date by 35 months.
- 3) San Benito responded quickly and comprehensively when the Hepatitis A vaccine became available in 2001. The numbers of reported cases dropped to zero by 2002 and have remained there. Pertussis is the only other vaccine-preventable disease reported with only 1-2 cases reported in each year of the decade 1991-2001.
- 4) Mental Health data is extremely difficult to access. The most recent report received from the local department indicates that 164 children ages 0-17 were clients in the fiscal year 99/00. Individual clients ages 18-64 numbered 202. Fifty-three youth ages 5 to 17 years were served by the Children's System of Care program between FY 2001 through 2003. Their ethnicity is reflective of the County demographics, 65% were males. The most common diagnoses are ADHD, conduct disorder, bipolar, depression, dysthymic disorder and adjustment disorder. The report compares issues on

enrollment with status at the time of the report, February 2004. Substance abuse was an issue for 65% of the youth on enrollment and remained at 60%; violent behavior 69% dropping to 51%; family violence 70% down to 37%, gang involvement 26% up to 64%; youth with juvenile hall placement 39% up to 48%; youth who have been physically abused 39% down to 14%; sexual abuse 28% down to 12%; poor school attendance 65% down to 28%. Continued funding for this program is uncertain. There have been efforts to establish a gang prevention program in the County but politics and economics have derailed this effort.

- 5) Rates and issues regarding perinatal substance abuse. The County substance abuse program has one perinatal counselor with a maximum caseload of 20 clients. Fortunately the counselor is bilingual. There are neither inpatient facilities in this rural county nor intensive day treatment nor sober living facilities. Representatives from MCAH, Public Health, Child Protective Services, Perinatal Substance Abuse and the local District hospital updated the Memorandum of Understanding, based on Assembly Bill 2669, in 2001. In the year 2000, a database of referrals for PHN services was initiated to track referrals of drug- exposed newborns. The data collection and analysis continue to be a work in progress however from the inception of the updated MOU to the present the incidence of locally identified infants with positive toxicology has increased by more than 200%. The result has been a much more effective, multidisciplinary team approach to services for the clients. MCAH works with this team and other community entities to educate health care providers about early identification and referral to treatment.
- 6) The National estimate of pregnant women with gestational diabetes is 2-5%, or between 18 and 46 occurrences per year in San Benito County. Between December 2002 and September 30, 2003, the consulting dietician for the San Benito Health Foundation, received 19 referrals for pregnant women with diabetes..... The majority of the referrals were of Hispanic origin. Local data from birth certificates..... Between July 2002 and December 2003 eight Stork's Nest clients reported gestational diabetes. In the past 3-4 years there has been a startling increase in the incidence of young children diagnosed with Diabetes II. San Benito County now ranks #1 for childhood obesity in the State based upon Child Health and Disability Prevention Program examinations, a condition recognized as a precursor to diabetes. Two new programs are beginning in the County in July 2004 to address diabetes.
- 7) Dental care. It is, again, very difficult to access data on dental insurance, what individuals have gone for care and what care was received. There is some information from the CHDP program on that specific population. Some information can be obtained about the Medi-Cal population but not about all the rest. Although some residents are members of Kaiser, there is no access to their collected data. The majority of the local providers are independent practices that accept the few private insured plans available to local residents. A small survey conducted about four years ago found that even if residents went for dental care they did not consistently receive such preventive services as fluoride varnishing or sealants. A grant is currently being prepared by the Childcare Health Linkages Program of MCAH to provide dental education and referrals services to all preschools and childcare settings. This will allow for some data collection as well as a wonderful opportunity to reach the very young to teach them preventive health care practices.

E. ASSESSMENT OF MCAH CAPACITY

- 1) The MCAH Program priority is implementation of the core public health functions: Assessment, Policy Development, and Assurance, and their integration in local planning processes. The Maternal Child Adolescent Health Program resides in the Public Health Services, a division of the Health and Human Services Agency of San Benito County under the direction of the MCAH Director in collaboration with the MCAH Coordinator and Perinatal Services Coordinator. Service coordination efforts are provided through outreach and education, case-finding activities for pregnant women, infants, and high-risk adolescents. An epidemiologist in training is a valuable addition to the MCAH team, and will assist with ongoing community assessment, monitoring trends and interpreting data for the MCAH team. The team will, in turn, educate and inform the community at large on selected indicators for maternal, child, and adolescent health.

The Perinatal Services coordinator provides oversight to the Stork's Nest Program, providing assurance of early entry into prenatal care and education on a variety of health related topics, in a culturally and linguistically appropriate manner. The PSC also manages the Comprehensive Perinatal Services Program, offering technical assistance to the CPSP Providers.

MCAH collaboration with Adolescent Family Life Program and Adolescent Sibling Pregnancy Prevention Program has improved with implementation of new leadership in these Programs. Culturally appropriate services to pregnant and parenting women as well as adolescents at high risk for unintended pregnancy are provided with life skills training, health promotion education, case finding and case management services.

MCAH Health Educators provide injury prevention education, focusing on the infant to adolescent population, coordinating as well as providing car seat checks and technician trainings. MCAH Health Educators are also at the forefront of issues in optimal nutrition and physical activity, disseminating information to the community at large.

MCAH Program works with other division programs and community agencies to address the growing problem of perinatal substance abuse, childhood obesity, childhood dental disease and diabetes developing systems to monitor trends, and coordinating efforts for prevention and access to care.

CHDP has been an important partner to MCAH, providing information on obesity, anemia, lead, and dental health that is utilized for preventative education and outreach by our Health Educators in conjunction with the local Dental Coalition and Nutrition network.

- 2) The Cultural Competency element of the MCAH Program relates well to our Community through the Program's comprehensive and coordinated plan addressing policy, infrastructure, program administration, evaluation, and the delivery of services enabling supports. The mandate that organizations, individuals and programs have the ability to value diversity, understand and respond to cultural differences, engage in cultural self-assessment, institutionalize cultural knowledge, and make adaptations to the delivery of services in a culturally, linguistically appropriate manner is reflected in MCAH commitment to serve our target population. According to the National Center for Cultural Competence; "cultural competence is defined as a set of values, behaviors, attitudes, and practices within a system, organization, and program or among individuals which enables them to work effectively cross culturally." It is further indicated; "cultural competence refers to the ability to honor and respect the beliefs, language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. Striving to achieve cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment of time."

- 3) Strengths and Weaknesses

Strengths: The MCAH Program assures cultural competence through staff development in conjunction with community needs and is reflective of the population served. Educational materials when unavailable in the dominant language, Spanish, or are translated by capable bilingual, bicultural staff.

Weaknesses: With the population increase and resulting increase in diverse populations, there has not been a corresponding increase in the MCAH staffing levels. Currently there are 1.5 PHN FTEs dedicated to the key components of the program's operation. All staff work together to meet the overall MCAH goals and specific staff address local priority objectives. The program is staffed with a total of 2.5 nurses, 1 social worker, 1 social work supervisor, 1.35 health educators and 1.75 office support staff; 7.60 staff in all. In order to provide services and activities to address priority health issues or to address the needs of populations not fluent in the dominant languages or other special populations, MCAH staff has repeatedly over the past many years, obtained private grant funding. However grant funding is often narrowly focused and always time limited and the local jurisdiction have been unable to achieve sustainability for but a few activities, such as car seats and helmets. With 43% of

monies allocated to MCAH Program staff dedicated to funding benefits alone, and projected decreases in local funding allocations, it becomes increasingly difficult to provide the range of needed MCAH services or recruit additional multicultural staff to address the emerging multilingual population. The State budget will have great impact in this rural County.

F. IDENTIFICATION OF THE PROBLEM/UNMET NEEDS OF THE LOCAL MCAH POPULATION

Non-medical health problems:

Cost of living in this rural Community has been greatly impacted by the proximity to the Bay Area. Many Silicon Valley employees who feel the price per square foot ameliorates the hour-long commute see it as an affordable alternative for home ownership. The salaries enjoyed by those commuters have had a great impact upon housing costs. Coupled with the building moratorium, new home starts have not kept pace with the increasing population. Many residents employed in the service industry or agricultural field do not earn sufficient income to purchase a home in today's market. Agricultural field workers are at a greater disadvantage with temporary housing units (see item A6), and current figures of seasonal workers expected to increase to approximately 12,000 at the height of the season.

The high percentage of commuters has other social ramifications as well, leading to a lack of community cohesiveness or "community spirit" on their behalf.

Health problems:

The incidence of overweight and obese infants, children, adolescents and adults continues to climb, reflecting the national scope of this new epidemic. Gestational diabetes, diabetes type II and pre diabetes rates are climbing as a result of over consumption, most commonly of high sugar-high fat foods.

While our key indicators paint a rosy picture of children with adequate access to dental services, we must qualify that indicator by also looking at the number of children who required follow up visits for dental caries or orthodontic issues, which by our CHDP count is considerable.

Lack of adequate prenatal care and corresponding increased risk for negative outcomes for mother and infant alike, continues to influence the health of future generations. Widespread use and abuse of alcohol and other drugs are contributory factors to a myriad of health problems.

V. PRIORITY MCAH PROBLEM NEEDS IN THE JURISDICTION

The priority Problem/Needs in the County based on the available data is presented based upon the judgment of the MCAH staff. Further prioritization will occur through focus groups, community meetings and the community survey to be conducted over the next six months.

Problem/Needs were chosen based upon high or increasing incidence, severity of health consequences, and ability for MCAH together with community partners to affect change.

Nutrition and physical activity
Diabetes and Pre-diabetes

The following needs will be considered secondary priorities (quality assurance, collaboration and support as opposed to core functions and interventions).

Substance Abuse (Alcohol and Other Drugs)
Lack of Adolescent Services
Mental Health
Dental Care
Early and adequate prenatal care
Provider resources
Injury prevention
Unintended pregnancy
Provider services

VI. PRELIMINARY PROBLEM ANALYSIS FOR THE IDENTIFIED LOCAL PRIORITY PROBLEMS

Priority problems of nutrition, physical activity, diabetes and pre-diabetes, may be addressed simultaneously as a causal relationship exists between the problems. According to the most recent data available from Family Health Outcomes Project and CHDP county data, the incidence and prevalence of over nutrition or over weight has increased. In the 2002 pediatric nutrition surveillance tool, a wide disparity exists with the Hispanic population ages five to <20 years having 19.5% of that population above the 85th percentile, and 28.7% greater than or equal to the 95th percentile. The link between overweight and diabetes is well established. Data obtained from the local Health Foundation confirms an increase in the medically diagnosed cases of diabetes.

In community survey conducted last year, N=542, 19.1% of respondents self identified as having been diagnosed with diabetes. 31.2% of respondents stated they had been advised by a medical professional to lose weight and 59.8% indicated they had tried to lose weight in the past. When queried as to how food was most commonly prepared for consumption, 55% of the respondents replied that they fried their food. 31.9% of respondents stated that they exercised to the point of breaking a sweat as less than once a week or never. An indication that the population is amenable to change is reflected in the response to whether they would attend a class on how to buy and cook healthy foods, 75.6% of the respondents replied in the affirmative.

Diabetes is preventable to some extent by adequate nutrition (not more than body requirements), and increased physical activity. MCAH and its community partners are committed to reducing the incidence and prevalence of these serious deterrents to health in our community.

Some causal pathways have been identified at the State and National level, with recent legislation in the State of California to remove soda-dispensing machines from school grounds.

Local intervention strategies are in the formation stages with grant funding approved to develop a county-wide strategic plan for a continuum of care from prevention through disease management that addresses the needs of underserved diabetic residents and those at risk for developing diabetes in San Benito County. Additional grant funds have been obtained for targeted diabetes outreach and education in the coming fiscal year. Consultation with partner agencies and collaboratives will continue to ensure effective targeted intervention strategies.

VII. APPENDICES

- California Center for Health Statistics, "Health Data Summaries for CA Counties," 2000, 2002
- California Center for Public Health Advocacy, "Epidemic Overweight and Unfit Children," 28th Assembly District, 2002
- California Department of Education, "San Benito County Physical Fitness Report," 2000-2003
- California Department of Education, "San Benito County Educational Demographics," 2004
- California Department of Finance, Profiles: "San Benito County," February 2002.
- California Department of Finance, Profiles: "San Benito County – Socioeconomics," 2000.
- California Department of Health Services IZ Branch, "CASA Summary Report," 6/30/2004
- California Department of Health Services, "County Health Status Profiles," 1996-2002
- California Department of Health Services, "San Benito County Reported Cases of Specified Notifiable Diseases," 1991-2003
- Family Health Outcome Project, "Fetal Death Data Book," 1990-01
- Family Health Outcome Project, "Patient Discharge Data Book," 1989-2000
- Family Health Outcome Project, "Perinatal Data Book," 1990-01
- Go Kids, Inc.: Kids Count Census Data: San Benito Census, 2003
- Kids Count Census Data, Profiles: "San Benito Census, 2000-2004
- Larson Assistance Services, "Migrant and Seasonal Farm Worker Enumeration Profiles Study, September 2000.
- San Benito Chamber of Commerce, California Calm: A Guide to San Benito County, 2003.
- San Benito County MCAH, "County Data Book" 1999
- San Benito County Mental Health, "Children's System of Care," February 2004
- San Benito County Office of Education, Profile: San Benito County, 2002-03
- San Benito County, "Quality of Life Survey Report"

State of California Fact Sheet, Immunization Branch, 1981-2003

State of California Fact Sheet, School Fact Sheet, 2004

U.S. Centers for Disease Control:

"Pediatric Nutrition Surveillance, San Benito," 2001

"General Populations: 1999, Census 1999

"Housing Characteristics: 1999, Census 1999

"Income and Poverty Status in 1989, Census 1990

"Labor Force Status and Employment Characteristics: 1999, Census 1999

"Profile of General Demographic Characteristics: 2000, Census 2000

"Social Characteristics: 1990, Census 1990