

Alameda County

Maternal Child and Adolescent Health Community Profile 2017-18

Section 1 – Demographics

Our Community

Total Population ¹	1,563,370
Total Population, African American.....	197,191
Total Population, American Indian/ Alaskan Natives.....	4,576
Total Population, Asian/Pacific Islander.....	454,406
Total Population, Hispanic.....	359,037
Total Population, White.....	548,161
Total Live Births ²	19,248

Our Mothers and Babies

% of women delivering a baby who received prenatal care beginning in the first trimester of their pregnancy ²	89.8%
% of births covered by Medi-Cal ²	28.5%
% of women ages 18-64 without health insurance ³	15.6%
% of women giving birth to a second child within 24 months of a previous pregnancy *.....	35.1%
% live births less than 37 weeks' gestation ²	8.6%
Gestational diabetes per 1,000 females age 15-44.....	11.5
% of female population 18-64 living in poverty (0-200% FPL) ³	28.3%
Substance use diagnosis per 1,000 hospitalizations of pregnant women*.....	16.6
Unemployment Rate ⁴	8.7

Our Children and Teens

Teen Birth Rate per 1,000 births (ages 15-19) ²	17.2
Motor vehicle injury hospitalizations per 100,000 children age 0-146.....	20.1
% of children, ages 0-18 years living in poverty (0-200% FPL) ³	35.2%
Mental health hospitalizations per 100,000 age 15-24*.....	1,435.8
Children in Foster Care per 1,000 children ⁵	5.3
Substance abuse hospitalization per 100,000 aged 15-24*.....	607.4

Data sources: ¹ CA Dept. of Finance population estimates for Year 2015, January 2013; ² CA Birth Statistical Master Files 2011-2013 Annual Average, 3 year average; ³ California Health Interview Survey, 2014; ⁴ [State of California, Employment Development Department, February 2017](#); ⁵ [Data from CA Child Welfare Indicators Project, UC Berkeley Point in Time Jul 2015](#); ⁶ [California Department of Public Health, Safe and Active Communities Branch](#); *Data carried over from the Community Profile 2015-2016. Not updated.

Section 2 – About Our Community – Health Starts Where We Live, Learn, Work, and Play

Alameda County is widespread geographically, consisting of 821 square miles, fourteen cities and six unincorporated places. Located on the east side of San Francisco Bay, it is home to over 1.5 million people and is among the most racially and ethnically diverse counties in California. The cities and places range in size from under 1,000 in population in rural Sunol to over 400,000 in urban Oakland. The major industries are professional, scientific and technology services, healthcare and social assistance, and manufacturing.4 Educational services, health care and social assistance are projected to add the most jobs in the next decade. The top employer is UC Berkeley, followed by the two Lawrence National Laboratories, the County of Alameda, Oakland Unified School District and the City of Oakland. Seventy-five percent of the people are privately employed; 14% are public workers; and 10% are self-employed.5 There are many large parks and open space areas in the county that are administered by the local and state park system, but many are inaccessible by public transit. Many of the smaller and more accessible parks suffer from poor upkeep and vandalism, and are not used regularly for recreation because of safety issues. The Walk Score ranks Oakland as having a good walk-ability (it made 9th on the top 10 list) but the score measures distance to amenities and does not account for safety.

Section 3 – Health System – Health and Human Services for the MCAH Population

- We have been working for the last four years on developing an early childhood home visiting and family support system of care. The system serves low income pregnant women and families with a child under the age of two, who are facing multiple health and social challenges. Specially targeted populations include medically fragile infants, first-time mothers and families at risk for child abuse and neglect. We have begun implementing common standards, have finalized a common outcomes evaluation framework, are providing comprehensive training and regular reflective supervision for staff and are building out our universal referral process to maximize the effectiveness and reach of our programs. The common outcomes framework is a starting point for a robust evaluation that will include data collection practices and an accompanying comprehensive database, and will allow us to measure the impact of the home visiting system on the health of mothers, infants, fathers and families in our community. In addition, we are developing a Home Visiting Integration unit, consisting of a manager, two data/evaluation staff and a quality assurance position, which will provide the necessary infrastructure to further our program integration and standardization, impact measurement efforts and quality improvement activities.
- The development of mental health consultation and intervention within the home visiting and family support system has been significant. After a year of determining funding and working with Human Resources, the Mental Wellness Team (MWT) was established within MPCAHA and became fully staffed a year later. In addition, we are working intently with the SAMHSA Project LAUNCH grant to provide consultation across the state in the area of mental health integration, including the development of a toolkit. Our MWT provides brief treatment, training, case conferencing, consultation, and referrals regarding mental health needs and issues among our MPCAHA home visiting/family support clients. In addition, to support our trauma-informed approach in MPCAHA, the MWT hosts quarterly transformational healing circles for MPCAHA staff and has institutionalized reflective supervision.
- The Perinatal Services and Family Planning unit is engaged in ensuring that women in our community receive quality comprehensive prenatal care and family planning services, as well as access to accurate and unbiased information that can help them to make healthy choices for themselves and their families. This goal is accomplished through provider trainings, community collaboratives and educational campaigns.
- An important component of MPCAHA that is closely connected to the Home Visiting System of Care is the Building Blocks for Health Equity unit (BB4HE). BB4HE aims to achieve health equity for the women, children, families and fathers we serve by forming partnerships with multi-sector agencies that will help us to address the social determinants of health for the MCAH population. Projects include strong collaboration with asset-building and financial coaching agencies to help clients avoid predatory financial products, build wealth and achieve financial security. These collaborations have informed the development of a financial coaching and asset-building grants program for home visiting clients, which is described in more detail below. In addition, a partnership with the City of Oakland’s Brilliant Baby campaign – which plans to establish college savings accounts for 1500 newborns from the city’s most marginalized communities – will benefit some of our most needy parents and create the expectation that their children can attend college if they so choose. The BB4HE is also home to our Best Babies Zone, located in the Castlemont neighborhood of East Oakland, which works with neighborhood residents to transform their communities into vibrant places where children and families can thrive.
- Our county’s Help Me Grow Initiative is working to ensure that all children receive developmental screening and referrals to services as needed. We are working closely with First 5 who is the lead agency to coordinate their services with our home visiting programs.

The Birth to 8 Initiative continues its work to build a comprehensive and coordinated early childhood system of care. Its work focuses on ensuring smooth transitions between programs within the system as well as building support among local leaders and policy-makers for home visiting and other critical early childhood interventions.

Section 4 – Health Status and Disparities for the MCAH Population

Poverty is a major driver of poor health and health inequities in the county. Alameda County has an overall child poverty rate of 14% which is highest among African American (29%), American Indian (25%) and Latino (22%) children (ACS 2014). High poverty neighborhoods, such as East and West Oakland, have higher foreclosure rates, lower 3rd grade proficiency, higher homicide rates and lower life expectancy than affluent areas. The stress of living in this environment and reliance on public transportation, limited access to supermarkets and higher liquor store density make it harder for residents to adopt healthy behaviors. We are piloting an asset-building grants program, with funding from the California Wellness Foundation, to make funds available to clients to help them survive a short-term financial crisis or support a small business venture or microenterprise, with the eventual goal of creating financial stability for the household. Clients must complete a series of financial workshops to qualify. Grants will be made in the \$500 to \$3000 range depending on need. In addition, our Place Matters staff use policy and place-based approaches to address criminal justice, economic development, education, housing, and transportation, all of which are related to poverty. Low-income and marginalized populations tend to experience higher levels of stress and trauma, which can have a negative impact on physical and mental health. For this reason, we are continuing to build a trauma-informed approach within our home visiting programs and the MPCA unit as a whole. Gaps in infant mortality and low birth weight have narrowed because of decreasing rates in both among African Americans, but inequities remain high with an almost two-fold difference. Teen birth rates continue to decrease and are at a history low for all races/ethnicities.