FIRST 5 SACRAMENTO COMMISSION

2750 Gateway Oaks Dr., Suite 330
Sacramento, CA 95833

Computer Link:
https://saccounty-net.zoomgov.com/j/1603240707?pwd=FcV4GNYNfWx8Lfb6A6hZEw7uocGXLY.1

Meeting ID: 160 324 0707
Passcode: 718513

EVALUATION COMMITTEE

AGENDA

Monday, May 19, 2025 – 1:30 PM to 3:30 PM

Members: David Gordon (Vice Chair), Nicole Kravitz-Wirtz, Olivia Kasirye, Robin Blanks, Tony Smith, Jennifer Mohammed (Alt.), Kairis Chiaji (Alt.)
Staff: Julie Gallelo, Carmen Garcia-Gomez, Elena Enriquez
Consultant: Applied Survey Research

1. Call to order and Roll Call
2. Public Comments on Off-Agenda Items
3. Approve Draft Action Summary of February 7, 2025
4. Select Committee Chair
5. Staff Update
6. General Evaluation Update – Applied Survey Research
7. Review and Provide Input: Reducing African American Child Deaths Report FY 2023-24
8. Committee Member Comments
    a. Miscellaneous
    b. Future Agenda Items/Presentations

If there is a need for an accommodation pursuant to Americans with Disabilities Act (ADA), medical reasons or for other needs, please contact the Clerk of the Board by telephone at (916) 874-5411 (voice) and CA Relay Services 711 (for the hearing impaired) or WillsSt@saccouty.gov prior to the meeting.

FIRST 5 SACRAMENTO COMMISSION
2750 Gateway Oaks Dr., Suite 330
Sacramento, CA 95833

EVALUATION COMMITTEE

DRAFT ACTION SUMMARY

Friday, February 7, 2025 – 2:00 AM - 4:00 PM

Members: David Gordon (Vice Chair), Dr. Olivia Kasirye, Robin Blanks, Tony Smith, Nicole Kravitz-Writz, Jennifer Mohammed (Alt.), Kairis Chiaji (Alt.)
Staff: Carmen Garcia-Gomez, Elena Enriquez
Attendance: In-person: D. Gordon, O. Kasirye, R. Blanks, Nicole Kravitz-Writz
Via Zoom: K. Chiaji
Absent: T. Smith, J. Mohammed
Consultant: Applied Survey Research

1. Call to order and Roll Call
   Action: Meeting was called to order at 2:03 PM.

2. Public Comments on Off-Agenda Items
   Action: None.

3. Approve Draft Action Summary of November 18, 2024
   Action: R. Blanks/O. Kasirye. Approved as recommended.

4. Evaluation Staff Report
   Action: None.

   Commission staff provided an update on the following items:

   - Staff shared that the First 5 Sacramento Community Conference Room has been dedicated in memory to Commissioner Steve Wirtz.

   - Evaluation Commission Seat: The commission appointed Nicole Kravitz-Writz to fill the seat.

   - CDRT Data: Due to the delay in receiving the CDRT data, staff requested to reschedule the March 17th evaluation meeting to allow time for the committee to review the data and provide input. Staff will follow up with an email to the committee to schedule a new date.

   - Persimmony: Staff has been working with Persimmony to change the way in which multiracial ethnicity is collected in Persimmony. Developers are working on implementing the change later this year. In the meantime, Fist 5 staff have created an assessment to begin collecting the data now.

5. General Evaluation Update – Applied Survey Research
   Action: None.

   ASR staff provided a summary report of activities that took place during the month of January.

6. Review and Provide Input: First 5 Sacramento Annual Report Fiscal Year 2023-2024
   Action: Review and provide input

   ASR presented the First 5 Sacramento Annual Report FY 2023-24.

   ASR reported that Result Area 1 is not available at the time due to the pending receipt of the countywide CDRT data.

   The committee provided input and had some general comments and questions.

   The report will be presented to the Commission in April. The Result Area 1- RAACD report will be presented to the commission in June.

7. Committee Members Comments
   a. Miscellaneous
   b. Future Agenda Items/Presentations: RAACD Annual Report

Adjourned: 3:34 p.m.

Respectfully submitted,

Carmen Garcia-Gomez, Evaluation Manager
First 5 Sacramento Commission

Evaluation Committee
Staff Report
May 19, 2025

1. End of the year: Staff have begun sending out follow-ups for the Family Information Form and other surveys, such as Playgroup and Parent Café follow-up surveys.

2. Birth & Beyond Annual Report: With the culmination of AmeriCorps funding, this report will no longer be completed. First 5 Sacramento will continue to evaluate the Birth and Beyond program for services offered to children ages 0-5 and their families.

3. Contractor waitlist: Staff is recommending not doing a special study looking deeper into contractor waitlist for programs. A special study would provide information for a specific period of time. Evaluation staff is recommending adding a couple of questions to the project narrative that addresses waiting periods or program capacity. This information will be shared on aa quarterly basis, giving commission staff on-going information and the ability to provide TA and address capacity issues. We will implement in July 2025, first report period for Q4 of 2024/25.

Summary of Evaluation Activities for First 5 Sacramento

May 2025

Strategy	Task
F5 Sac Eval Report	– Presented to Commission on April 7th – Preparing final version of report and executive summary with CDRT data
RAACD	– FY 2023-24 report for review (excluding Overall 0-5 Child Death chart and 0-5 CAN homicides chart pending receipt of CDRT data 5/26)
Trend Report	– Tableau dashboard and PDF draft in progress
Building Strong Families	– Ongoing quarterly report metrics provided to partner orgs
Special Study	– Proposal for exploring Parent Leadership Training Institute (PLTI) outcomes in progress
Persimmony/Tools	– Ongoing support/TA for assessments, services, and procedures – In development: FY 2024-2027 Strategic Framework and Data Tracker

Timeline

	May	June	July	Aug	Sept
RAACD	Eval Comm Review*	Graphic Design		Commission	
Core Eval Report	Finalize w/ CDRT data	End of FY surveys		Data	Data
Trend Report	Write	Edit	Eval Comm Review		
Building Strong Families			Data		
Special Study	Plan	Write Proposal	Eval Comm Review	Data	
Database	TA Support & Informal Data Reviews			Cleaning/AR data pulls	

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Reduction of African American Child Deaths (RAACD)

FY 2023-24 Annual Report

Executive Summary

Background & Goals

In 2011, the Sacramento County Child Death Review Team (CDRT) released a 20-Year Report which revealed that African American children were dying at twice the rate (102 per 100,000) of any other ethnic group.[i] In response to these alarming findings, the Sacramento County Board of Supervisors created the Blue Ribbon Commission on Disproportionate African American Child Deaths. In 2013, the Blue Ribbon Commission released a report with a set of specific goals to be achieved by 2020.[ii] The goals included an overall reduction in African American child deaths, and specific reductions for four leading preventable causes of disproportionate African American child deaths, including infant perinatal conditions, infant sleep-related, child abuse/neglect, and third-party homicides.

1. Reduce the African American child death rate by **10-20%**
2. Decrease the African American infant death rate due to infant **perinatal conditions** by at least **23%**
3. Decrease the African American infant death rate due to **infant safe-sleep** issues by at least **33%**
4. Decrease the African American child death rate due to **abuse and neglect** by at least **25%**
5. Decrease the African American child death rate due to **third-party homicide** by at least **48%**

To meet the Blue Ribbon Commission (BRC) goals, efforts have focused on the Sacramento County neighborhoods with the highest rates of child death, including: Arden Arcade, Fruitridge/Stockton Boulevard, Meadowview, Valley Hi, North Sacramento/Del Paso Heights, North Highlands, and Oak Park. Planning efforts and coalition-building between 2013-2014 and 2014-2015 resulted in two integrated initiatives across Sacramento County:

- The Black Child Legacy Campaign (BCLC): Led by the Sierra Health Foundation, Community Incubator Lead (CIL) organizations are located in each of the targeted neighborhoods and lead prevention and intervention efforts to reduce disproportionate African American child deaths.
- Reduction of African American Child Deaths: Led by First 5 Sacramento, this strategy complements and contributes to BCLC, and includes four programs focused on preventing deaths due to Perinatal Conditions, Child Abuse and Neglect, and Infant Sleep-Related causes.

PROGRESS TOWARD BLUE RIBBON COMMISSION GOALS

Since its development, the RAACD Initiative has likely contributed to substantial progress on BRC goals. As of the 2020 benchmark, three of the four mortality reduction goals (overall infant mortality, infant safe sleep, and child abuse and neglect) were fully met for the 0-5 population. In 2020-2022, the rate of perinatal deaths among African Americans was higher than the 2012-2014 baseline. Infant sleep related deaths also continued to increase, highlighting alarming new challenges in the RAACD focal areas.

Available countywide data now surpass the 2020 benchmark year (data current as of 2022). However, rates continue to be measured by the 2020 goals, as the Steering Committee actively works to set updated goals. There is still work to be done to reduce disparities and improve the overall well-being of children in Sacramento County. RAACD programs are appropriately positioned to explore patterns in these trends and “scale up” direct services, public outreach, and systems-level initiatives to reach more Sacramento families. First 5 continues to advocate for policy and systems change for Sacramento County and the state of California as a whole, and has incorporated more deliberate and specific efforts to promote racial equity, diversity, and inclusion in their 2024-2027 strategic plan.

Figure 1 — Progress toward Blue Ribbon Commission Goals to Reduce African American Child Deaths (ages 0-5)

2020 BRC Goal:	BRC Goal Status as of 2020Benchmark 2012-2014 to 2018-2020	As of Most Recent Data (2020-2022)... % Change 2012-2014 to 2020-2022	As of Most Recent Data (2020-2022)... Disparity Gap 2012-2014 to 2020-2022
10% to 20% reduction of African American **child deaths**	Goal Exceeded * 30% **Reduction**	XX% Reduction (ages 0-5)	XX% Reduction (ages 0-5)
At least 23% reduction of *infant deaths due to* ***perinatal conditions*** (ages < 1 month)	Goal Unmet 4% **Reduction**	14% Increase (ages 0-1)	32% Increase (ages 0-1)
At least 33% reduction of ***Infant sleep related*** *(ISR) deaths* (ages 0-1)	Goal Exceeded 54% **Reduction**	30% Reduction (ages 0-1)	32% Reduction (ages 0-1)
At least 25% reduction **of child abuse and neglect (CAN)** deaths	Goal Exceeded * 85% **Reduction**	XX% Reduction (ages 0-5)	XX% Reduction (ages 0-5)
At least 48% reduction of **third-party homicides**	Not funded or reported by First 5 Sacramento – see BCLC report		

* Not a direct comparison to the BRC goals as these were intended to reflect countywide progress for all children ages 0-17. Values presented here are limited to rates for children ages 0-5.

This summary provides FY 2023-24 highlights of First 5 Sacramento's efforts to reduce perinatal and infant/child deaths (birth through age five), including the Black Mothers United Pregnancy Peer Support Program, RAACD-focused activities at two Birth & Beyond family resource centers, Safe Sleep Baby Education, and a Public Perinatal Education Campaign. Additional details about program activities, analysis, and countywide patterns are available in the full report.

Pregnancy Peer Support Program

Her Health First (HHF) manages the Black Mothers United (BMU) pregnancy peer support program. BMU provides a community-based network of support to empower Black mothers during their pregnancies and the transition into motherhood through culturally relevant outreach, education, and individualized support.

The BMU program includes weekly check-ins with **pregnancy coaches, as well as access to doula care, lactation support, health resources, and social/educational gatherings**.

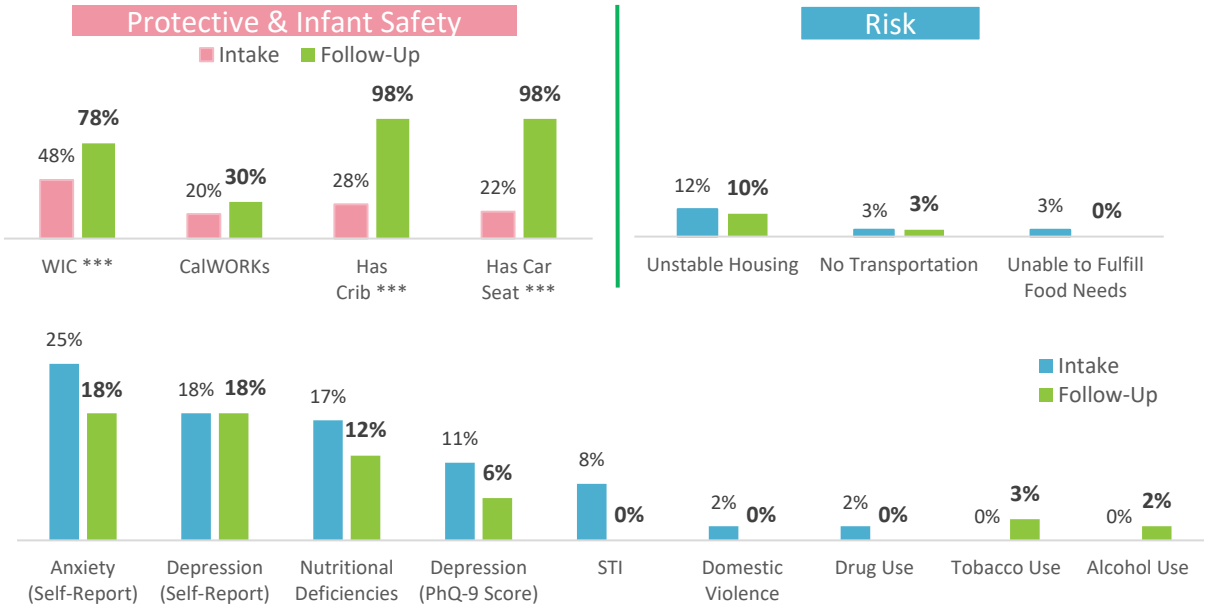
For the **fifth** consecutive year, there were **zero newborn deaths** among infants born to BMU participants at program exit.
85% of infants were born **full term** and had a **healthy birth**

RISK AND PROTECTIVE FACTORS

Between July 1, 2023 and June 30, 2024, BMU served 121 prenatal participants (81 new and 40 rollover) as well as 19 participants who returned for supplemental postpartum services. More than half (53%) of the participants lived in one of the seven RAACD focal areas. Half of the participants learned about BMU through BMU outreach or upon recommendation from a friend, family, or neighbor. About one in five participants (19%) enrolled during their first trimester. At intake, **more than four out of five (84%) BMU participants had at least one health and/or socioeconomic risk factor**. However, nearly all participants also had at least one protective factor, such as regular prenatal care (97%) or WIC enrollment (50%).

Peer support, case management, and connections to resources helped reduce risk factors and **improve access to protective factors.**[1] There was a significant increase in the proportion of participants enrolled in WIC (48% to 78%), and nearly all participants had a crib and car seat post-delivery.

Figure 2 — Changes to Protective and Risk Factors between Intake and Post-Delivery Follow-Up



Source: Health Assessment Intake and Follow-Up Matched sets; N = 65. Statistically significant change (indicated on column names) reported as * p < .05, ** p < .01, *** p < .001.

[1] Among all clients who delivered in FY 2023-24, including rollover clients with an intake was during the prior FY (N = 60). In this section, intake percentages may differ from intake totals reported earlier since this is limited to a matched set of participants with an intake *and* post-delivery follow-up assessment.

"…everyone is so welcoming and supportive. **I feel so at home and comfortable** and it's refreshing to be around people who I can relate to." - BMU Client

BIRTH OUTCOMES

There were 66 BMU infants born during FY 2023-24, including 64 singletons and one set of twins. Among them, **85% had an overall healthy birth (healthy birth weight *and* full term)**. For the third consecutive fiscal year, all twins born to BMU participants were full term and a healthy birth weight, despite higher risks for multiple gestation pregnancies. Twenty-six infants were born to participants who received doula support (prenatally and/or during the birth). Among the doula-served births, only one infant was born with a low birth weight (LBW) and another was born preterm (neither were born *both* preterm and LBW). **For the fifth consecutive fiscal year, there were zero newborn infant deaths reported** as of the mothers' postpartum follow-ups.

Figure 3 — Characteristics of Infants Born to BMU Clients during FY 2023-24

	All Infants (N = 66)		Twins (n = 2)		Singletons (n = 64)		Served by Doula (n = 26)	
Favorable Outcomes								
Healthy birth weight	62	**94%**	2	**100%**	60	**90%**	25	**96%**
Full term birth	60	**91%**	2	**100%**	58	**94%**	25	**96%**
Healthy birth weight *and* full term	56	**85%**	2	**100%**	54	**84%**	24	**92%**
Unfavorable Outcome								
Low birth weight *(< 5 lb, 8 oz)*	4	**6%**	0	**0%**	4	**6%**	1	**4%**
Preterm birth *(< 37 weeks)*	6	**9%**	0	**0%**	6	**9%**	1	**4%**
Low birth weight *and* preterm	0	**0%**	0	**0%**	0	**0%**	0	**0%**

Source: BMU Post Delivery Health Assessment & Pregnancy Outcomes. Note: all categories are not mutually exclusive and do not sum to equal 100%.

Additional statistical analyses exploring outcomes for three BMU cohorts combined (FY 2021-22 through FY 2023-24) identified key relationships between protective factors, risk factors, and program involvement on healthy birth outcomes. **BMU check-ins with a pregnancy coach and BMU doula services were significantly correlated with more positive birth outcomes.** Other risk factors, such as a higher number of pressing needs at intake, having a child under the age of one, a history of gestational diabetes, prior preterm births, and high stress levels significantly predicted unfavorable outcomes.[2] These results can help the BMU program identify and support higher risk participants.

[2] Includes variables marginally significant at $p < .10$. Full details about statistical significance available in the Appendix of the full report.

Family Resource Centers

First 5 Sacramento provides funding for Birth & Beyond Family Resource Centers (FRCs) with the goal of decreasing child abuse and neglect through prevention and early intervention. FRCs are strategically located in neighborhoods characterized by high birth rates, low income, and above average referrals to the child welfare system for child abuse and neglect. Locations tend to coincide with neighborhoods identified by the Blue Ribbon Commission as RAACD-initiative focal areas.

EBPP home visiting has helped families foster strong, **healthy self-esteem** and **pride in Blackness.** Home visitors have also built **deep connections with families** beyond the curriculum.

While all nine Birth & Beyond FRCs provide crucial support to Sacramento families with the intention of decreasing child abuse and neglect, **the following section describes efforts from the two FRCs that received RAACD funding**, Mutual Assistance Network Arcade Community Center's (MAN Arcade) Stronger Families, Stronger Generations (SFSG) and the Sacramento Children's Home Valley Hi Village programs.

In total, **328 adults and 150 children** participated in RAACD-funded activities at these locations.[3] RAACD-funded services reached a **high-need, high-risk population**. Nearly three-quarters (73%) accessed food/nutrition services in the six months prior to intake, and 60% had a family income of $25,000 or less.[4]

In FY 2023-24, the SFSG and Village programs provided:

414 home visits to 67 families, using an Effective Black Parenting (EBPP) model.	*Participants increased agreement with effective Black parenting behaviors, improved protective factors, and improved access to immediate support needs.*
338 parenting education workshop sessions to 41 unduplicated caregivers, using the Make Parenting A Pleasure (MPAP) and Effective Black Parenting (EBPP) curricula.	*All participants with an MPAP pre- and post-assessment showed improvements in at least one domain.*
241 crisis intervention services (ranging from resources and referrals to individualized case management) to 191 adults	*Case management participants commonly selected housing (53%), employment (28%), and budgeting/finances (18%) as their focal areas.* *All participants with a follow-up case management assessment improved in at least one domain.*
474 Social and Emotional Learning and Support **"light touch" activities**	*Examples include Sistah 2 Sistah and Colorful Connections group meetings, diaper distributions, transportation, and other pop-up events.*

"I want her to know as much about her African culture as she can, and I wanted to be able to learn from Black women." - SFSG Home Visiting Participant

[3] A small portion (4%) identified as another race/ethnicity other than Black/African American or Multiracial. No one is turned away from participating activities focusing on communities of color. Multiracial participants may include those that are not Black/African American but a more detailed breakdown of racial/ethnic composition of multiracial families are not available.
[4] Based on most recent Family Information Form completed at intake

Safe Sleep Baby

Safe Sleep Baby (SSB) is an education campaign managed by the Child Abuse Prevention Council (CAPC) of Sacramento to increase knowledge and change behaviors about infant safe sleeping practices. The overarching goal is to decrease infant sleep-related deaths in Sacramento County, especially among African American infants.

Specific strategies include a public education campaign, direct education for caregivers and community professionals, providing education and cribs to caregivers who do not have a safe place to sleep their baby, and systems change efforts.

SSB participants consistently show significant improvements in safe sleep knowledge and practices.

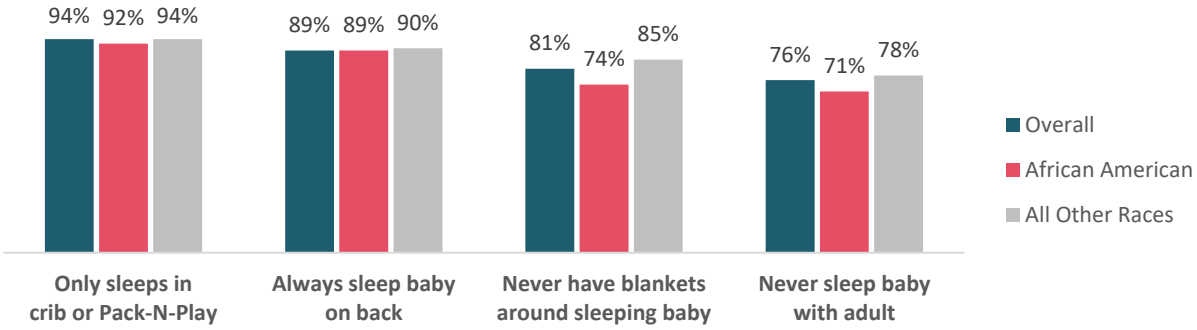
Cribs4Kids provided free Pack-N-Plays to nearly 200 Black/African American families to safely sleep their infants.

Although SSB is a universal program offered to caregivers of all races, there is a special focus on reaching African American families. In FY 2023-24, **1,086 caregivers received Safe Sleep Baby training**, 32% of whom were African American, and 61% lived in the RAACD focal zip codes.

Pre- and post-training data showed statistically significant improvements in safe sleep knowledge, including *Babies should NOT be tightly swaddled when sleeping for the first six weeks*, *Babies placed on their backs to sleep are NOT more likely to choke on their own spit up*, and *Babies should be slept ONLY on their backs for the first year of life.*

Additionally, SSB staff reached 185 participants with a follow-up assessment to understand the extent to which they were using infant safe sleep practices 3-4 weeks after taking the SSB course. Most caregivers reported *Sleeping baby in a crib or Pack-N-Play* (94%; 173/185), and *Always sleeping their baby on their back* (89%; 165/185), followed by *Never had blankets around their sleeping baby* (81%; 150/185).

Figure 4 — Percent of SSB Participants Practicing Infant Safe Sleep Behaviors at Follow-Up, by Race



Source: SSB Follow-Up Survey. N = 185 (All Follow-Ups in fiscal year). African American N = 62; All Other Races N = 123

"… I feel more confident keeping my baby safe while she sleeps. I didn't realize it was such an important topic but now I do, and I also have a safe place for her."
- SSB Participant

In addition to direct education for caregivers, the Safe Sleep Baby Campaign provided:

- **"Train the Trainer" workshops to 232 community-based service providers** and 70 healthcare workers. These trainings help providers convey safe sleep knowledge to clients and patients.

- **602 cribs to parents and caregivers** through the Cribs4Kids program, one-third of which (33%, 197/602) were distributed to African American caregivers.

Public Perinatal Education Campaign

The fourth strategy funded by First 5 is the Perinatal Education Campaign (PEC) which includes public outreach and education about perinatal causes of death. Her Health First (HHF) manages the PEC strategy, together with partners XTG Media and Runyon Saltzman, Inc. (RSE).

PEC includes two primary education campaigns: Sac Healthy Baby and Model of Caring (formerly Unequal Birth). **Sac Healthy Baby** (SHB) is focused on reaching African American expecting and new parents and families to provide them with information and to connect them to local resources. The **Model of Caring** (MOC) campaign aims to be a hope- and solution-oriented strategy while raising public awareness of institutionalized racism as the root cause of the racial disparities in safe births for both infant and mother.

During FY 2023-24, the PEC team:

- … further honed the MOC campaign to provide community birth workers with tools for their work environment to connect families to resources that will help support positive birth outcomes.
- … merged landing pages for the MOC campaign onto the SHB website.
- … created a social media kit containing 10-12 social media posts, MOC birth storytelling video edits, and social media images, as well as printable flyers promoting MOC, a printable MOC door hanger, and the MOC website content.
- … reached 585 users across 636 sessions on the SHB site and 104 users across 161 sessions on the MOC site, during the first quarter of the fiscal year. In the fourth quarter, the combined SHB site reached 421 total users across 466 sessions and had an engagement rate of 36.9%.

It is important to note that direct funding from First 5 Sacramento concluded in FY 2023-24. As a result, social media content and events were limited as the PEC team focused on strategies to merge platforms and redirect efforts.

Countywide Trends

The four programs funded by First 5 Sacramento (Pregnancy Peer Support Program, Family Resource Centers, Safe Sleep Baby, and Public Perinatal Education Campaign) aim to help reduce the rate of African American perinatal, child abuse and neglect, and infant sleep-related deaths across Sacramento County.

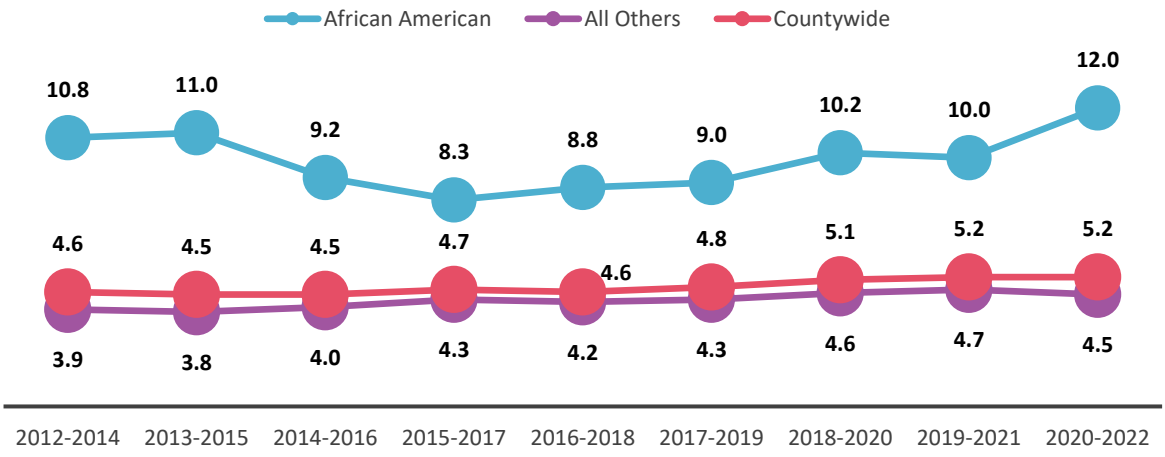
To measure countywide progress toward these goals and inform future efforts, Sacramento County Public Health (SCPH) and Child Death Review Team (CDRT) data are reported by RAACD focal area. Data are presented as three-year rolling (overlapping) rates due to the instability of one-year estimates.

OVERALL INFANT MORTALITY

SCPH defines infant death as any death of a Sacramento County resident which occurs before one year of age. During the 2012-2014 baseline, African American infants died at a rate of 10.8 per 1,000 births. During 2020-2022, the African American infant death rate was 12.0 per 1,000 births. This reflects an 11% increase compared with the 2012-2014 baseline. The disparity between African American infant deaths and all others increased 8% compared with the 2012-2014 baseline.

During 2020-2022, African American infant deaths (all causes) was higher than the 2012-2014 baseline.

Figure 5 — Three-Year Rolling Rates of Total Infant Death in Sacramento County



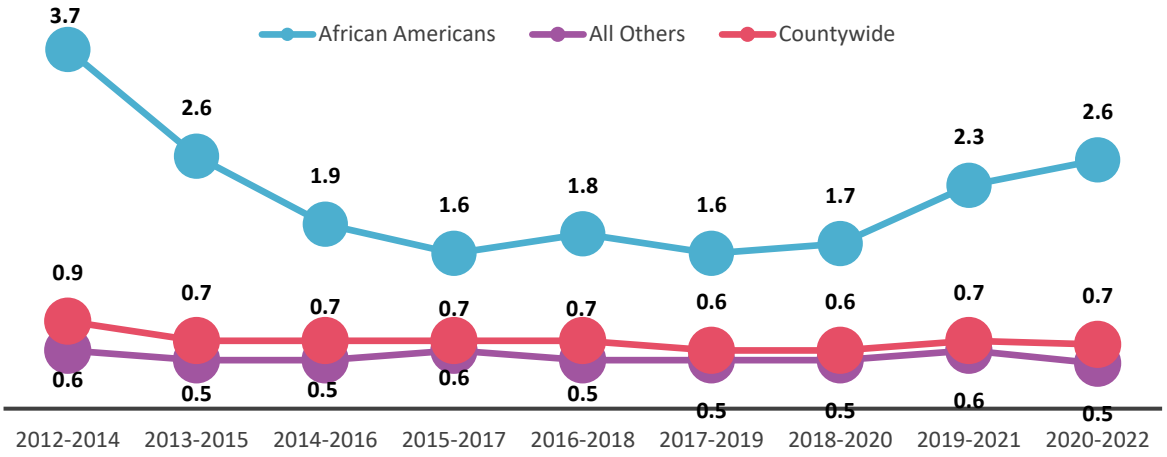
Source: Sacramento County Public Health (SCPH) Epidemiology Program Data Request. Rate is per 1,000 infants.

INFANT SLEEP RELATED DEATHS

Rolling rates of African American ISR deaths occurring in Sacramento County continued to increase following a significant long-term decrease between 2012-2014 (3.7 per 1,000 births) and 2017-2019 (1.6 per 1,000). As of 2020-2022, African American ISR deaths occurred at a rate of 2.6 per 1,000 births. The 2020-2022 rate was slightly higher than the Blue Ribbon Commission reduction goal rate (2.5).

Since 2012-2014, African American infant sleep-related deaths in Sacramento County decreased 32%. The disparity gap disparity gap between African Americans and all other races had a 32% net decrease.

Figure 6 — Three-Year Rolling Rates of Infant Sleep Related Deaths in Sacramento County



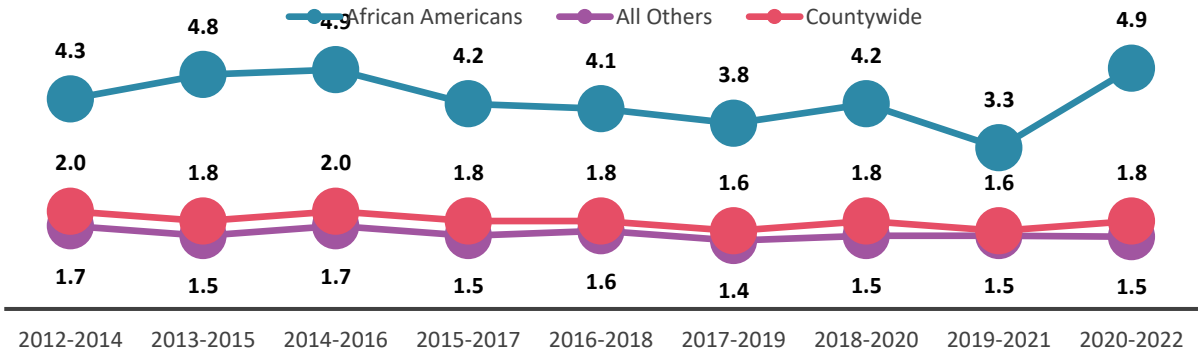
Source: 2012 through 2022 Sacramento County Child Death Review Team Reports. Rate is per 1,000 births.

INFANT DEATHS DUE TO PERINATAL CAUSES

During the 2012-2014 baseline period, African American infants died from perinatal causes at a rate of 4.3 per 1,000 births. Despite a promising decrease resulting in the lowest rate for African American infants in 2019-2021 (3.3 per 1,000 births), ISR deaths increased substantially as reflected in the 2020-2022 rolling rate (4.9 per 1,000 births). This rate is higher than the 2012-2014 baseline, and comparable to the peak in 2014-2016. In 2020-2022, African American infants died from perinatal causes at 3.3 times the rate of all others.

Sacramento County African American infant deaths due to perinatal conditions increased 14% since 2012-2014, and the disparity gap between African Americans and all other ethnicities increased 32%.

Figure 7 — Three-Year Rolling Rates of Infant Death Due to Perinatal Causes in Sacramento County



Source: 2012 through 2022 Sacramento County Child Death Review Team Reports. Rate is per 1,000 births.

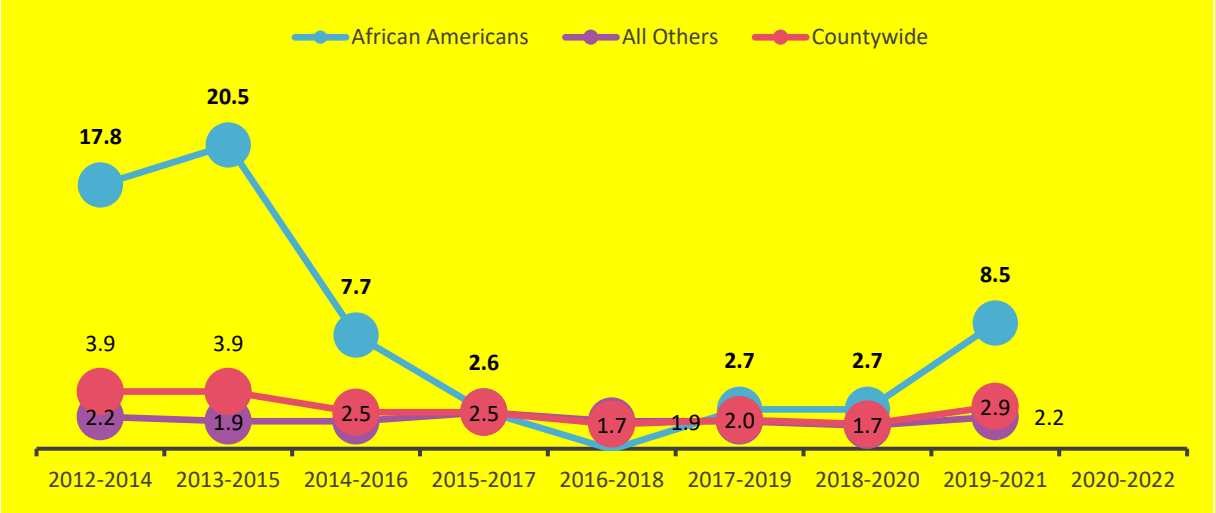
DEATHS DUE TO CHILD ABUSE AND NEGLECT (0-5)

During the baseline period of 2012-2014, African American children (0-5) died from **Child Abuse and Neglect (CAN)** at a rate of 17.8 per 100,000 children. Due in large part to the broad RAACD initiative efforts throughout Sacramento County, this rate drastically declined, reaching zero African American CAN deaths during 2016-2018. Since then, rates have increased (2.7 per 100,000 in 2017-2019 and 2018-2020, and 8.5 per 100,000 children in 2019-2021). In 2020-2022, rates [placeholder text pending data receipt]. However, despite these increases, rates reflect overall small numbers, with 2.7 per 100,000 representing one child, and 8.5 per 100,000 representing three children. Trends should be monitored and addressed but interpreted with caution.

Since 2012-2014, deaths due to child abuse and neglect (ages 0-5) decreased XX% among Sacramento County African Americans. The disparity gap between African Americans and all other races decreased XX%.

As of 2020-2022, the disparity gap reduced XX% compared with the 2012-2014 baseline. However, African American children remain XX times as likely to suffer a CAN homicide compared with all others.

Figure 8 — Three-Year Rolling Rates of Child (0-5) Death due to Child Abuse and Neglect in Sacramento County



Source: 2012 through 2022 Sacramento County Child Death Review Team Reports. Rate is per 100,000 children ages 0-5.

[i] Sacramento County Child Death Review Team: A Twenty Year Analysis of Child Death Data 1990 – 2009. http://www.thecapcenter.org/admin/upload/final%2020%20year%20cdrt%20report%202012_1%2026%2012.pdf

[ii] Blue Ribbon Commission Report on African-American Child Deaths, 2013. http://www.philserna.net/wp-content/uploads/2013/05/Blue-Ribbon-Commission-Report-2013.pdf

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Reduction of African American Child Deaths (RAACD)

FY 2023-24 Annual Report with Three-Year Trends

Table of Contents

RAACD Background & Goals

In 2011, the Sacramento County Child Death Review Team (CDRT) released a 20-Year Report which revealed that African American children were dying at twice the rate (102 per 100,000) of any other ethnic group.[i] In response to these alarming findings, the Sacramento County Board of Supervisors created the Blue Ribbon Commission on Disproportionate African American Child Deaths. In 2013, the Blue Ribbon Commission released a report with a set of specific goals to be achieved by 2020.[ii] The goals included an overall reduction in African American child deaths, and specific reductions for four leading preventable causes of disproportionate African American child deaths, including infant perinatal conditions, infant sleep-related, child abuse/neglect, and third-party homicides.

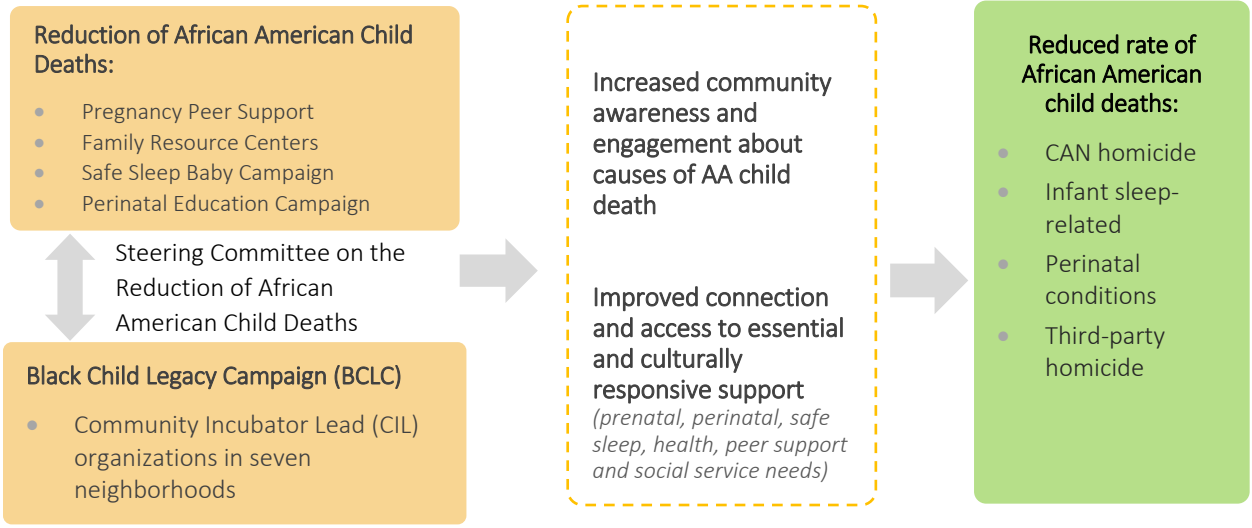
1. Reduce the African American child death rate by **10-20%**
2. Decrease the African American infant death rate due to infant **perinatal conditions** by at least **23%**
3. Decrease the African American infant death rate due to **infant safe-sleep** issues by at least **33%**
4. Decrease the African American child death rate due to **abuse and neglect** by at least **25%**
5. Decrease the African American child death rate due to **third-party homicide** by at least **48%**

The Blue Ribbon Commission report also called for the establishment of the Steering Committee on Reduction of African American Child Deaths (RAACD). Convened by the Sierra Health Foundation, the RAACD Steering Committee released a Strategic Plan[iii] and Implementation Plan[iv] in 2015. RAACD plans outlined strategies to address the top four causes of disproportionate African American child deaths Using a Collective Impact model harnessing the power of multiple county and community stakeholders and funding sources. Over time, these plans evolved into two interdependent components:

- The Black Child Legacy Campaign (BCLC): Led by the Sierra Health Foundation, Community Incubator Lead (CIL) organizations are located in each of the targeted neighborhoods and lead prevention and intervention efforts to reduce disproportionate African American child deaths.
- Reduction of African American Child Deaths (RAACD): Led by First 5 Sacramento, this strategy complements and contributes to BCLC. First 5 programs focus on preventing deaths due to Perinatal Conditions, Child Abuse and Neglect, and Infant Sleep-Related causes, including a *Pregnancy Peer Support Program, Family Resource Centers, the Infant Safe Sleep Campaign, and a Public Perinatal Education Campaign.*

The graphic below presents a strategic framework for how Sacramento County is coordinating efforts to reduce African American child deaths.

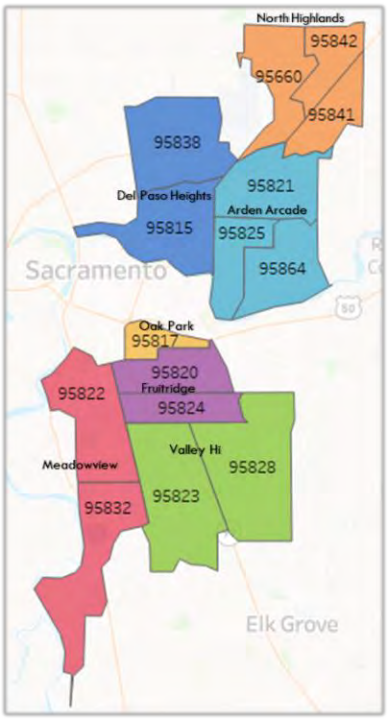
Figure 1. Sacramento County's Strategic Framework to Reduce African American Child Death



Note: There are many other programs and projects that are also working to decrease the rate of African American child deaths. The current report focuses on perinatal, infant, and child (0-5) deaths among African Americans and does not include deaths of all children 0-17.

To meet the Blue Ribbon Commission goals, efforts have focused on the Sacramento County neighborhoods with the highest rates of child death. Not only do these neighborhoods experience high proportions of child death, almost two-thirds of all African Americans that live in Sacramento County reside in these neighborhoods. These communities include:

- Arden Arcade
- Fruitridge/Stockton Boulevard
- Meadowview
- Valley Hi
- North Sacramento/Del Paso Heights
- North Highlands
- Oak Park



FIRST 5 STRATEGIES TO REDUCE AFRICAN AMERICAN INFANT AND CHILD DEATHS

To address the preventable causes of infant death and 0-5 child death, First 5 Sacramento has partnered with various community organizations to launch and implement four programs:

- Pregnancy Peer Support Program
- Family Resource Centers
- Safe Sleep Baby Education Campaign
- Public Perinatal Education Campaign

This report includes the ongoing evaluation of First 5 Sacramento's efforts, including FY 2023-24 outcomes for each strategy and recommendations about areas to strengthen.

PROGRESS TOWARD BLUE RIBBON COMMISSION GOALS

The Blue Ribbon Commission (BRC) identified 2020 as the year by which its initial goals should be met and if applicable, to reconvene and create a new set of goals. Available countywide data now surpass this benchmark year (data current as of 2022). However, rates continue to be measured by the 2020 goals, as the Steering Committee actively works to set updated goals. Sacramento County had key successes toward the BRC goals as of the 2020 benchmark, with countywide progress exceeding three of the four mortality reduction goals (among ages 0-5). In 2020-2022, the rate of perinatal deaths among African Americans was higher than the 2012-2014 baseline. Infant sleep related deaths also continued to increase, and CAN deaths XXXXXXXX, highlighting alarming new challenges in the RAACD focal areas.

It is important to note that some BRC goals do not align exactly with the focus of this report. BRC goals were developed with the entire Sacramento County infant, child, and young adult population (ages 0-17) in mind, whereas the RAACD Initiative, funded by First 5 Sacramento, provides services to families with children ages prenatal through age five. The figure below outlines the 2020 Blue Ribbon Commission goals, the goal status as of the 2020 benchmark, and the percent change for each goal area as of 2020-2022 (compared with the 2012-2014 baseline, based on 0-5 data). This information should be used when revisiting goals and fine tuning where funding should be focused to continue to promote positive change.

Progress toward Blue Ribbon Commission Goals to Reduce African American Child Deaths (ages 0-5)

2020 BRC Goal:	BRC Goal Status as of 2020 Benchmark *2012-2014 to 2018-2020*	As of Most Recent Data (2020-2022)...	
		% Change *2012-2014 to 2020-2022*	Disparity Gap *2012-2014 to 2020-2022*
10% to 20% reduction of African American **child deaths**	Goal Exceeded * 30% Reduction	XX% Reduction (ages 0-5)	XX% Reduction (ages 0-5)
At least 23% reduction of *infant deaths due to* ***perinatal conditions*** (ages < 1 month)	Goal Unmet 4% Reduction	14% Increase	32% Increase
At least 33% reduction of ***Infant sleep related*** *(ISR) deaths* (ages 0-1)	Goal Exceeded 54% Reduction	30% Reduction	32% Reduction
At least 25% reduction of child abuse and neglect (CAN) deaths	Goal Exceeded * 85% Reduction	XX% Reduction (ages 0-5)	XX% Reduction (ages 0-5)
At least 48% reduction of third-party homicides	Not funded or reported by First 5 Sacramento – see BCLC report		

* Not a direct comparison to the BRC goals as these were intended to reflect countywide progress for all children ages 0-17. Values presented here are limited to rates for children ages 0-5.

Pregnancy Peer Support Program

Her Health First (HHF) manages the Black Mothers United (BMU) pregnancy peer support program. BMU provides a community-based network of support to empower Black mothers during their pregnancies and the transition into motherhood through culturally relevant outreach, education, and individualized support.

For the **fifth** consecutive year, there were **zero newborn deaths** among infants born to BMU participants at program exit.

85% of infants were born **full term** and had a **healthy birth weight.**

The BMU program includes weekly check-ins with **pregnancy coaches, as well as access to doula care, lactation support, health resources, and social/educational gatherings**. The program is open to pregnant women prior to their 30th week of pregnancy who reside in Sacramento County and self-identify as African American.

Pregnancy coaches are Black/African American women from within the community who are trained to provide education, offer information about medical and social service options, and help mothers prepare for the birth of their child. Coaches provide individualized support through regular check-ins during pregnancy and up to 12 weeks postpartum, as well as recurring peer support events such as Mommy Mingles, birth education classes, lactation support groups, a weekly walking group, and The Last Nine birth story-sharing sessions.

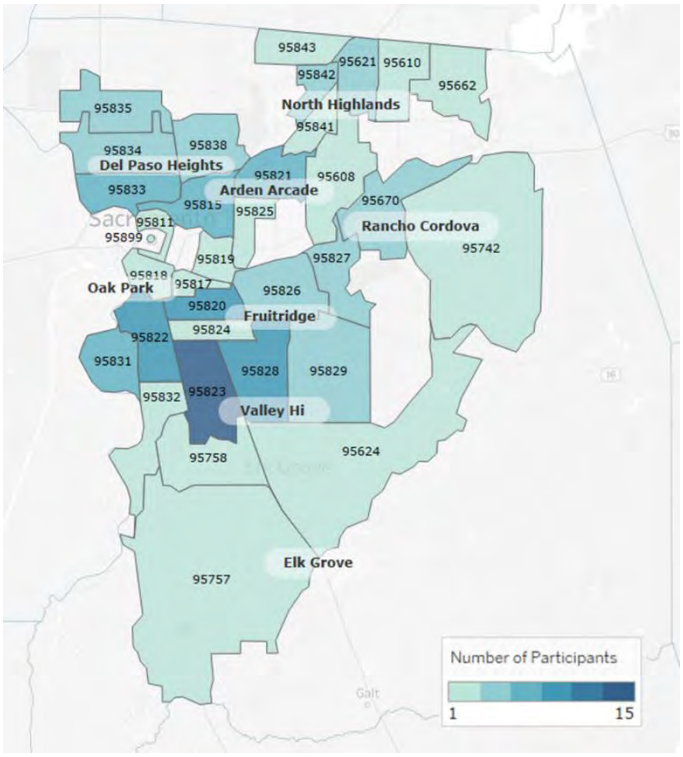
PROFILE OF CLIENTS

In FY 2023-24, BMU served 121 prenatal participants (81 new and 40 rollover),[1] as well as 19 participants who returned for supplemental postpartum services.[2]

More than half (53%) of the participants engaged this FY lived in one of the seven RAACD focal areas. Participants most frequently lived in the Valley Hi neighborhood (see map). The proportion of participants living in the RAACD focal zip codes decreased compared with FY 2021-22 (66%) and FY 2022-23 (59%).

The new and rollover participants (N = 121) commonly learned about the program via BMU outreach (32%) or from a friend, family, or neighbor (18%).

Figure 2. Residence of BMU Participants Served in FY



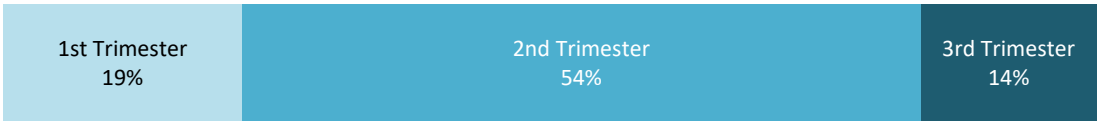
BMU clients reported an average of 2.3 **pressing needs** at intake. The most common pressing needs were pregnancy information and support

[1] Participants who enrolled in previous FY. New and rollover participants received BMU's prenatal services in FY 2023-24.
[2] For instance, participants who enrolled and delivered in a previous fiscal year but engaged in BMU's postpartum activities such as Mommy Mingle Support Groups, Navigation, Postpartum Visits, etc. during the FY.

(70%) and baby supplies (62%). Additionally, more than one-quarter of participants reported housing as a pressing need (27%).

Clients who enter the program earlier have more time to receive pregnancy education and necessary referrals, including support connecting to prenatal care earlier (as needed). While most participants enter the program during the second trimester, **about one in five participants joined during their first trimester each year**. Nineteen percent of participants receiving services in FY 2023-24 enrolled in their first trimester, compared with 20% in FY 2021-22 and 23% in FY 2022-23.

Figure 3. Number of Mothers Served, by Trimester of Entry



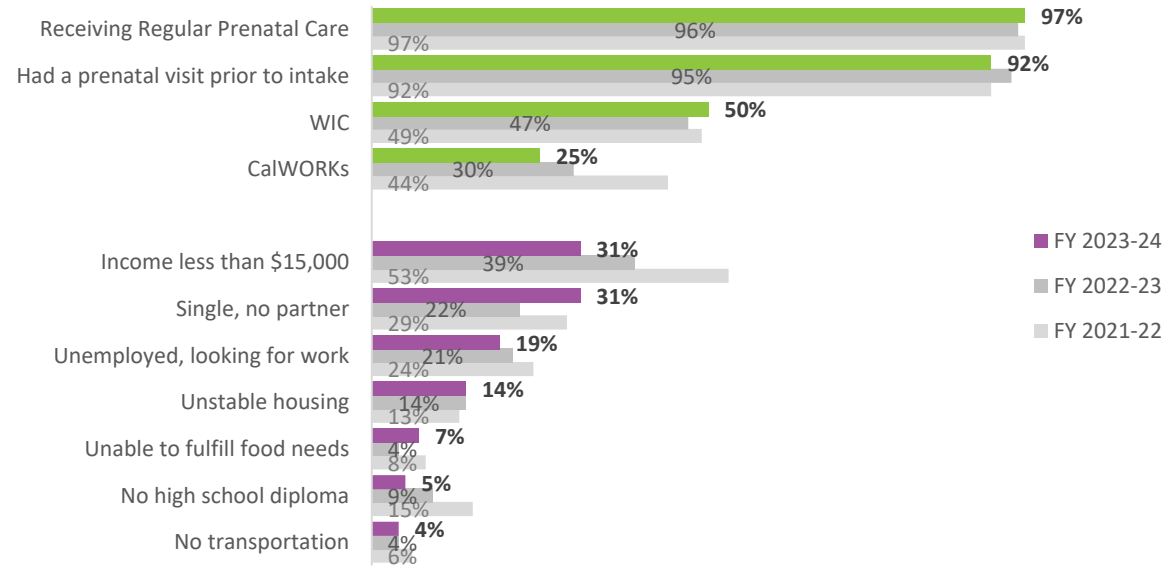
Source: BMU Service Records, Persimmony. N = 121. Excludes participants receiving postpartum services only in FY.

Oftentimes, BMU serves pregnant African American women with substantial needs that may be most at-risk of adverse pregnancy outcomes. The BMU pregnancy peer support program provides resources, referrals, and support to increase protective factors and reduce risks to the health and well-being of participants and their babies.

Participants' **protective factors** include utilization of WIC, CalWORKs, and the timely initiation and use of prenatal care. Nearly all participants completing an initial health assessment (N = 118) were receiving regular prenatal care (97%) and have had a prenatal visit (92%). Half (50%) of the participants were enrolled in WIC and 25% were on CalWORKs. WIC and CalWORKs are considered protective factors to support low-income participants, however not all BMU participants qualify or need this support.

In terms of other **socioeconomic characteristics**, nearly one-third (31%) reported a family income less than $15,000, one in five (19%) were unemployed and looking for work, and 14% had unstable housing (see additional characteristics below).

Figure 4. Protective Factors and Socioeconomic Characteristics at Intake, Three Year Trend

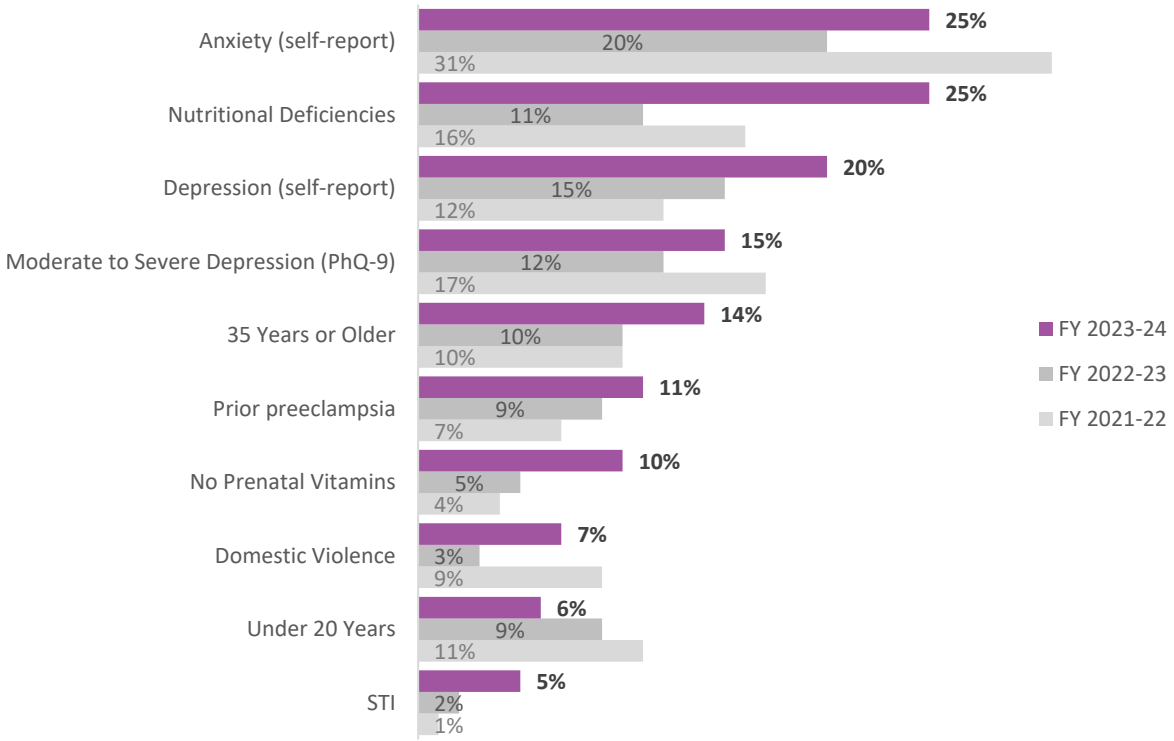


Source: Health Assessment Intake (N = 118) and Family Information Form (N = 102).

The most commonly self-reported **health risks** at intake were anxiety (25%), nutritional deficiencies (25%), and depression (20%). Additionally, PHQ-9 assessments (N = 110) showed that 15% of participants had moderate to severe depression. When combined, more than one-third (36%) of BMU participants had anxiety and/or depression at intake.[3]

36% of BMU clients were experiencing **anxiety and/or depression** at intake

Figure 5. Top Health Factors Reported at Intake, Three-Year Trend



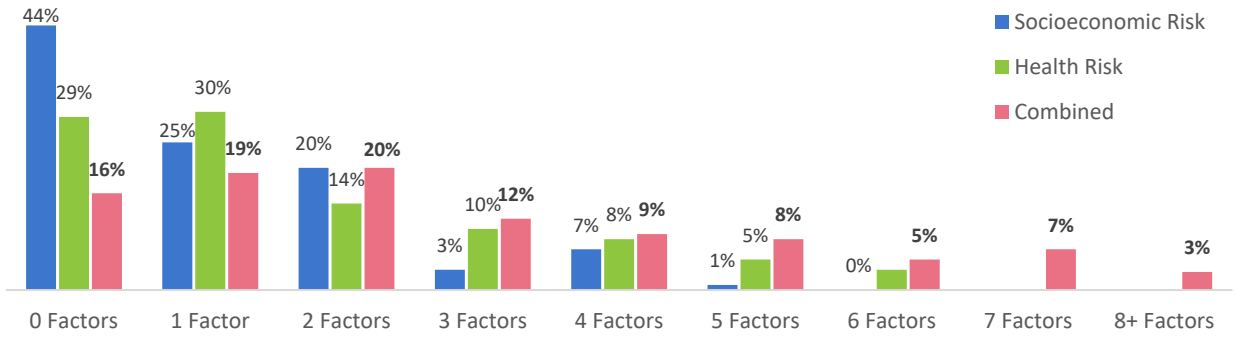
Source: Health Assessment Intake (N = 118) and PhQ-9 Assessment (N = 110), though response rates may vary for each variable. Chart includes most common health factors reported and does not represent all characteristics measured.

More than half of the participants served in FY 2023-24 reported at least one socioeconomic (56%) or health (71%) risk. When combined, more than four out of five (84%) BMU clients had one or more health and/or socioeconomic risk at intake (detailed breakdown below). Additionally, two out of five (39%) participants served during the FY had one or more pre-existing medical condition (e.g., asthma, high blood pressure, diabetes, obesity) at intake.[4]

84% of BMU clients had at least one **health and/or socioeconomic risk** factor at intake

[3] Unduplicated count of self-reported anxiety, self-reported depression, and/or moderate to severe PhQ9 depression scores. Does not represent the sum of these categories described independently.
[4] Reported pre-existing medical conditions (e.g., autoimmune diseases, kidney disease, obesity, diabetes, high blood pressure) are not included in total counts of socioeconomic and health risk factors.

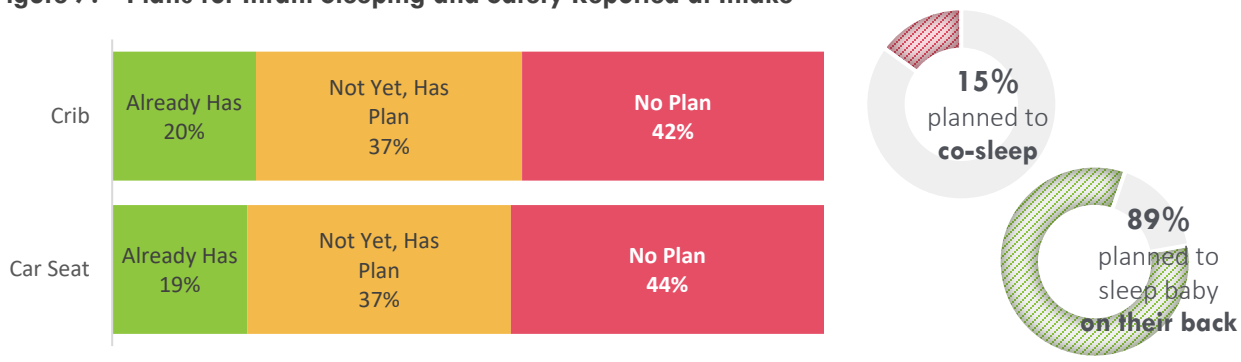
Figure 6. Percentage of Clients Experiencing Socioeconomic or Health Risks, by Number and Type



Source: Health Assessment Intake (N = 118), Family Information Form (N = 102), and PhQ-9 Assessment (N = 110).

BMU pregnancy coaches also provide support for **infant safety preparedness**. At intake, most participants did not yet have a crib (80%) or car seat (81%). Two out of five participants did not yet have a plan for a car seat (44%) or crib (42%). Additionally, 80% planned to sleep their baby in a crib and 83% planned to sleep their babies on their back. On the other hand, 15% of clients planned to co-sleep with their baby. Participants reporting plans to co-sleep increased compared with FY 2021-22 (9%) and FY 2022-23 (12%).[5]

Figure 7. Plans for Infant Sleeping and Safety Reported at Intake



Source: Health Assessment Intake. N = 118

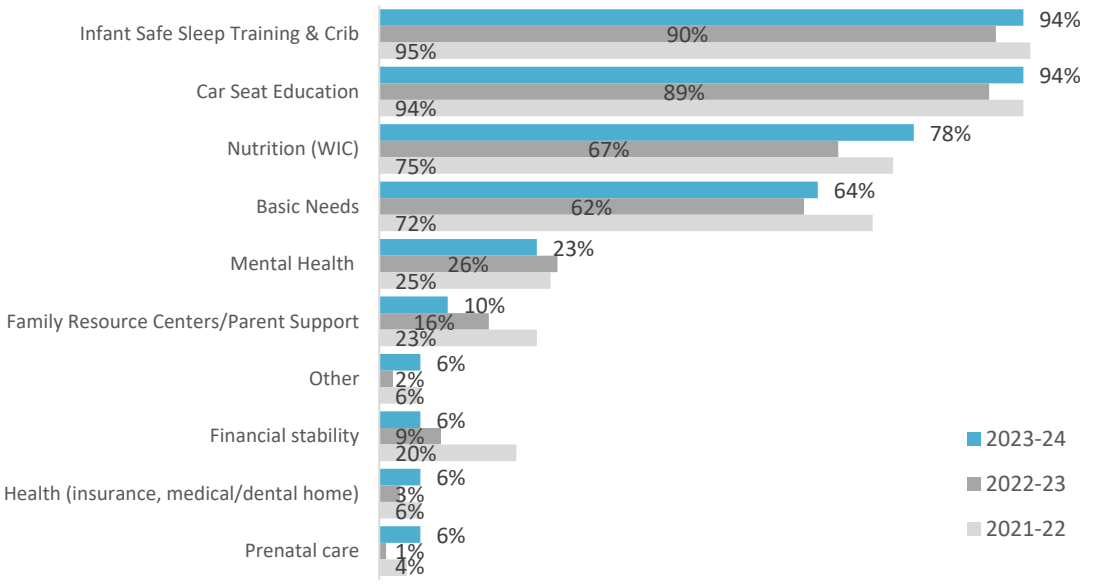
"I have enjoyed my time in Black Mothers United. Mommy Mingles are super inviting and everyone is always so friendly. My pregnancy coach was super helpful. She even picked me up and took me to the Mommy Mingles when I didn't have a way to get there. … **I like being in a group setting of moms where everyone looks like me, I don't feel isolated.** Since having my baby, I am now enrolled in school, and they sometimes help me with transportation to get there**. I still reach out to my pregnancy coach for advice** as well. Overall, I've had a great experience with BMU." - BMU Client

REFERRALS

BMU pregnancy coaches provide individualized referrals to other community support resources based on participants' needs and goals. Participants served in FY 2023-24 most commonly received referrals for infant safe sleep training (94%), car seat education (94%), and nutrition services (78%). The most commonly provided referrals have been similar across the past three fiscal years.

Figure 8. Most Common Referrals Provided to BMU Clients, Three-Year Trend

[5] Comparisons to behaviors following program support discussed in the "Changes in Risk and Protective Factors" section



Source: BMU Service Referral Log. N = 108, participants receiving prenatal services in FY 2023-24. For each item, denominator excludes participants who were "already receiving services." Chart includes most common referrals and does not represent all referrals provided.

Because referrals and follow-ups are ongoing, the next section explores the **closed-loop referral status** for 74 clients who received at least one referral and exited the program in FY 2023-24.[6] Pregnancy coaches assist participants with the referral process, provide warm handoffs, and follow-up with clients to identify if they were able to *receive services* from the provider.

For instance, 93% (68/74) of exited clients were referred for infant safe sleep. A HHF pregnancy coach provided Zoom and hybrid Safe Sleep Baby trainings or referred clients to other agencies, as needed. More than half of those who connected with another provider (58%, 7/12) reported that they received the safe sleep training. In most instances, **at least half of the clients who contacted providers were able to receive services**. The BMU program will begin using the First 5 Referral Portal in FY 2024-25, which will further strengthen families' direct connection to providers and services.

Figure 9. Type of Referrals Provided and Service Connections *among Exited Program Participants*

Referral Type	Referrals Provided		Referral Contacted		Received Services		Already Receiving
	#	%	#	%	#	%	#
Infant Safe Sleep Training and Crib	68	93%	12	18%	7	58%	1
Car Seat Education	66	93%	10	15%	9	90%	3
Basic Needs	45	65%	15	33%	8	53%	5
Nutrition (WIC)	43	77%	17	40%	10	59%	18
Mental Health	19	27%	10	53%	5	50%	4
Family Resource Centers/Parent Support	9	12%	3	33%	2	67%	0
Financial Stability	6	8%	1	17%	1	100%	1
Other	5	7%	2	40%	0	0%	0
Prenatal care	4	6%	4	100%	0	0%	6
Health (Insurance, Medical/Dental Home)	3	5%	2	67%	0	0%	8
Domestic Violence	2	3%	1	50%	1	100%	0
Previous High-Risk Pregnancy	2	3%	1	50%	1	100%	1
Help Me Grow	2	3%	1	50%	0	0%	0

[6] Participants receiving prenatal services in FY 2023-23, had at least one referral during their time in the BMU program, and exited the program during FY 2023-24 (Client Exit Form). Includes participants who exited for reasons other than program completion (e.g., lost contact or dropped out). As a result, closed loop data may not be complete for all participants.

School Readiness	2	3%	1	50%	1	100%	0
Alcohol, Tobacco, Drug	1	1%	0	0%	0	-	0
Child Care	1	1%	1	100%	1	100%	0
Home Visiting Program	1	1%	0	0%	0	-	0

Source: BMU Service Referral Log (N = 74). Because referrals are ongoing, service connections are assessed only for clients who have both a referral form and an exit form, therefore counts will not match referrals described above. *Referrals Provided* percentage denominator is exited clients minus clients who were already receiving services (no referral provided) which will vary from total for each item. *Referral Contacted* percentage denominator is total number of referrals provided. *Received Services* denominator is total number who contacted referral.

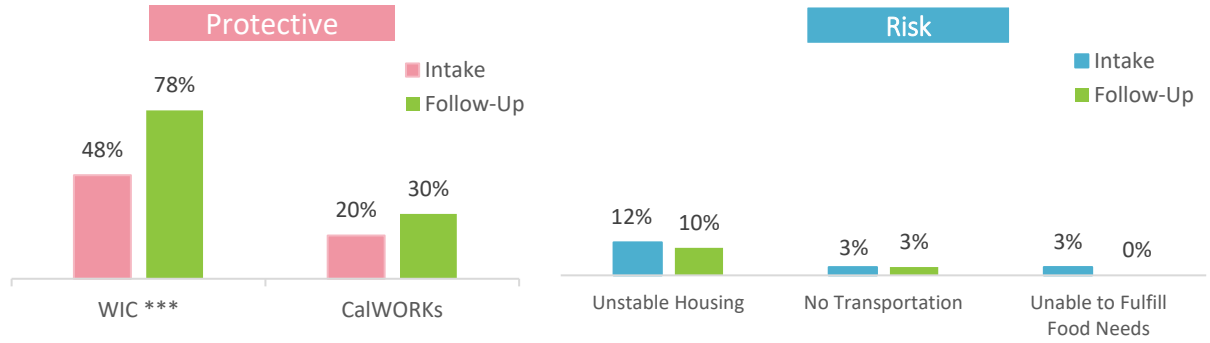
CHANGES IN RISK AND PROTECTIVE FACTORS

> "…everyone is so welcoming and supportive. **I feel so at home and comfortable** and it's refreshing to be around people who I can relate to."
> - BMU Client

BMU Pregnancy Coaches provide a postpartum visit with participants where they check-in on participants' self-reported health, safety, and socioeconomic conditions. The following section explores changes in risk and/or protective factors between intake and the post-delivery follow-up (n = 64).[7] For instance, enrollment in WIC as a **socioeconomic protective factor** significantly increased.[8] At intake, 48% of participants who delivered were enrolled in WIC, while 78% were enrolled in WIC post-delivery. CalWORKs enrollment also increased from 20% (12/60) at intake, to 30% (18/60) post-delivery, although changes were not statistically significant.

Reductions in risk factors further highlight the value of peer support on participants' connections to essential services for their families' stability and basic needs. At intake 12% were experiencing unstable housing, compared with 10% at follow up, and all participants reported that they were able to fulfill their family's food needs, post-delivery.

Figure 10. Change in Reported Socioeconomic Factors from Intake to Follow-up Assessment



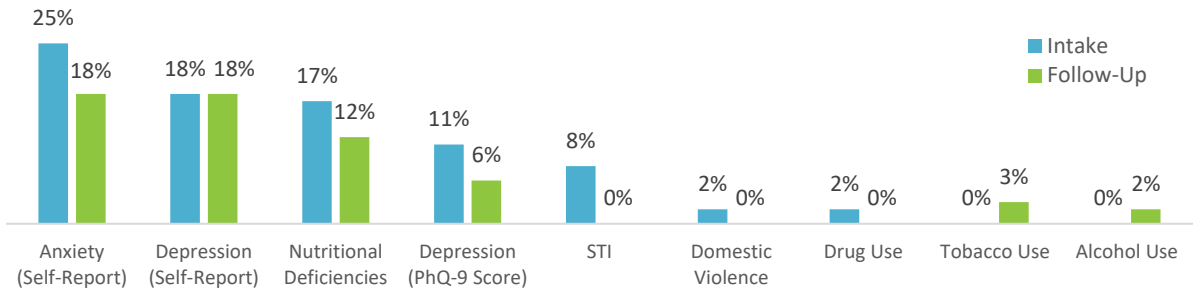
Source: Health Assessment Intake and Post-Delivery Follow-up matched set (N = 60). Ns for each item may vary due to missing data/non-responses. Statistically significant change (indicated on column names) reported as * $p < .05$, ** $p < .01$, *** $p < .001$.

Among the matched set of participants with intake and post-delivery assessments, the most prevalent **maternal health risk factors** were self-reported anxiety (25%), self-reported depression (18%), and nutritional deficiencies (17%). Similarly, about one in ten participants (11%) had moderate to severe depression scores, according to the PHQ-9 assessment. At follow up, a smaller proportion self-reported anxiety (18%) and nutritional deficiencies (12%). Additionally, 6% had moderate to severe PHQ-9 depression scores post-delivery. A small number of participants increased tobacco and/or alcohol use,

[7] This section is limited to participants who completed a health assessment at intake, delivered, *and* completed a post-delivery health assessment, although ns may vary per question due to missing item data.
[8] Statistically significant increase at $p < .001$.

which may refer to a few individuals who abstained during pregnancy but chose to use tobacco and/or alcohol post-delivery.

Figure 11. Change in Reported Health Factors from Intake to Follow-up Assessment

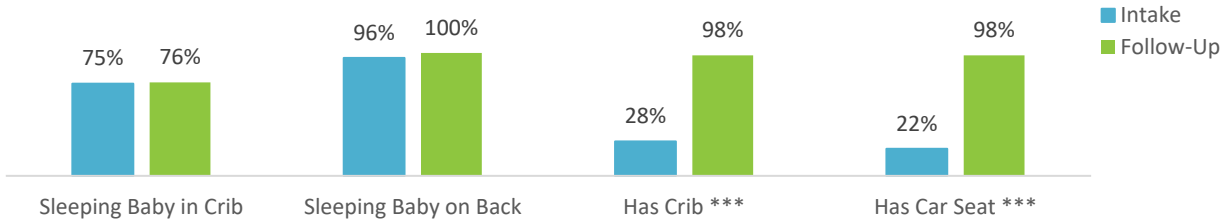


Source: Health Assessment (N = 60) and PhQ-9 Assessment (N = 55) Intake and Follow-up Matched Sets. Changes not statistically significant.

Participants also showed significant improvements in their **preparedness for infant safety**. About one in five (22%) had a car seat at intake, compared with all but one participant (98%) post-delivery. Similarly, 28% reported that they had a crib for their baby at intake, compared with 98% post-delivery. Additionally, all participants reported they slept their baby on their back, while 76% said their baby was sleeping exclusively in a crib.

At follow-up, **100%** of participants were **sleeping babies on their back.**

Figure 12. Change in Reported Infant Safety Practices from Intake to Post-Delivery Follow-Up



Source: Health Assessment Intake and Follow-Up Matched sets; N = 65. Statistically significant change (indicated on column names) reported as * $p < .05$, ** $p < .01$, *** $p < .001$.

BIRTH OUTCOMES

There were 66 infants born to mothers served in FY 2023-24,[9] including 64 singletons and one set of twins (two infants). One-quarter (26%) of the 65 deliveries were C-Sections and eight babies initially stayed in the NICU. For the fifth consecutive fiscal year, there were **zero newborn infant deaths** reported as of the mothers' postpartum follow-ups. There were also no stillborn births for the second consecutive year.

Of the 66 infants, 94% (62/66) were born at a healthy birth weight, 91% (60/66) were born full term, and combined, **85% (56/66) had an overall healthy birth (healthy birth weight *and* full term)**. On the other hand, nine infants were born low birth weight or preterm (14%). There were no infants born with low birth weight and pre-term, however gestational age was unknown for one infant. The proportion born preterm (9%) was lower than FY 2021-22 (11%, 8/71) but higher than FY 2022-23 (6%, 4/67). The proportion of infants born with low birth weight (6%) was lower than FY 2021-22 (10%, 7/71) and FY 2022-23 (9%, 6/67).

BMU participants who received doula services during their time in the program had promising birth outcomes. In FY 2023-24, there were 26 infants born to mothers who received BMU doula support.

[9] Births documented in FY 2023-24, including births to rollover clients who joined in prior FY.

Among them, only one was born preterm, and one was low birth weight. The table below describes birth outcomes for infants. Further, a list of family socioeconomic and health characteristics is detailed in Appendix 1 for each birth with at least one adverse outcome.

Figure 13. Birth and Perinatal Outcomes of Pregnancy Peer Support Clients

	All Infants (N = 66)		Twins (n = 2)		Singletons (n = 64)		Served by Doula (n = 26)	
Live Births	66	100%	2	100%	64	100%	26	100%
Favorable Outcomes								
Healthy birth weight	62	94%	2	100%	60	94%	25	96%
Full term birth	60	91%	2	100%	58	91%	25	96%
Healthy birth weight *and* full term	56	85%	2	100%	54	84%	24	92%
Unfavorable Outcome								
Low birth weight *(< 5 lb, 8 oz)*	4	6%	0	0%	4	6%	1	4%
Preterm birth *(< 37 weeks)*	6	9%	0	0%	6	9%	1	4%
Low birth weight *and* preterm	0	0%	0	0%	0	0%	0	0%
Newborn death	0	0%	0	0%	0	0%	0	0%
Stillborn	0	0%	0	0%	0	0%	0	0%

Source: Birth Outcomes – Baby and Post-Delivery Health Assessment. Served by Doula section refers to infants born to mothers who received any doula service, some of which may have been prenatal services only, not a doula-supported birth. Infants born to mothers served by doula are also represented in the total births.

Longitudinal Outcomes of BMU Participants

There were 241 infants born to mothers in the BMU program during the 2020 through 2022 calendar years. Unfortunately, one infant passed away due to a sleep related (SUIDS) death at approximately five months of age. This equates to an infant mortality rate of 4.1 per 1,000 births in the three-year period. The countywide African American infant death rate in 2020-2022 was 12.0 per 1,000 births overall (see Appendix 3), and 2.6 per 1,000 births for sleep-related deaths.

Note: This review includes infants born to BMU participants served in 2020 through 2022 for consistency with countywide CDRT data. Public Health data used for this lookup are available through 2023 which ensures 12-month outcomes for all BMU infants.

The figure below represents the prevalence of various protective and risk factors compared with the different profiles of birth outcomes: *Healthy births* (neither low birth weight, nor preterm) or o*ne unhealthy birth outcome* (low birth weight *or* preterm). There were no participants with *Both unhealthy birth outcomes* (low birth weight *and* preterm) this FY, so this group is excluded from analysis. [10] In both groups, all or most participants who delivered were receiving regular prenatal care, taking prenatal vitamins, and had their first prenatal visit during the first trimester. Among the socioeconomic risk, participants in both groups were most likely to report an income below $15,000 and being unpartnered. A larger portion of those with an unhealthy birth outcome identified a preexisting medical condition (60%, 6/10) compared with those with healthy births (36%, 20/56). Additionally, four out of 10 participants with an unhealthy birth outcome (40%) were ages 35 or older, compared with 14% (8/56) of those with a healthy birth. However, comparisons between groups should be interpreted with caution due to large differences in group size and small numbers of births with unhealthy birth outcomes.

[10] Interpret comparisons between groups with caution due to large difference in group size.

Figure 14. Birth Outcomes and Health and Socioeconomic Factors Identified at Intake

Pregnancy Risk and Protective Factors at Intake	Healthy Births (n = 56)		LBW *or* Preterm (n = 10)		LBW *and* Preterm (n = 0)	
Protective Factors	n	%	n	%	n	%
Receiving Regular Prenatal Care	51	91%	10	100%	-	-
Taking Prenatal Vitamins	51	91%	9	90%	-	-
Prenatal visit in first trimester	49	88%	9	90%	-	-
Enrolled in WIC	23	41%	6	60%	-	-
Receiving CalWORKs	8	14%	5	50%	-	-
Socioeconomic Risks	n	%	n	%	n	%
Household Income less than $15,000	13	23%	4	40%	-	-
Single, Unpartnered	11	20%	3	30%	-	-
Unemployed, Looking for Work	7	13%	1	10%	-	-
Unstable Housing	6	11%	1	10%	-	-
Unable to Fulfill Food Needs	2	4%	0	0%	-	-
Did Not Graduate High School	1	2%	1	10%	-	-
No Transportation	1	2%	1	10%	-	-
Maternal Health Risks	n	%	n	%	n	%
One or more pre-existing medical condition†	20	36%	6	60%	-	-
Anxiety (Self-Report)	13	23%	2	20%	-	-
Depression (Self-Report)	10	18%	2	20%	-	-
Nutritional Deficiencies	9	16%	2	20%	-	-
35 years or older	8	14%	4	40%	-	-
Moderate to Severe Depression (PhQ-9)	6	11%	0	0%	-	-
STI	5	9%	0	0%	-	-
2+ Prior Miscarriages	4	7%	0	0%	-	-
Prior Preeclampsia	4	7%	3	30%	-	-
High Stress Level (quite a bit or very)	3	5%	4	40%	-	-
Under 20 years old	2	4%	1	10%	-	-
Prior Gestational Diabetes	2	4%	0	0%	-	-
Has child under a year old	2	4%	0	0%	-	-
Domestic Violence	1	2%	1	10%	-	-
Prior Preterm Birth(s)	1	2%	3	30%	-	-
Prior Low Birth Weight Delivery	1	2%	2	20%	-	-
Drug Use	1	2%	1	10%	-	-
Prior Stillbirth(s)	1	2%	0	0%	-	-
Alcohol Use	0	0%	0	0%	-	-
Tobacco Use	0	0%	0	0%	-	-
Program Factors	M	SD	M	SD	M	SD
Gestational Weeks at BMU Intake	20.5	7.2	21.1	7.9	-	-
Gestational Weeks at First Prenatal Visit[11]	8.1	2.9	8.4	4.3	-	-
Number of BMU Weekly Check-Ins	20.6	14.2	15.4	13.2	-	-

Source: Health Assessments (intake and post-delivery), Birth Outcomes Form, and Service Records (N = 66)
† Pre-existing medical conditions include AIDS/HIV+, asthma, autoimmune disease, cancer, diabetes (Type I/II), high blood pressure, gastrointestinal diseases, kidney disease/UTI, obesity, polycystic ovary syndrome, thyroid disease, or other health condition.

[11] Participant information on gestational weeks at first prenatal visit not available for six (9%) of the 67 infants born.

FACTORS ASSOCIATED WITH HEALTHY BIRTH OUTCOMES

Next, a series of statistical analyses were conducted to further understand factors associated with **healthy birth outcomes**. Three cohorts of BMU clients (FY 2021-22 through FY 2023-24) were combined to increase statistical power.[12] It is important to note that these analyses identify statistical relationships among characteristics, but *do not* imply causation. It is likely that other unmeasured factors contribute to the relationship between the characteristics described here.

This section explores the impact of various risk factors on three major outcomes:

- A binary outcome of whether the birth was **healthy** (neither LBW nor preterm) (yes/no).
- A numerical, continuous outcome of all reported **birth weights**.
- A numerical, continuous outcome of all reported **gestational ages**.

ASR entered correlated variables into a regression model to determine how each characteristic independently predicted birth outcomes in the larger model.[13] Regressions can discern if a variable can independently predict an outcome variable, over and above the influence of any other covariates. *Variables that were not marginally or significantly correlated with birth outcomes were not included in regression models since they did not have a statistical relationship or impact on one another.*[14]

BMU check-ins with a pregnancy coach and BMU **doula services** were significantly correlated with more positive birth outcomes.

The first regression explored factors independently predicting the dichotomous measure of whether the birth had both healthy outcomes (yes/no). Participants who reported more **pressing needs** at intake had significantly reduced odds of a healthy birth. Having a **child under age one** was marginally significant at predicting reduced odds of a healthy birth, and **receiving BMU doula services** was marginally significant at predicting increased odds of a healthy birth.

Having a **child under the age of one** also significantly predicted a lower birth weight. Participants reporting regular prenatal care at intake was marginally significant with birth weight, although the relationship was in the unintended direction and likely spurious (meaning misleading, caused by random chance) due to the vast majority of participants reporting regular prenatal care. Since the significance is only marginal, this relationship can be monitored but no action or concern is warranted at this time.

Regression analyses identified several variables that each significantly predicted gestational age at birth. **Prior gestational diabetes, prior preterm birth(s),** having a **child under the age of one, high stress** levels**,** and the number of **pressing needs** reported at intake each independently predicted lower gestational age. On the other hand, having a higher number of **weekly BMU check-ins** independently predicted a higher gestational age.

The table below displays the factors that independently predicted each birth outcome of interest. Additional details for the logistic and linear regressions are available in Appendix 2.

[12] Combined data sets resulted in a total sample size of 204 live births. Includes duplicate records when clients re-entered BMU for subsequent births and/or had multiple gestations (twins).
[13] Includes variables marginally and significantly correlated ($p < .10$).
[14] See Appendix 2 for analytical details, including outcomes of bivariate correlations for inclusion in regression models, as well as the statistical outcomes of the three multivariate regression models.

Figure 15. Factors that Independently Predict Birth Outcomes[15]

Risk/Protective Factors at Intake	Healthy Birth *(Dichotomous; Y/N)* *N =154*	Birth Weight *(Continuous)* *N = 154*	Gestational Age *(Continuous)* *N = 148*
Number of Pressing Needs at Intake	●		●
Has a Child Under One Year of Age	*M*	●	●
Prior Gestational Diabetes			●
Prior Preterm Birth			●
High Stress Level at Intake			●
Number of BMU Check-Ins			●
Received BMU Doula Service(s)	*M*		
Regular Prenatal Care at Intake		*M*	

Source: Health Assessment Form(s), Birth Outcomes Form, and Exit Form. Statistical significance reported as (blue dot) = at least $p < .05$, *M* marginal significance at $p < .10$.

It is important to note that regression model outcomes exclude the unmeasurable structural level characteristics that may impact birth outcomes (e.g., adverse childhood experiences; the long-term toll of racism and/or socioeconomic conditions on the mother's health). Additionally, several factors which significantly predict less desirable birth outcomes may be outside the scope of program services. Regardless, these results may provide guidance for future countywide and program focus.

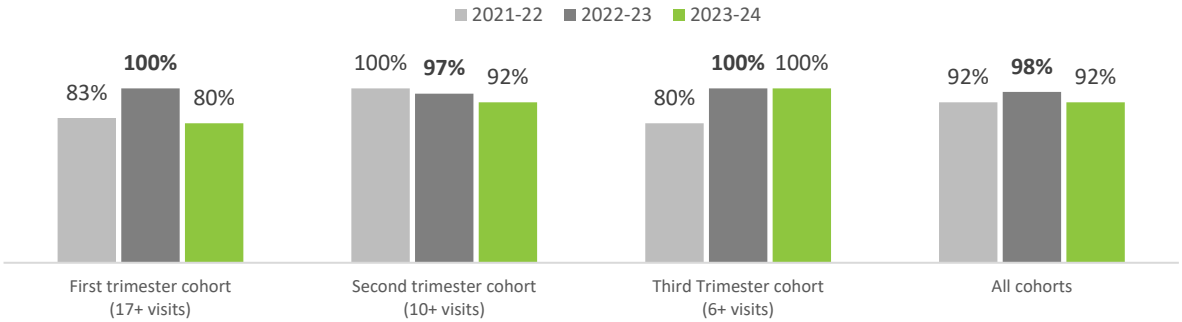
LEVEL OF PROGRAM COMPLETION

Program completion is defined as completing the minimum prenatal service requirements based on the trimester of entry[16] and a postpartum visit with the BMU pregnancy coach. Partial completion is defined as completing one but not both requirements. Participants who exited without completing either requirement are categorized as *not* completing the program.

Retention of program participants may be a challenge, particularly among those with several pressing needs. Additionally, residual effects of the COVID pandemic continue to pose challenges for families served by BMU (e.g., varied comfort levels with Pregnancy Coach transportation/in-person check-ins, clients return to work impacting availability for coaching sessions). Despite this, **92%** of the 59 mothers who delivered *and exited* the program during FY 2023-24 **completed the minimum number of prenatal visits with a BMU coach** based on their trimester of entry.[17] The proportion of participants who delivered and exited who completed the minimum prenatal dosage was the same as FY 2021-22 (92%) and slightly lower than FY 2022-23 (98%).

[15] Each regression model included variables correlated with the corresponding outcome. See Appendix 2 for full analysis details.
[16] Minimum prenatal service requirements are specified for each trimester at entry as women who enter the program earlier in their pregnancy have more time between program entry and anticipated delivery. The minimum service requirement for women entering during their first trimester is 17 prenatal visits; second trimester entries should complete ten or more prenatal visits; and third trimester entries should have six or more prenatal visits.
[17] N = 54/59. Includes participants who may have joined the program in the prior FY if delivered and exited during FY 2023-24. Excludes participants who exited during FY 2023-24 but delivered in FY 2022-23.

Figure 16. Prenatal Service Dosage Completion among Participants who Delivered during Fiscal Year, by Trimester Cohort of Entry, Three-Year Trend



Source: Exit Form. Excludes clients who delivered but did not have a completed exit form, as the dosage status is unknown. FY 2021-22 N = 51, FY 2022-23 N = 49, FY 2023-24 N = 59,

> "The program has given me great advice on pregnancy in general, but my biggest take away was the breastfeeding advice.
>
> Everyone there is so helpful and does everything they can to help with resources. It was heart feeding to have my coach check on me. I look forward to mommy mingles every month."
>
> – BMU Client

Another essential component of the Pregnancy Peer Support model is the **postpartum support provided by coaches**. These visits typically occur within 30 days of delivery and offer an opportunity for coaches to learn about the delivery, check in on mom and baby's well-being, complete postpartum paperwork, and provide any additional referrals needed. All participants (100%, 59/59) who delivered and exited during FY 2023-24 met with their pregnancy coach for at least one postpartum visit.

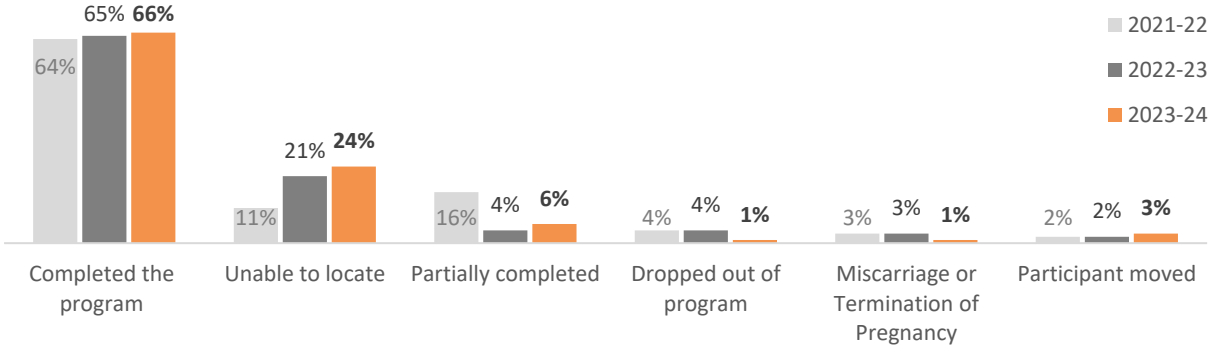
At follow-up, 89% of infants born in FY 2023-24 had a well-baby visit with a pediatrician, a larger proportion than FY 2021-22 (80%) and comparable to FY 2022-23 (90%). The proportion of babies exclusively breastfed in the hospital (70%, 46/66) decreased compared with FY 2022-23 (79%) and was slightly higher than FY 2021-22 (68%). BMU participants in-hospital exclusive breastfeeding rates exceed the state and Sacramento County averages for African Americans.[v] As of their postpartum follow up with BMU, 58% of infants were exclusively receiving breastmilk. Exclusive breastfeeding rates decreased compared with 72% in FY 2022-23 but remained higher than FY 2021-22 (51%). Overall, **four out of five BMU infants born in FY 2023-24 (83%) were receiving breastmilk**, exclusively or in combination with formula. This highlights the effectiveness of the program's focus on lactation focus via "Titty Talks" support groups, the Lactation Support Specialist, and pregnancy coaches. Increased rates of combination feeding may be related to post-COVID return to work policies, WIC or CalWORKs eligibility during maternity leave/postpartum, and the lack of weekly check-ins during the postpartum period.

Among *all participants who exited* the BMU program in FY 2023-24 (regardless of exit reason),[18] nearly two-thirds (66%, 67/102) completed both the minimum number of prenatal visits and a postnatal visit with their coach. Another 6% exited after completing one, but not both, of the two requirements.[19] One-quarter of the exits (24%) were participants who were exited due to lost contact/unable to locate. A small number of participants moved (3%), dropped out (1%), or miscarried or terminated the pregnancy (1%). The proportion of participants for whom BMU lost contact increased between FY 2021-22 (11%), FY 2022-23 (21%), and FY 2023-24 (24%). This may warrant a deeper dive into the experiences of those who are

[18] May include participants who did not receive services during FY 2023-23 as some individuals exited due to lost contact or drop out between fiscal years.
[19] Five out of six individuals completed a postpartum visit but did not complete the minimum prenatal visits based on their trimester of entry.

not following through with the program such as communication preferences, competing priorities, or challenging circumstances. Staffing challenges continue to impact participants' consistency in the program. During FY 2023-24, three pregnancy coaches were on leave at various points in the FY. BMU may have challenges maintaining contact with participants during staffing shortages as well as maintain the interest of participants who built strong rapport with one individual. BMU leadership reprised the position of Enrollment Specialist to focus efforts on strategies for recruitment, enrollment of pregnant clients and to support retention efforts. However, the Enrollment Specialist left the agency to pursue her own business. Despite this, staff and leadership continue to implement creative strategies to increase opportunities to engage participants. For instance, the Weekly Walking group emerged in response to bring participants into the program to complete paperwork and check-ins while engaging in healthy physical activity and getting fresh air. BMU also began a strengths-based approach to screen and match clients to a pregnancy coach. Staff will also follow up about one month after enrollment and "rematch" a client, if needed, to ensure the most cohesive match and increase the likelihood of retention.

Figure 17. Status at Program Exit, Three-Year Trend



Source: BMU Exit Forms, FY 2021-22 (N = 96), FY 2022-23 (N = 98), and FY 2023-24 (N = 102)

CLIENT SUCCESS STORY: BLACK MOTHERS UNITED

Shanice (fictional name) is a 26-year-old expecting her first child. Her boyfriend learned about BMU through an outreach event at his job. Shanice has minimal family support and enrolled in BMU for guidance through her first pregnancy journey. She received an individualized care plan to map out which services and referrals best fit her needs. She also began attending monthly "Mommy Mingle" support groups which included discussion topics like pregnancy health, self-care, and community resources. Shanice also received baby supplies, like clothes, diapers, and a gift card.

Shanice and her boyfriend participated in a childbirth class provided by BMU where they learned about pain management and comfort measures to prepare for labor and delivery. Shanice also received referrals for housing and rental assistance, food support, and car seat safety training.

Shanice's pregnancy coach also attended her birth in-person, where she helped advocate for Shanice's needs and follow her birth plan as closely as possible. Because of the support received, Shanice felt better equipped for what to expect during delivery and was able to use the comfort techniques she learned. Their son was born at a healthy weight and gestational age. Shanice continues to maintain a close relationship with her pregnancy coach and regularly attends BMU events to share her birthing experience with other expectant parents.

"My experience with Black Mothers United was a different and loving experience. … I built a relationship with … my [coach] while I was pregnant. Later down the line I started attending gatherings [like Mommy Mingles and Friday Walks]. **I was so blown away by how kind and loving the environment was. I felt so welcomed and seen for my skin color…**

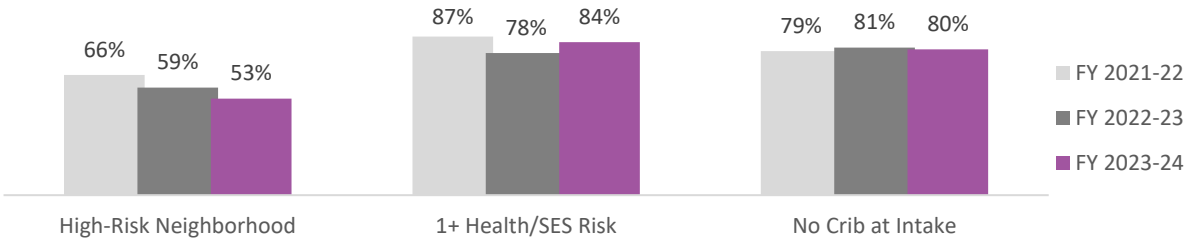
They care deeply about the Black community. They give so much. I have not had to buy not one diaper because they have been providing them for me. The events are definitely well worth it and being able to see other moms out and enjoying [themselves]…" – "Shanice," BMU Client

THREE-YEAR TRENDS, FY 2021-22 THROUGH FY 2023-24

Between FY 2021-22 and FY 2023-24, BMU served an average of 150 participants each year, providing culturally relevant outreach, education, empowerment, and pre- and postnatal individualized support. Most participants were experiencing key vulnerabilities and pressing needs during their pregnancy.

- At least half of the participants lived within the seven designated high-risk neighborhoods, although the proportion has been declining, suggesting a broader reach of services.
- A majority of participants had at least one health and/or socioeconomic risk factor at intake, and about one-third had one or more pre-existing medical condition.[20]
- On average, participants reported at least two pressing needs at intake. The most common needs were Pregnancy Information/Support, Baby Supplies, and Housing.[21]
- At intake, four out of five BMU participants did not yet have a crib for their baby.

Figure 18. Three-Year Risk Factors (2021-22 to 2023-24)



Each year, nearly two-thirds of participants entered the program during their **second trimester** and one in five entered during their first trimester. BMU clients have consistently shown improvements in protective factors, safe sleep practices, access to resources, and decreased health risks and psychosocial barriers. Among participants with intake and follow-up health assessments, BMU clients typically:

- Increased connections to WIC and CalWORKs as protective factors
- Increased access to stable housing, transportation, and were able to fulfill food needs
- Decreased the prevalence of moderate to severe depression (PHQ-9) and anxiety

All or most participants reported engaging in **safe sleep practices** with their baby. Each year at follow up, all participants (100%) were sleeping their baby on their backs, and 98% of participants had a crib. Most participants said that their baby was sleeping exclusively in a crib, however the proportion of participants using *only* a crib decreased in FY 2023-24 (76%) compared with FY 2021-22 (100%) and FY 2022-23 (96%).

[20] Data available for 2022-23 (30%) and 2023-24 (39%) only due to change in wording of Health Assessment questionnaire.
[21] FY 2021-22: 61% Pregnancy Info, 76% Baby Supplies, 26% housing; FY 2022-23: 74% Pregnancy Info, 66% Baby Supplies, 22% Housing; FY 2023-24: 70% Pregnancy Info, 62% Baby Supplies, 27% Housing. Participants can select multiple pressing needs.

Overall, BMU participants had favorable **birth and perinatal outcomes** between FY 2021-22 and FY 2023-24.

- At least four out of five babies had a healthy birth weight and were full term each year.
- In FY 2022-23 and FY 2023-24, nine out of ten infants had a well-baby check with a pediatrician (90% and 89% respectively), an increase from FY 2021-22 (80%).
- Most participants reported exclusively breastfeeding in-hospital, and at least three-quarters were receiving breast milk either exclusively or in combination with formula at follow up.

Between FY 2021-22 and FY 2023-24, BMU check-ins with a pregnancy coach were significantly correlated with more positive birth outcomes (healthy birth weight and/or gestational age). Participants' pressing needs at intake and other health risks significantly predicted less desirable birth outcomes. These patterns may highlight the added vulnerabilities of mothers served by BMU and the importance of these services in Sacramento County.

Each year, there were zero newborn infant deaths reported at participants postpartum follow up. Additionally, in partnership with Public Health, First 5 has completed look-up of deaths within the first 12-months of life for infants born to mothers in the program. Among all BMU births in 2020, 2021, and 2022, there was unfortunately one SUIDs death. This reflects a three-year rate of 4.1 per 1,000 births in the BMU program, compared with a countywide total of 12.0 per 1,000 African American births for the same period.

OPPORTUNITIES FOR IMPROVEMENT

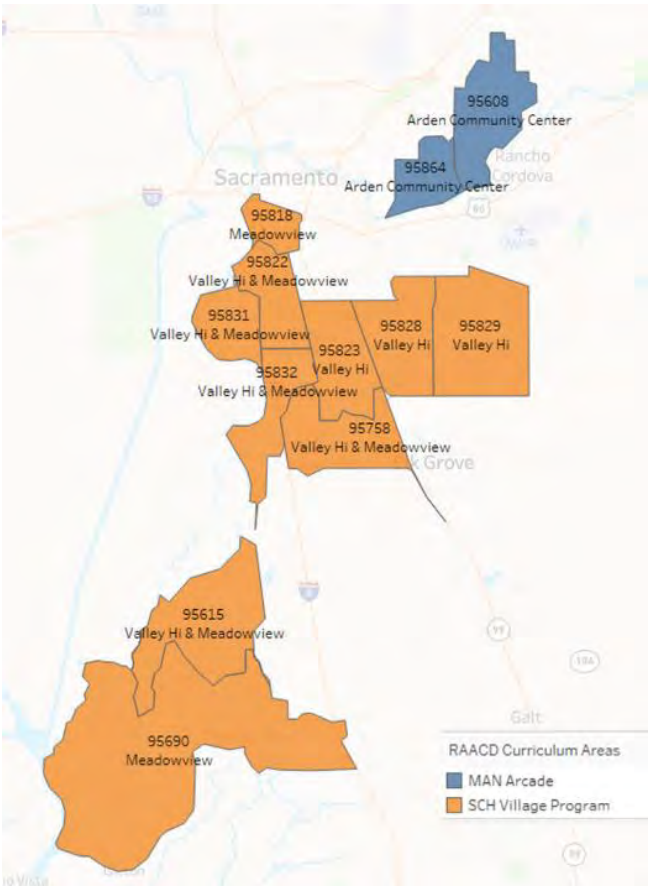
The BMU program has a positive impact on participants served. Her Health First continues to seek sustainable funding activities to enhance and expand Doula and Lactation support services to further support positive birth and breastfeeding outcomes. The following items highlight areas for Her Health First and their funder(s) to consider to support the availability and quality of these highly-valued services.

1. Improve client **retention** by utilizing a strengths-based approach for screening and matching clients with coaches that will best meet their personality and pregnancy needs and seek additional ways to obtain and include client feedback in program plans. Continue employing creative strategies to keep clients engaged in the program, such as the weekly walking group established by staff to invite participants on site for a healthy way to interact and bond. As coaches see more circumstances where active participants stop responding to attempted contacts, staff may wish to continue identifying strategies that work for participants' schedules, interest, and preferred means contact.
2. Increase outreach, enrollment, and program access. Strategies may include:
    - Build connections with local clinics for improved referrals and coordination of services.
    - Build connections with health plans to investigate opportunities for referrals, billing, and reimbursement, particularly through CalAIM.
    - Reaffirm established partnerships and use fresh approaches to engage untapped potential referral partners and revitalize BMU's presence in the Sacramento community.
    - Identify gaps or additional outreach strategies needed to reach areas or populations which may not currently be accessing the program as easily as others.
3. Provide **training and development opportunities** to assist coaches in establishing trusted relationships that enable high frequency of weekly check-ins to promote positive birth outcomes. Further, incorporate more staff supports to ensure retention and wellbeing of program staff (e.g., staff mindfulness workshops, trainings, supports to prevent burnout and secondary trauma, employee experience surveys, suggestion boxes, and a quarterly employee recognition program).

4. Identify opportunities to collaborate and integrate efforts with complementary services to facilitate referrals or joint services. Similarly, continue efforts to ensure "closed loop" referrals for immediate and longer-term support services to alleviate participants' pressing needs, stress, and health risks.
    - Strengthen relationships between BMU coaches and medical providers to ensure clients with previous adverse birth outcomes, prior miscarriages, and high-risk pregnancies receive collaborated assistance navigating medical services, doctor appointments, and managing care.
    - Develop relationships with mental health providers as potential partners to strengthen the referral process for mental health and counseling services.
5. Together with First 5 Sacramento and Applied Survey Research, identify tactics to reduce paperwork burden on participants. In FY 2023-24, staff identified challenges getting clients to complete electronic consents and other assessments using the Persimmony database. Collecting community feedback about their concerns and challenges may provide insight to strategies to maintain essential data collection for program and evaluation purposes without adding burden on participants or dissuading them from participating in program activities.

Family Resource Centers

First 5 Sacramento provides funding for Birth & Beyond Family Resource Centers (FRCs)[22] with the goal of decreasing child abuse and neglect through prevention and early intervention. FRCs offer a wide range of services, including social-emotional learning and supports, crisis intervention, group parenting education workshops, and home visiting. FRCs are strategically located in neighborhoods characterized by high birth rates, low income, and above average referrals to the child welfare system for child abuse and neglect. The locations of the FRCs tend to coincide with neighborhoods identified by the Blue Ribbon Commission as the focal areas for the RAACD initiative.



In FY 2013-14, the Commission funded more equitable prevention and early intervention services for African American families, which led to the expansion of Family Resource Centers in the Arden Arcade and Meadowview/Valley Hi communities.

Beginning in FY 2021-22, First 5 began intentionally tracking these services as part of the larger RAACD initiative to offer a comprehensive look at services targeted by this funding.

While all nine Birth & Beyond FRCs provide crucial support to Sacramento families with the intention of decreasing child abuse and neglect, **the following sections describe efforts from the two FRCs that received RAACD-funding**, Mutual Assistance Network Arcade Community Center (MAN Arcade)'s Stronger Families Stronger Generations (SFSG) program, and the Sacramento Children's Home Village Program (serving Valley Hi and Meadowview).[23]

In total, **328 adults and 150 children** participated in RAACD-funded activities at these locations, including 507 home visits and 215 parenting education workshops. While the majority of participants identified within the Black/African American or multiracial focus populations, a small portion of participants identified as some other race/ethnicity (4%)[24] as no one is turned away from participation in RAACD parenting education classes and light touch activities.

[22] FRCs are implemented by seven community-based organizations that aim to prepare staff with the skills and competencies to serve families through home visiting, parenting education workshops, crisis intervention, and social-emotional learning and supports in nine Sacramento County neighborhoods.
[23] Information about all nine FRCs can be found in the Birth & Beyond Annual Report.
[24] May be a slight underestimation as some multiracial participants may not be Black/African American but a more detailed breakdown of racial/ethnic composition of multiracial families are not available.

RAACD-funded services are reaching a high need, high risk population. Among those receiving RAACD-funded services, 292 caregivers (89%) completed a Family Information Form (FIF) in the FY. Nearly three-quarters (73%) had accessed food/nutrition services in the six months prior to intake, and 60% reported a family income of $25,000 or less (see figure below).

Figure 19. RAACD Funded Participants Family Information at Intake (Caregivers)

	FY 2023-24
# Caregivers Served with Recent Family Information Form *(Unduplicated)*	292 (89%)
Support Services Used in Six Months Prior to Intake	
Food/Nutrition (e.g., WIC, CalFresh, Food Bank)	73%
FRC Services	21%
Parenting Education/Support	20%
Home Visits	19%
Perceptions of Support and Hope: % (n) who agree or strongly agree (at intake)[25]	
I know of safe places for my child to play that are outside of my home	82%
I involve my child in day-to-day tasks for our family	78%
I know what to expect at each stage of my child's development	70%
I am able to handle the stresses of day-to-day parenting	69%
I have people in my life who provide me with support when I need it	67%
I know which program to contact when I need advice on raising my child	60%
I am able to take a break and do something enjoyable at least once a week	59%
I know which program to contact when I need help with basic needs	58%
I attend events in my community with my child	48%
I find myself in stressful situations at least once a week	45%
In the past two weeks I have felt down, depressed, or hopeless	27%
Family Income[26]	
Less than $15,000	45%
$15,000 - $25,000	15%
$25,001 - $50,000	13%
$50,001 - $75,000	3%
$75,001 or more	2%
Don't Know/Prefer not to Say	22%

Source: Birth & Beyond Family Information Form – Caregiver and Family Information Form - Parent (recent FIFs among those who received RAACD-funded services during FY 2023-24). N = 292 although ns may vary by question due to missing data/non-response. Percentages include participants who have valid responses, by question.

Family Information Forms were also available for 116 (77%) children engaging in RAACD-funded activities during the FY. Responses showed that **most children were current on their well-child visits and had a strong support network** – 89% had a well-child visit with a pediatrician in the last 12 months, 61% had a hearing screening, and 54% had a recent vision screening. Most children (89%) had at least two non-parent adults in their lives who take a genuine interest in them, and most families had one-on-one play time with the child (84%), shared meals together (81%), told stories or sang songs (78%), and talked together (73%) between five and seven days a week.

[25] Percentages are out of those who have responses to each question.
[26] Percentages include participants with valid income data only (N = 271).

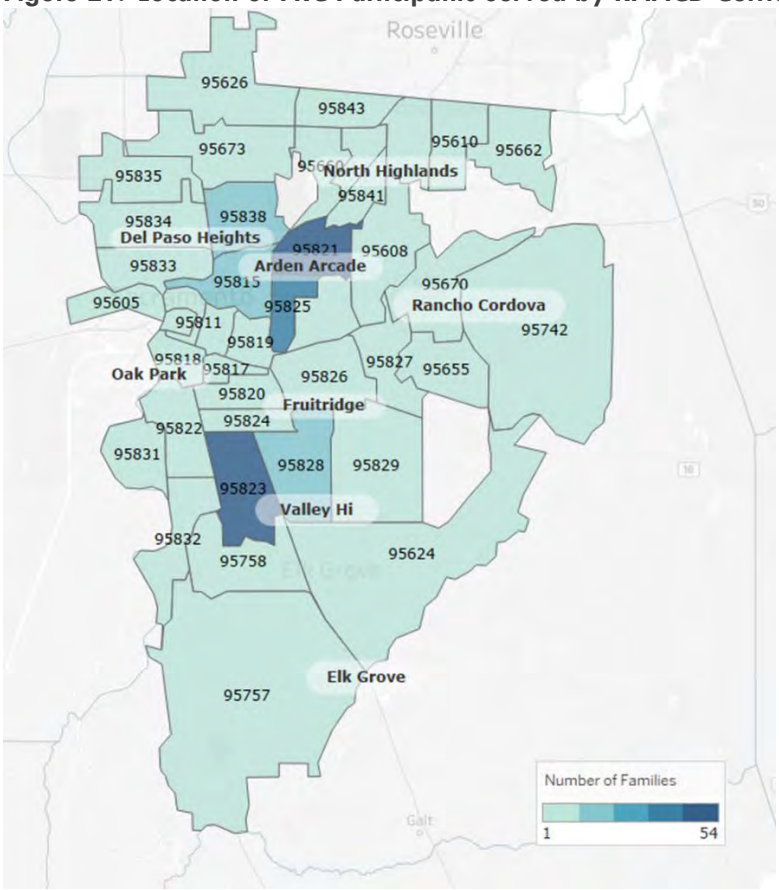
Figure 20. RAACD-Funded FRC Participants Family Information at Intake (Children)

	FY 2023-24
# Children Served with Recent Family Information Form *(Unduplicated)*	116 (77%)
Health Services and Supports Used in Six Months Prior to Intake	
Has had a well-child health check-up in the past 12 months	89%
Has had a hearing screening in the past year	61%
Has had a vision screening in the past year	54%
Has had a developmental screening in the past year	37%
Has seen a dentist in the past six months	34%
Family Activities and Social Support (as of intake)	
Child has at least two non-parent adults who take a genuine interest in them	89%
Played one-on-one with child *(5-7 days per week)*	84%
Sat and shared a meal together *(5-7 days per week)*	81%
Told stories or sang songs together *(5-7 days per week)*	78%
Talked with child about things that happened during the day *(5-7 days per week)*	73%
Practiced the same bedtime routine *(5-7 days per week)*	73%
Read together at home for 10+ minutes *(5-7 days per week)*	50%

Source: Birth & Beyond Family Information Form – Child (recent FIFs among those who received RAACD-funded services during FY 2023-24). N = 116 although Ns may vary by question due to missing data/non-response. Percentages include participants who have valid responses, by question.

Families engaged in RAACD-funded FRC activities through MAN SFSG and the SCH Village Program in FY 2023-24 most commonly lived in Valley Hi (95823) and Arden Arcade (95821) zip codes, likely due to the proximity to the two FRCs. However, participants had addresses across most of Sacramento County.

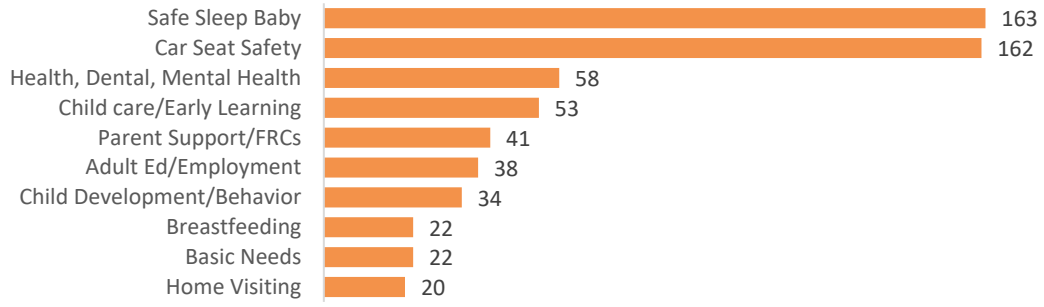
Figure 21. Location of FRC Participants Served by RAACD Curriculum and/or Activities



Source: Service Records unduplicated by Family ID and zip code (N = 330). Excludes families with no address entered into Persimmony.

Families engaging in RAACD-funded activities and curriculum are also connected to additional services at FRCs and other community-based support systems based on their individualized needs. Participants most often received referrals for safe sleep training/crib, car seat safety resources, and health services.

Figure 22. Top Referrals Provided to Participants in RAACD-funded Services



Source: Persimmony Service Records and Referral Portal. Counts are duplicated as participants may receive more than one referral of each type.

GROUP PARENTING EDUCATION

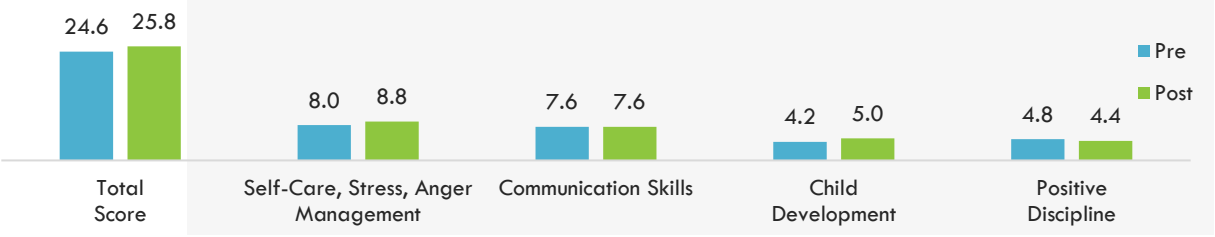
Group parenting education workshops are the primary prevention strategy to reduce the risk of child abuse and neglect and enhance parenting skills by building parent efficacy, empathy, and increasing knowledge of child development and safety. Group parenting education workshops include evidence-based curricula designed to be culturally responsive for Black/African American families. RAACD-funded parenting education included the Effective Black Parenting Program (EBPP) and the Make Parenting A Pleasure (MPAP) curriculum.

Make Parenting A Pleasure (MPAP)

Make Parenting A Pleasure (MPAP) is a court-approved, research- and evidence-based parenting curriculum targeting highly stressed families to improve the protective factors, increase knowledge of parenting skills, and reduce the risk of child abuse and neglect. MPAP is group-based and discussion-focused and typically consists of 13 modules. MPAP measures key topics including self-care, stress and anger management, understanding child development, communication skills, and positive discipline.

In FY 2023-24, 12 unduplicated parents/caregivers participated in a total of 43 MPAP classes at MAN Arcade. The number of MPAP participants was comparable to FY 2022-23 (11). According to MAN Arcade, the return to fully in-person courses has decreased interest in participation. Five participants completed both a pre-test and a post-test upon course completion. All five participants improved in at least one domain, and average scores increased for the Self-Care, Stress, Anger Management and the Child Development domains. On average, participants reported the most "high risk" perceptions of Positive Discipline. However, results should be interpreted with caution due to the small sample size.

Figure 23. Average Scores for Make Parenting A Pleasure Curriculum, Pre- and Post-Tests



Source: MPAP Pre and Post Test Scores, Matched set N = 5. Scores for each domain range from 1 = *High Risk* to 10 = *Low Risk*. Total score represents the average of participant's totals including all four domains. Due to small sample sizes, significance levels not calculated.

Effective Black Parenting Program (EBPP)

The Effective Black Parenting Program (EBPP) is a group-based, culturally sensitive, and culturally specific training program designed to serve Black and African American families. The goals of the program include developing parenting skills, promoting family pride and cohesion, and helping families cope with the negative effects of racism. Skills taught include setting family rules, using positive reinforcement as a reward for respectful and desirable child behavior, and using corrective consequences to address undesirable and disrespectful childhood behavior. EBPP provides activities for families to practice the skills learned in the session as well as information on drug use, single parenting, and child abuse.[vi] As of FY 2023-24, the EBPP curriculum was court approved for participants attending classes as part of a court mandate.

During the fiscal year, **29 participants engaged in 283 EBPP parenting education sessions** through the SCH Village Program and MAN Arcade. Due to small sample sizes and ongoing implementation efforts, outcomes data are not presented in this report.

HOME VISITING

RAACD-funded FRCs provided families with home visiting based in the participant-centered Effective Black Parenting Program (EBPP) model. The addition of the EBPP home visiting model has been highly regarded by participants and staff as a for its cultural responsiveness to the needs and experiences of Black families. EBPP was designed to serve Black and African American families, "promote family pride and cohesion and to help families cope with the negative effects of racism."

> EBPP home visiting has helped families foster strong, healthy self-esteem, and pride in Blackness. Home visitors have also built deep connections with families beyond the curriculum.

Parents have shared with staff that EBPP gives good guidance for fostering strong, healthy self-esteem, and pride in Blackness. EBPP home visitors also focus on building deep connections with families and providing well-rounded support beyond the model materials. In FY 2023-24, the SCH Village and MAN Arcade Stronger Families, Stronger Generations (SFSG) programs completed 47 new intakes into the EBPP HV model[27] and provided **414 home visits to 67 families** during the fiscal year.

The MAN SFSG and the SCH Village programs measured program impact and family progress using the 40-question EBPP pre- and post-test, the Protective Factors Survey -2 (PFS-2),[28] and/or Family Strengths Builder (FSB).[29] Due to the range of assessments and variations in facilitation, limited insights are available. However, the following information offers preliminary highlights based on available data.

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[27] Count of EBPP HV Case Records. Includes duplicate individuals who may reenter program at different points in time, and not intended to represent the total number of individuals who received RAACD-funded home visits during the fiscal year.
[28] The Protective Factors Survey, 2nd Edition (PFS-2) is an evidence-based tool which evaluates improvements in protective factors while engaged in home visiting. The PFS-2 measures five areas of protective factors: *Family Functioning and Resilience*, *Social Supports*, *Concrete Supports, Nurturing and Attachment*, and *Caregiver-Practitioner Relationship*.
[29] Following the termination of the Family Development Matrix (FDM) resource at the end of FY 2022-23, staff used the Family Strengths Builder (FSB) questionnaire in partnership with EBPP HV participants to identify immediate needs and strengths and set goals. Participants were asked to complete a follow-up FSB 30-45 days to review their progress and refocus goals (as needed).

- **Participants increased agreement with Effective Black Parenting behaviors.** Thirty-three participants completed an EBPP intake assessment. Among them, seven also completed a post-assessment during FY 2023-24. Six of the seven (86%) had a net improvement in their responses to questions related to parenting behaviors.[30] On average, the group had the largest improvements in the statements "Parents should help their child develop pride in Blackness" and "Family rules should be fair and reasonable to the children."
- **Participants improved their protective factors.** Sixteen EBPP HV participants completed a PFS-2 assessment at intake. Their average total score was 2.62 (range 0 to 4). Further, six of the 16 participants completed a second PFS-2 questionnaire during the FY. Among them, the group average increased from 2.63 to 3.20. All six participants improved in at least one PFS-2 domain. At follow-up, participants had the highest average score in the Caregiver-Practitioner domain (3.95), followed by Family Functioning & Resilience (3.39). Caregiver-Practitioner Relationship includes statements such as "I feel like staff here understand me." Family Functioning & Resilience includes measures such as "In my family, we take time to listen to each other."
- **Participants improved access to immediate needs**. Thirty-four EBPP HV participants completed an FSB with their home visitor to identify their family's strengths and support areas. Among them, the most common focal areas selected were housing (13/34, 23%), managing a budget/finance (19%), and employment (16%). Further, 10 of the 34 participants completed at least two FSB questionnaires in FY 2023-24. Six of the 10 participants All 10 participants improved in at least domain[31] and 60% improved in their focal area(s).

Success Story: Effective Black Parenting Program Home Visiting

Skye (fictional name) is a 26-year-old Native American mother with a multiracial seven-month-old daughter. While she is not partnered with the child's father, they have a great co-parent relationship. Skye was referred to MAN Arcade's Stronger Families, Stronger Generations (SFSG) home visiting program by a friend who was also enrolled in home visiting. She was seeking support with parenting skills and child development for her daughter. Further, Skye was thrilled to learn about the SFSG home visiting program's focus on effective Black parenting, as she wanted to support her daughter as she grows into understanding and embracing her African American identity.

"I want her to know as much about her African culture as she can, and I wanted to be able to learn from Black women."

Skye completed the Safe Sleep Baby education workshop, received a Pack-N-Play for her daughter, and received an ASQ screening which showed her daughter is developing on schedule. Skye's home visitor also referred her to Medi-Cal, and she was successfully able to obtain insurance for her daughter.

Skye shared that she learned a lot about safe sleep practices and ways to keep the home environment safe. She also

[30] Note the EBPP assessment does not have established domains or groupings of measures. For this group, only the 13 questions rated on a scale of *Strongly Disagree* to *Strongly Agree* are included here, excluding 25 true-false or yes-no assessment questions.
[31] Out of 21 domains measured, participants showed improvements in a range of three to 19 categories.

shared that the Effective Black Parenting curriculum helped with her ongoing learning about historical and modern parenting skills using the African proverbs which illustrate the relationship between the focus of each lesson to the perspective and wisdom of African ancestors.

She also shared that she is learning a lot about child development and continues to implement the information from the weekly sessions into her everyday parenting. She learned about different methods of effective, corrective consequences such as effective praises, and understands how the different stages of child development will influence her daughter's ability to understand.

As Skye described, "connecting with home visitation has been such a huge support in helping me recognize my own challenges when it comes to parenting and understanding my daughter's development. I learned that my daughter's developing abilities will support me in knowing how much reasoning and cooperation I can realistically expect from my child. My friend told me about how amazing [SFSG HV staff were] in helping her in her parenting skills and in providing resources. As a Native American woman with and Black little girl, I want her to know as much about her African culture as she can, and I wanted to be able to learn from Black women. [My SFSG home visitor] has been amazing in providing support and making me feel that I can be and have the tools to be the best parent to my child."

CRISIS INTERVENTION SERVICES (IS)

RAACD-funded FRCs also provide intensive, short-term case management to parents/caregivers who are experiencing an urgent crisis such as homelessness, food insecurity, domestic violence, or substance abuse to mitigate the crisis and help the family stabilize. Once a family's crisis is stabilized, they are connected to the other service strategies offered through the FRC, such as social and emotional supports, parenting classes, and home visiting.

IS case management helped families improve areas of concern through resources and individualized goal plans.

The MAN Stronger Families, Stronger Generations (SFSG) and SCH Village programs received 132 new IS referrals during FY 2023-24 for Level 2 support.[32] About one-third (32%) of referrals were from a B&B staff, volunteer, or event, and more than one-quarter (28%) were self-referrals. Among these referrals, 68% received IS services, and among those served (n = 90), 60 (67%) completed their services. Only a small number referred during this fiscal year dropped out, moved, or were unable to be located.

In total, the RAACD-funded FRCs provided 241 intervention services to 191 adults during FY 2023-24. Services included the light touch (Level 1) and more intensive case management for those with higher needs (Level 2). Following the termination of the Family Development Matrix (FDM) resource at the end of FY 2022-23, staff used the Family Strengths Builder (FSB) questionnaire in partnership with Level 2 families receiving case management support. The FSB case management was used in partnership with families to identify focal areas of support and set goals. Participants were asked to complete a follow-up FSB 30-45 days to review their progress and refocus goals (as needed). In FY 2023-24, 57 IS participants completed an FSB in coordination with staff to identify strengths and support areas. Among them, the most common focal areas selected were housing (30/57, 53%), employment (28%), and managing a budget/finance (18%). Additionally, 56 unduplicated participants completed a Family Strengths Plan (FSP), an individualized plan created to identify goals and steps to take to meet those goals.

[32] Includes participants seeking more intensive case management for higher needs. Includes duplicate individuals if referred at different times throughout the fiscal year.

Further, 12 of the 57 participants completed at least two FSB questionnaires in FY 2023-24. All 12 participants improved in at least domain and 10 of the 12 (83%) improved in at least one of their focal areas.[33]

Success Story: Crisis Intervention Services (IS) Case Management

Imani (fictional name) is a mother of four children between the ages of seven months to 15 years old. Imani was fleeing domestic violence and was living in transitional housing when she reached out to MAN Arcade for housing support. Imani was initially connected to the Stronger Families, Stronger Generations home visiting program, then transitioned to IS case management. Through case management, she was connected to the diaper distribution program, micro-transit, and food boxes. She was also connected with leads to access permanent housing.

Following the housing leads, Imani won a housing lottery drawing for multiple income-based housing locations. Micro-transit support also helped her save enough money to purchase her own car. Case management staff also connected the family to a gift registry service through Sutter Health Adopt a Family, and they were extremely happy. Imani shared with IS staff that she is very appreciative of the support. Following the short-term Crisis Intervention support, Imani is now expecting to move into her own place and has reliable transportation. She occasionally utilizes support for diapers, but overall, she is increasingly independent and self-sufficient.

SOCIAL AND EMOTIONAL LEARNING AND SUPPORT (SELS)

First 5 provides RAACD funds for FRC supports for African American families with a focus on building strong, resilient families and increasing positive childhood experiences. These activities facilitate social/community engagement to reduce isolation, child maltreatment, and trauma. Social and Emotional Support and Learning activities include "light touch" child development activities, child safety workshops, resource and referral, stress reduction activities and peer support groups, and more.

170 caregivers and 71 children participated in **474 SELS services**

In FY 2023-24, the MAN Stronger Families, Stronger Generations (SFSG) and the SCH Village programs provided 474 RAACD-funded SELS services, including but not limited to Sistah 2 Sistah and Colorful Connections group meetings, distribution of resources (e.g., diapers, backpacks), Family Hui Peer Support, MRT presentations, and other pop-up activities and outreach such as a Mother's Day event. Additionally, 25 parents/caregivers received transportation services, and 20 families received Play Care services for their children while attending the various SELS events.

THREE-YEAR TRENDS, FY 2021-22 THROUGH FY 2023-24

RAACD-funded activities went through numerous continuous improvement transitions and implementations between FY 2021-22 and FY 2023-24. For example, in FY 2021-22, Black/African American home visiting families were given the opportunity to transition from the Nurturing Parenting Program (NPP) model to a modified Parents as Teachers (PAT) which aimed to be more culturally

[33] Out of 21 domains measured, participants showed improvements in a range of three to 19 categories.

responsive to Black/African American families. However, various challenges led MAN Arcade to decide that PAT was not the ideal curriculum for the program in practice. In FY 2022-23, RAACD-funded programs began the transition from PAT to EBPP as the primary home visiting model. In FY 2023-24, RAACD-funded programs were fully offering the EBPP home visiting model.

Ongoing efforts to adapt to the best-fitting home visiting model as well as other unexpected changes (i.e., interpersonal and community tragedies impacting staff's well-being and availability; closure of the Family Development Matrix data tool impacting home visiting and crisis intervention procedures; vacancies; recruitment challenges; staff training; and implementation differences across sites) led to challenges in consistent and clear data collection to show quantitative impact, particularly for home visiting.

Despite the challenges, highlights from FY 2021-22 through FY 2023-24 program activities include:

- Home visiting participants showed improvements in protective factors, access to immediate needs, and effective Black parenting behaviors.
- All or most parenting education workshop participants improved in at least one MPAP domain. The sites also offered the EBPP parenting education program. In FY 2023-24, EBPP became an approved model for families attending for court-related reasons.
- RAACD-funded program staff provided 767 Crisis Intervention Services (IS) to more than 500 caregivers between FY 2021-22 and FY 2023-24. Participants received resources/referrals and, when beneficial, case management from a Crisis Intervention Specialist. Families receiving case management developed goal plans with their IS Specialist to progress on their focal areas.
- RAACD-funded program sites offered light touch Social and Emotional Learning and Support (SELS) activities to an average of 255 caregivers each year. In total, participants engaged in more than 2,100 SELS services, including, but not limited to Sistah to Sistah and Colorful Connections group meetings, resource distributions, MRT presentations, anger management courses, and other pop-up events.

OPPORTUNITIES FOR IMPROVEMENT

During FY 2023-24, the RAACD-funded SFSG and Village programs continued to fine tune the Effective Black Parenting Program strategies, while facing various challenges such as unexpected shifts in measurement tools, staffing shortages, and participation challenges. Program staff have to be very intentional to build trust and engage African American families through this targeted strategy. Trust building to highlight the benefits of program involvement takes time. They continue to strengthen their messaging and address challenges as they emerge. Based on the ongoing implementation challenges, MAN and SCH may consider working toward:

1. Strengthening relationships with local and state leaders to ensure ongoing support and funding for the Stronger Families, Stronger Generations and Valley Hi Village Program activities. With the current Presidential administration's attempts to dismantle Diversity, Equity, and Inclusion (DEI) and create barriers for racial justice, it is more important than ever to ensure local and statewide backing for these essential services. First 5 and the Birth & Beyond Collaborative can leverage community relationships to continue strengthening an understanding of the impact of these services on marginalized communities and developing plans to ensure the safety and stability of these activities despite the current national climate.
2. Engage staff, families, and community members to identify and address barriers to recruitment. For instance, staff noted decreased interest as programs shifted back to a fully in-person model and staffing shortages limiting reach.

3. Increase program enrollment, including gaining support within the Birth & Beyond Collaborative by sharing the information about the RAACD Black Parenting Program's opportunities and benefits of the curriculum and connecting African American parents/caregivers with culturally-matched facilitators.
4. Continue providing RAACD-served families opportunities to engage as parent leaders. Families who build rapport, stability, and insights through Birth & Beyond services offered by the MAN SFSG and SCH Village programs provide essential input to identify barriers to recruitment and retention, as well as opportunities to strengthen messaging around disparities in African American child deaths. Parent leaders serve as an essential bridge between service providers, county leaders, and community members in the ongoing efforts to reduce the disparities and occurrence of African American child deaths, as well as potential misconceptions based on varying experiences and concerns about social services.
5. Together with First 5 and ASR, continue streamlining measurements across RAACD sites including data collection tools and data entry procedures, to ensure more robust evaluations without added burden on program staff or families. This includes the important addition of qualitative, detailed stories from program participants to provide a more well-rounded depiction of curriculum impact on Black/African American families in Sacramento County.

Safe Sleep Baby

SSB participants consistently show significant improvements in safe sleep knowledge and practices.

Cribs4Kids provided free Pack-N-Plays to nearly 200 Black/African American families to safely sleep their infants.

Safe Sleep Baby (SSB) is an education campaign managed by the Child Abuse Prevention Council (CAPC) of Sacramento to increase knowledge and change behaviors about infant safe sleeping practices. The overarching goal is to decrease infant sleep-related deaths in Sacramento County, especially among African American infants. Specific strategies include:

- Perinatal education campaign to share SSB messages.
- Direct SSB education for expectant and new caregivers with a child under twelve months old
- SSB Education for hospital staff, health professionals, and social service professionals
- Cribs4Kids program to provide education and a free crib to expectant or new caregivers with a child under twelve months old who do not have a safe place to sleep their baby
- Quarterly SSB Collaborative meetings
- Systems change efforts related to safe sleep education policies and procedures at local birthing hospitals and clinics serving pregnant and new caregivers.

SAFE SLEEP BABY EDUCATION CAMPAIGN

Since the beginning of the Campaign, CAPC has worked to create and deliver safe sleep education and messaging in a culturally relevant and sensitive manner consistently throughout Sacramento County. All SSB materials were created with extensive input from African American community members, including caregivers engaged in SSB workshops, and distributed through the neighborhoods with the highest rates of African American infant sleep-related death in Sacramento County. In FY 2023-24, SSB education was also included for all Black Infant Health (BIH) Prenatal and Postpartum groups and provided in BIH's safety checklist given to all BIH program participants.

SSB Parent Health Educators used SSB social media to share safe sleep education and describe factors that cause infant sleep-related deaths. Social media campaigns help expand the reach of this information to an intergenerational audience beyond informational resources in physical, public spaces. The CAPC SSB team continued to co-promote the SSB program through the BIH social media pages, highlighting SSB's purpose and details on how to schedule a workshop.

- In FY 2023-24, SSB social media reached 36,840 users across the BIH Instagram and Facebook, the Safe Sleep Baby Instagram, and the Birth & Beyond Facebook pages.
- SSB created 338 posts across the SSB platforms, which is 27 times the annual target. Posts generated 339 likes and social media pages acquired 276 new followers in FY 2023-24.

SAFE SLEEP BABY DIRECT EDUCATION

SSB Education for Community Service and Health Providers

SSB conducted "Train-the-Trainer" workshops for professionals who work with pregnant or new caregivers to increase providers' knowledge about infant safe sleep practices and promote referrals to SSB caregiver workshops for infant safe sleep education and cribs. Trained providers included representatives from select community-based organizations working with families, who became Cribs for Kids (C4K) partners. The C4K partners are trained to provide the one-hour caregiver workshops, pre- and post-tests, and distribute cribs.

Between July 1, 2023 and June 30, 2024, 232 community-based service providers were trained (compared with 206 in FY 2022-23). Additionally, 70 healthcare workers were trained during FY 2023-24, including providers from hospital systems and neighborhood medical offices. Community and medical providers trained include representatives from:

- Birth & Beyond Family Resource Centers
- Child Action
- Community Incubator Leads
- Dignity Health
- Her Health First
- Kaiser Permanente South Sacramento Medical Center
- Mercy General Hospital
- Mercy San Juan Medical Center
- Sacramento County Department of Children, Family, and Adult Services (DCFAS)
- Safe Kids Coalition
- Shine Together
- Stanford Sierra Youth & Families
- Sutter Medical Center, Sacramento
- UC Davis Medical Center
- Local foster agencies and a dental office

The number of providers trained exceeded the program's annual target of community providers (220) hospital providers (68).[34]

SSB Education for Caregivers

> "I know how to protect my baby, which gives me peace of mind."
>
> - SSB Participant

SSB provides education to families through home visits and one-hour-long (in-person or virtual) workshops. While families of all ethnicities participate in the program, there is a special emphasis on reaching African American families. Home visits and workshops are valuable tools to increase knowledge about infant safe sleep practices as caregivers receive information from a trusted source in a private and welcoming setting. Each session offers several key pieces of knowledge, including statistics about infant death due to sleep-related causes, the Six Steps to Safely Sleep Your Baby, and an educational video. After successfully completing the training, caregivers receive a free Pack-N-Play crib if they do not have a safe place to sleep their infant.

During FY 2023-24, First 5 Sacramento funded SSB trainings for **1,086 unduplicated caregivers**. Among them, about one-third (32%, 351/1,086) were African American. Additionally, 44 participants took the SSB course more than once,[35] resulting in a total of 1,130 SSB workshops provided.[36] The number of workshop

[34] Sum of YTD target of 60 nurses and hospital staff and eight staff from neighborhood medical providers.
[35] This could include parents/caregivers taking the course for a subsequent baby or to repeat the education. SSB's priority is for parents to understand *and* follow the education in their behavior of safely sleeping their baby no matter how many times they need to receive the information.
[36] Count includes First 5 funded only and excludes additional trainings provided using other funding sources.

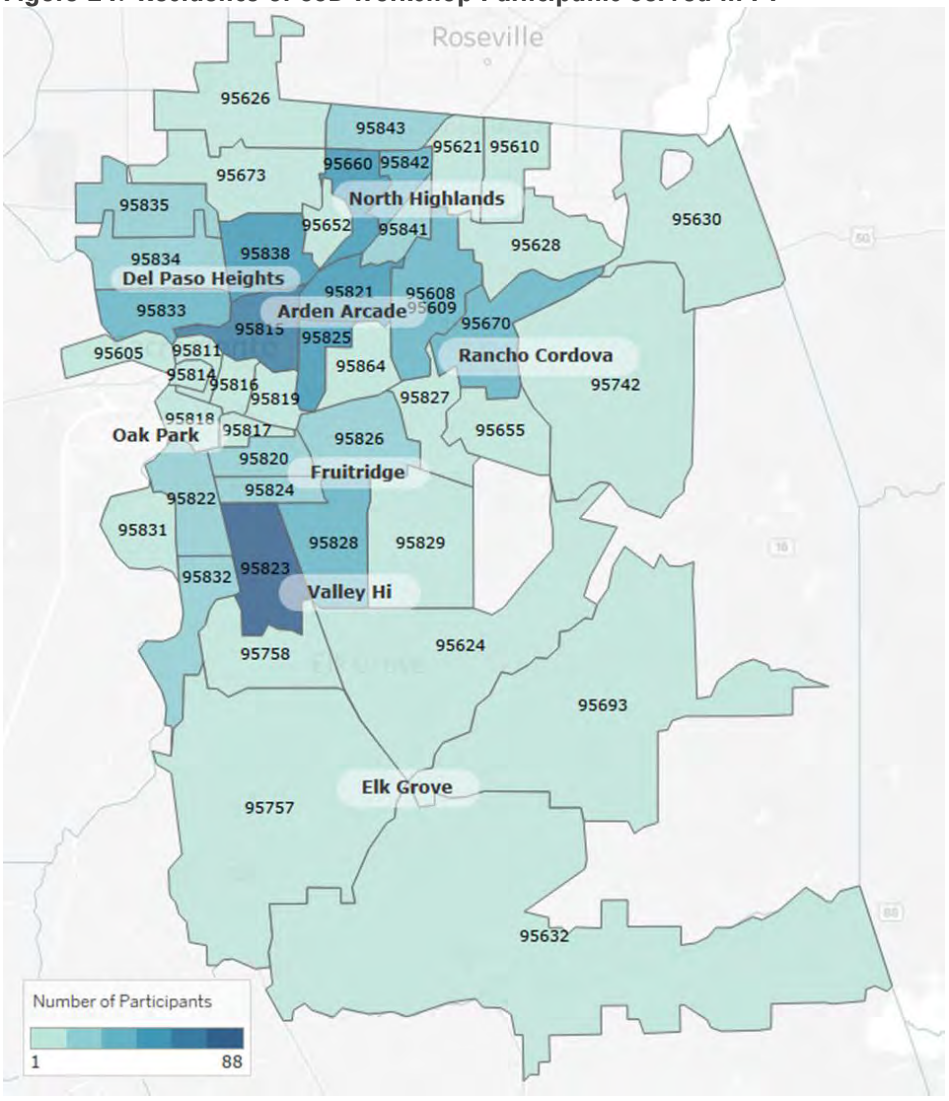
participants increased 31% compared with FY 2022-23 (832 unduplicated participants), and the number of African American participants was 44% more than FY 2022-23 (243).

The following Cribs for Kids partners provided the FY 2023-24 workshops:

- CAPC
- Her Health First
- Liberty Towers
- Nine Birth & Beyond Family Resource Centers
- Rose Family Partnership
- Sacramento County Office of Education
- Sutter Health Teen Program
- The Children's Better Life Service

Three out of five (61%, 522/852) participants receiving a SSB workshop lived in one of the seven RAACD focal areas.[37] Participants most frequently lived in the Valley Hi neighborhood (see map). The proportion of participants living in the RAACD focal zip codes decreased compared with FY 2021-22 (68%) and FY 2022-23 (64%).

Figure 24. Residence of SSB Workshop Participants Served in FY

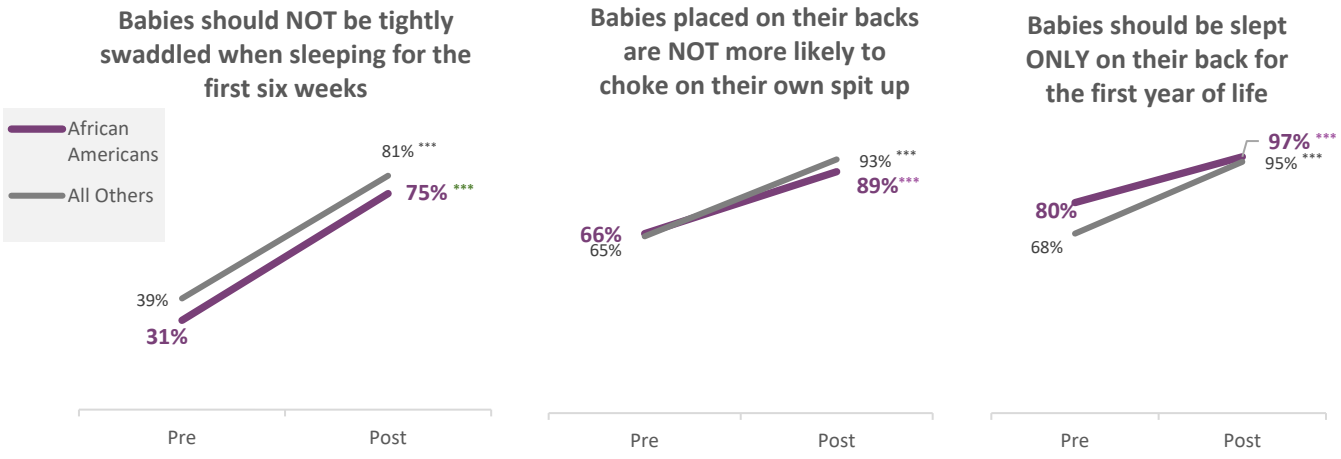


Source: First 5 Sacramento Service Records (N = 852). Map excludes participants who did not provide an address or were unhoused at the time of their program involvement.

[37] Limited to those with a Sacramento County address in the Persimmony database (N = 852). Counts may exclude those who did not provide an address or were unhoused at the time of their involvement with SSB.

Short-term program impact is measured using a pre- and post-test assessing changes in **infant safe sleep knowledge** before and after the SSB training. In FY 2023-24, 99% of participants (1,123/1,130) completed both a pre- *and* post-test.[38] Among them, 33% (370/1,123) identified as African American. Participants showed significant improvements across the various measures of infant safe sleep knowledge. The figure below highlights knowledge changes for the top three questions with most improvements. Because of SSB's focus on African American infant sleep safety, African American participants' responses are displayed separately from all other races.

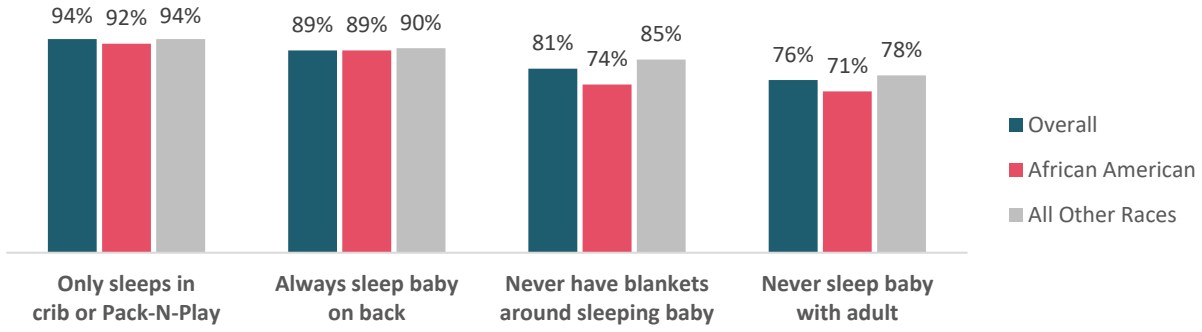
Figure 25. Increases in Correct Answers about Infant Safe Sleep Knowledge in Pre- and Post-Test



Source: SSB Pre- and Post-Tests. African American N = 370, All Others = 753. Statistical significance reported as *** $p < .001$.

Safe Sleep Baby's medium-term program impact is measured by participants' **safe sleep intentions and practices.** Follow-up calls were made to caregivers that received SSB training and received a crib. Among them, 185 participants were reached for a follow-up assessment in FY 2023-24, including 62 African Americans (33%).[39] Nearly all caregivers reported their child was only *Sleeping in a crib or Pack-N-Play* (94%, 173/185), 89% were *Always sleeping their baby on their backs* (165/185), and 81% *Never had blankets around their sleeping baby* (150/185). Across all questions, a smaller proportion of African American participants were practicing safe sleep behaviors, although sample sizes (33% African American) may exacerbate these differences.

Figure 26. Percent of SSB Participants Practicing Infant Safe Sleep Behaviors at Follow-Up, by Race



Source: SSB Follow-Up Survey. N = 185 (All Follow-Ups in fiscal year). African American N = 62; All Other Races N = 123.

[38] Includes duplicate participants who completed the training more than once. Parents/caregivers are able to participate in the training as many times as needed.

[39] SSB aims to reach a minimum of 30% of caregivers who receive SSB training for follow-up calls, and aims for 35% of those reached to be African American participants.

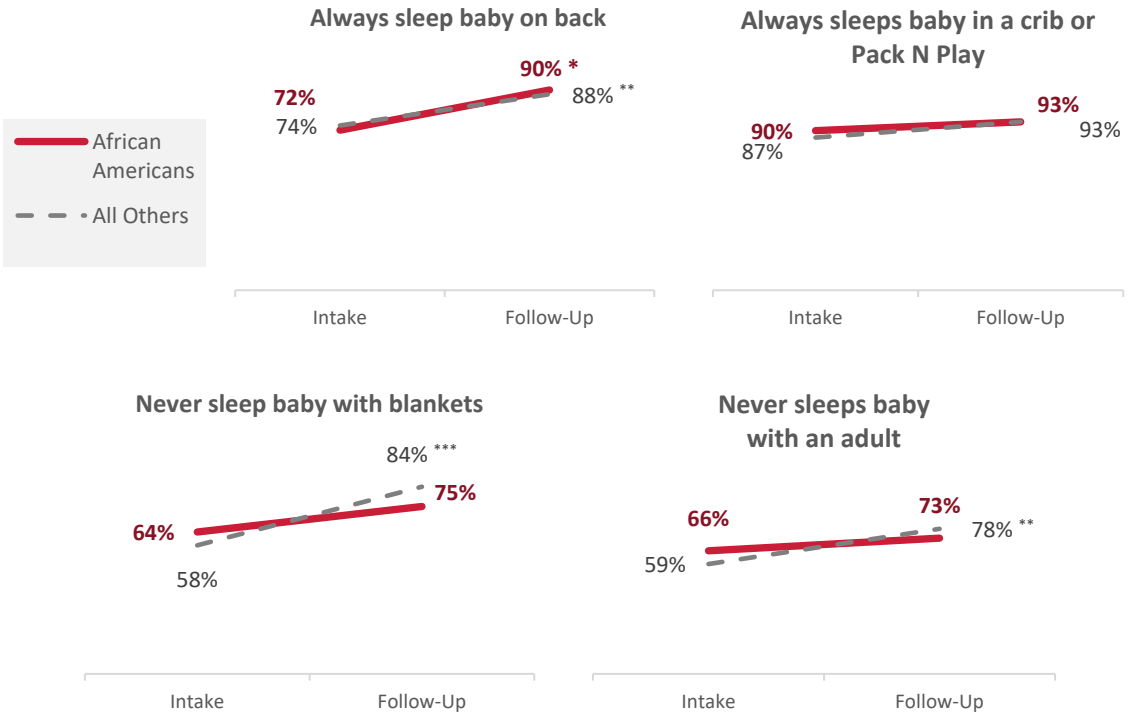
> "… I feel more confident keeping my baby safe while she sleeps. I didn't realize it was such an important topic but now I do, and I also have a safe place for her."
>
> - SSB Participant

Intentions for infant safety practices at the start of the Safe Sleep Baby workshop were compared with practices reported at follow-up to further identify the impact of the SSB program. Participants with intake *and* follow up data (185/186) showed **significant improvements in safe sleep practices compared to intentions prior to the workshop**.

The figure below demonstrates changes between intention and follow-up, comparing African American participants with all others. Black/African American participants were significantly more likely to report that they *Always sleep their baby on their back* at follow-up (90%) compared to intake (72%). A larger portion of participants also reported *Always sleeping their baby in a crib/Pack-N-Play*, *Never sleeping baby with an adult*, and *Never sleeping the baby with blankets*, although changes were not statistically significant.

While changes were not statistically significant, at least nine out of ten African American participants reported always sleeping their baby in a crib or Pack N Play. This continues to be an important highlight following a *decrease* in crib usage among Black/African American participants during FY 2021-22 (94% intake to 88% follow up). Following anecdotal evidence about some families' difficulty using the Pack-N-Plays (e.g., unstable housing, challenges with the size of the Pack-N-Play), Safe Sleep Baby staff began updating trainings and incorporating insights from focus groups to mitigate challenges. Data for FY 2022-23 (85% to 97%) and FY 2023-24 (90% to 93%) may highlight the impact of renewed strategies to meet families where they are.

Figure 27. Differences Between Intentions at Intake and Behaviors at Follow-Up in Infant Safe Sleep Practices (Matched Pairs)



Source: CAPC SSB Intake and Exit Surveys. African American N = 61; All Others N = 184. Statistical significance reported as * $p < .05$, ** $p < .01$, *** $p < .001$.

CRIBS FOR KIDS (C4K) PROGRAM

CAPC also manages the Cribs for Kids (C4K) Program, which partners with community hospitals and local organizations that are trained to provide expectant or new caregivers with infant safe sleep information. C4K partners also provide Pack-N-Play cribs, funded by First 5 Sacramento and Sacramento County Department of Child Family and Adult Services (DCFAS). Participants who did not have a safe location to sleep their infant were able to receive a free crib after completing a one-hour SSB workshop with CAPC or other C4K partners.

The list below includes partners that house and distribute cribs, which contains some overlap with organizations who provide the SSB workshops.

- Nine Birth & Beyond Family Resource Centers
- CAPC
- Her Health First, Black Mothers United
- Help Me Grow/Sacramento County Office of Education
- Kaiser Permanente South Sacramento Medical Center
- Liberty Towers
- MAN Arcade Black Infant Health
- Mercy General Hospital
- Mercy San Juan Medical Center
- Methodist Hospital of Sacramento
- Rose Family Partnership
- Sutter Medical Center, Sacramento
- UC Davis Medical Center, NICU, and Labor and Delivery

In FY 2023-24, **C4K partners provided 602 cribs to caregivers** in need.[40] One-third of the cribs (33%, 197/602) were provided to African American caregivers. The proportion of cribs distributed to African American caregivers was consistent with FY 2021-22 (33%) and FY 2022-23 (31%).

SAFE SLEEP BABY EDUCATION POLICIES AND PROCEDURES

SSB seeks to mobilize focal communities to understand the importance of infant safe sleep practices. SSB works to ensure the program's impact and sustainability by encouraging the adoption of SSB policies and education with hospitals and medical providers. This ensures a uniform message about infant safe sleep is provided across the community and that infant safe sleep information is provided before, or at, birth. Prior to the implementation of the SSB campaign in 2015, hospitals did not uniformly provide infant safe sleep education.

In FY 2023-24, SSB continued to successfully partner with **all eight Sacramento County birthing hospitals and the four hospital systems** which operate the eight birthing hospitals.

- Dignity Health
- UC Davis Medical Center
- Kaiser Permanente
- Sutter Medical Center

Additionally, SSB informational videos were broadcasted in labor and delivery hospitals, as well as pediatric and OBGYN waiting rooms. Nurses provide a unique opportunity to engage caregivers in an infant safe sleep conversation, asking expectant or new caregivers the SSB question: ***"Where will you sleep your baby when you return home?"*** This wording offers the opportunity to begin a non-judgmental conversation about infant safe sleep practices and the risk of infant sleep-related death. In hospital settings, caregivers receive information and a referral to CAPC for follow-up.

[40] Includes cribs provided through additional leveraged funding sources.

CLIENT SUCCESS STORIES: SAFE SLEEP BABY WORKSHOP

Mia (fictional name) is a 36-year-old African American mother of three children. She was nervous about being a new mom again, since she has two older children (ages 15 and 17) and recognized that times have changed since her older children were infants. Mia was also excited about the baby, since her partner was becoming a first-time-father. As a result, both parents were eager for additional support. Mia encountered a Black Infant Health (BIH) Health Initiatives Coordinator who was completing a delivery for another client and asked the Coordinator about the services. After learning about BIH and SSB, Mia expressed interest in taking a class to learn new information she may not have known 15+ years ago. Mia also plans to have her partner complete the SSB training before the baby is born.

Mia completed a virtual SSB workshop, received information about BIH, and was connected to Birth & Beyond and BMU for ongoing services, as she had previously engaged with both programs and expressed interest in reconnecting. After completing the SSB workshop, Mia reflected on the new information she learned. She learned how breastfeeding can benefit her baby and reduce the risk of a sleep-related infant death. Mia mentioned that she did not breastfeed her previous two children since she was a single parent without the support of their father but plans to try breastfeeding the new baby since she has more support this pregnancy. Because of her interest in breastfeeding, Mia was also informed about the Lactation Consultants available through WIC that could assist her on her breastfeeding journey. She also learned about the importance of the Safe Sleep ABCs and plans to do things differently than when her older children were babies.

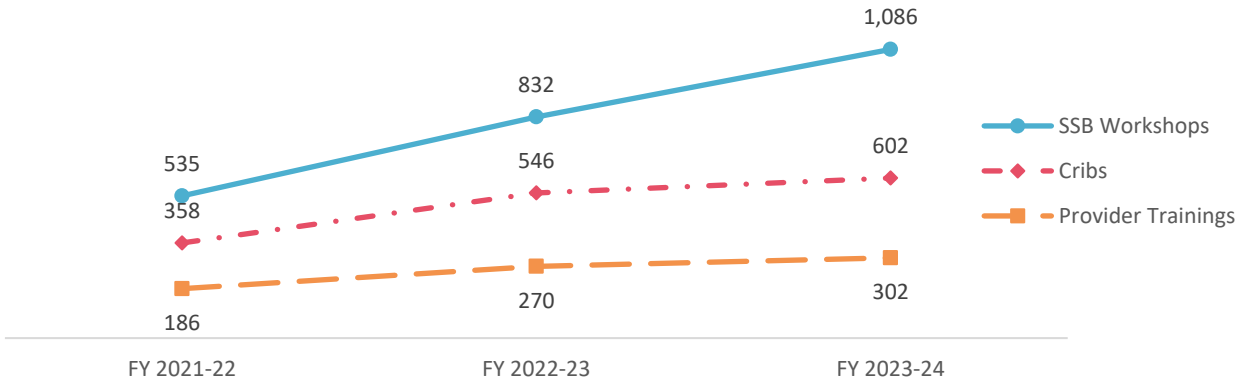
> "[SSB] taught me about the importance of breastfeeding my baby and my baby having her own place to sleep. I slept with my oldest two children not knowing any better [so] I am glad they are alive." - "Mia," SSB participant

THREE-YEAR SUMMARY, FY 2021-22 THROUGH FY 2023-24

Between FY 2021-22 and FY 2023-24, the Safe Sleep Baby program provided 2,556 SSB workshops to 2,453 caregivers. SSB Cribs for Kids partners distributed 1,506 cribs to those who needed a safe place to sleep their baby.[41] Frequencies for caregiver workshops, crib distribution, and provider trainings have all increased since FY 2021-22, which was uncharacteristically low, likely due to COVID-19. Fewer families were able to be reached during quarantine and many caregivers had competing stressors during this time, which resulted in lower numbers. In FY 2023-24, the number of SSB workshops reached its peak, even surpassing pre-COVID-19 counts. This increase likely has to do with increased community outreach from the SSB team, leveraging closed-loop referrals with participants, improved partnerships with hospitals, emphasizing the importance of providing SSB workshops to staff at Birth & Beyond Family Resource Centers (FRCs), and addressing challenges and improving processes by holding SSB technical assistance sessions twice a week with FRC staff.

[41] SSB Cribs for Kids partners distributed additional cribs during this time with different funding sources.

Figure 28. Trainings and Cribs Provided by Safe Sleep Baby; Three-Year Trends

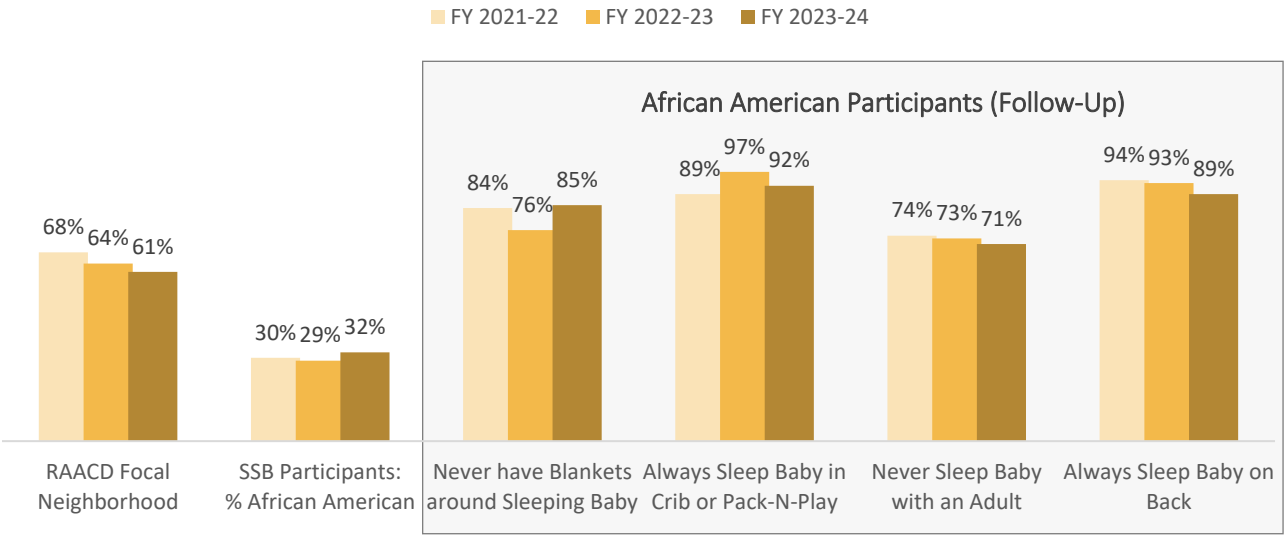


Source: SSB Performance Measures and Persimmony Service Data (FY 2021-22 through FY 2023-24)

Between FY 2021-22 and FY 2023-24, SSB has made intentional efforts to reach participants in underserved communities with historically high rates of infant sleep-related deaths. SSB also employed a focused intent on supporting the African American community. During the three-year period:

- Each year, at least three out of five participants lived in one of the RAACD focal neighborhoods.
- An average of 31% of SSB participants each year were Black/African American
- A majority of African American participants reported safe sleep behaviors at follow-up

Figure 29. SSB Participant Demographics and Outcomes, Three-Year Trend



Source: Persimmony Service Records and CAPC SSB Follow-Up Survey (FY 2021-22 to FY 2023-24)

OPPORTUNITIES FOR IMPROVEMENT

- Provide CAPC's SSB Team with **Motivational Interviewing Training** to strengthen their ability to connect with pregnant and new moms to facilitate deeper, more meaningful conversations to uncover barriers to infant safe sleep and enhance understanding of each family's unique needs. This will build trust and offer appropriate support while promoting infant safe sleep practices.

- Develop and implement a "**closed loop referral**" practice for hospital systems and community-based medical clinics to promptly receive a referral disposition update from the CAPC SSB team indicating whether the referred caregiver received SSB education. This closed-loop process can further build relationships between CAPC and the referring system and encourage future referrals.
- Continue identifying and building **relationships with diverse community-based organizations**, such as refugee support programs, who may benefit from integrating SSB into their work. Leverage these partnerships to increase community outreach and strengthen cultural responsiveness (e.g., translation support, tips for reaching and sharing program messaging with new populations).

Perinatal Education Campaign (PEC)

The fourth strategy funded by First 5 is the Perinatal Education Campaign (PEC), which includes public outreach and education about perinatal conditions, causes, and resources. Her Health First (HHF) manages the PEC strategy, together with partners XTG Media and Runyon Saltzman, Inc. (RSE). PEC activities include social media, websites, podcasts, blogs, community events, a Community Advisory Team, and a medical provider toolkit to share resources with families (in progress).

PEC includes two primary education campaigns: Sac Healthy Baby and Model of Caring (formerly Unequal Birth). Sac Healthy Baby (SHB) is focused on reaching African American expecting and new parents and families to provide them with information and to connect them to local resources. The Model of Caring (MOC) campaign aims to be a hope- and solution-oriented strategy while raising public awareness of institutionalized racism as the root cause of the racial disparities in safe births for both infant and mother. In FY 2023-24, the MOC campaign goal was further honed to provide community birth workers with tools for their work environment to connect families to resources that will help support positive birth outcomes. In FY 2023-24, the PEC team began merging MOC content to a subsection on the SHB site.

The PEC team continued to meet throughout the FY to reevaluate the direction of the strategies and collect input from medical providers and birth workers for insights on the issues they encounter in birthing spaces when caring for Black/African American women to help shape MOC toolkit content.

SOCIAL MEDIA AND WEBSITE CONTENT

During FY 2023-24, the PEC team primarily focused on rebranding and merging landing pages for the MOC campaign onto the SHB website. As a result, public social media and website content during the FY were limited.

However, in Q1, the SHB site reached 585 users across 636 sessions, and the MOC site reached 104 users across 161 sessions. In Q4, the combined SHB site reached 421 total users across 466 sessions. The updated site had an engagement rate of 36.9% in Q4.

In Q4, the PEC team also created a social media kit containing 10-12 social media posts, MOC birth storytelling video edits, and social media images, as well as printable flyers promoting MOC, a printable MOC door hanger, and the MOC website content.

THREE-YEAR SUMMARY, FY 2021-22 THROUGH FY 2023-24

The PEC team continued to shape and finetune the public outreach strategies, relying heavily on community input. For instance, the Unequal Birth campaign was developed to raise awareness of racism as the root cause of racial disparities in maternal and infant health outcomes. While outreach efforts sharing statistics and images of local families were well-received, community feedback also indicated that a more hope- and solution-oriented approach was desired. This led to a rebranding of the campaign as

the Model of Caring (MOC). The PEC team also identified a need to have more systems-level impact by engaging medical providers and birth workers in the process of sharing resources and improving outcomes for Black/African American birthing parents. In FY 2023-24, the PEC team sought input from medical providers to support and implement efforts to further hone the provider-focused MOC strategy.

Because First 5 funding for MOC and SHB ended after FY 2023-24, the PEC team focused on finalizing an easily accessible toolkit to have the most impact with the remaining resources. Other highlights between FY 2021-22 and FY 2023-24 for the Unequal Birth, SHB, and MOC campaigns included:

- **Public engagement at community events:** Activities included outreach at annual Juneteenth events and a Champions of Maternal Health Mixer and celebration event.
- **Organic and paid social media campaigns**
- **Podcast episodes, blog posts, website learning courses,** and
- **A Birth Storytelling event** featuring local BMU participants sharing their birth story to add community voice to the campaign's rebranded focus on informing providers on ways to improve prenatal and postnatal care by listening to and supporting African American mothers.

OPPORTUNITIES FOR IMPROVEMENT

As First 5 funding for the PEC strategy comes to an end, the PEC team's strategies to incorporate community feedback, finalize the rebrand of the MOC campaign, and develop easily accessible and wide-reaching toolkit resources to best align with the updated campaign goals may ensure lasting impact of the PEC efforts. The organizations behind the PEC team may also:

1. Explore campaign **sustainability/funding** resources through partnerships with the birthing hospitals health systems through the rebranded MOC campaign partnerships to ensure continued use of the critical messages.

2. Explore opportunities in partnership with First 5 to continue **engaging health care systems** and advocates within health care systems to create safe spaces where providers, community partners, and African American families can share their unique experiences to create opportunities for understanding and change.

Countywide Trends

The four programs funded by First 5 Sacramento (Pregnancy Peer Support Program, Safe Sleep Baby Initiative, Family Resource Centers, and Public Perinatal Education Campaign) aim to help reduce the rate of African American perinatal, child abuse and neglect, and infant sleep-related deaths in Sacramento County.

The following section includes population-level data about infant deaths, by cause, consistent with the focus areas of the Blue Ribbon Commission report. The Blue Ribbon Commission goals to reduce African American child deaths by 2020 include:

While program participants have promising outcomes, countywide disparities remain, particularly in the leading preventable causes of death.

1. Reduce the African American child death rate by **10-20%**
2. Decrease the African American infant death rate due to infant perinatal conditions by at least **23%**
3. Decrease the African American infant death rate due to infant safe-sleep issues by at least **33%**
4. Decrease the African American child death rate due to abuse and neglect by at least **25%**
5. Decrease the African American child death rate due to third-party homicide by at least **48%**

To measure progress toward these goals, population data from Sacramento County Public Health include:

- All infant deaths (by race)
- Preterm births
- Low birth weight infants

Additionally, data from the Child Death Review Team (CDRT) include:

- Infant deaths due to perinatal conditions
- Infant deaths due to sleep-related conditions (ISR)
- Child abuse and neglect homicides (infants and children ages 0-5)

It is important to note that countywide data lag behind data for the First 5-funded initiatives reported earlier. Countywide data is current as of 2022, while First 5-funded program data reflect FY 2023-24 activities. Additionally, 2012 is the countywide data baseline year as the RAACD efforts by First 5 and other partners began following the 2013 publication of the Blue Ribbon Commission recommendations.

To account for the effect of small population size, death rate data represent three-year rolling (overlapping) rates (total number of infant deaths in the three-year period divided by the total number of infant births on those three years). Please also note that child death rates (ages 0-5) are presented as deaths per 100,000 children and infant death rates are reported as deaths per 1,000 live births. Additional technical details related to these data and calculations can be found in Appendix 5.

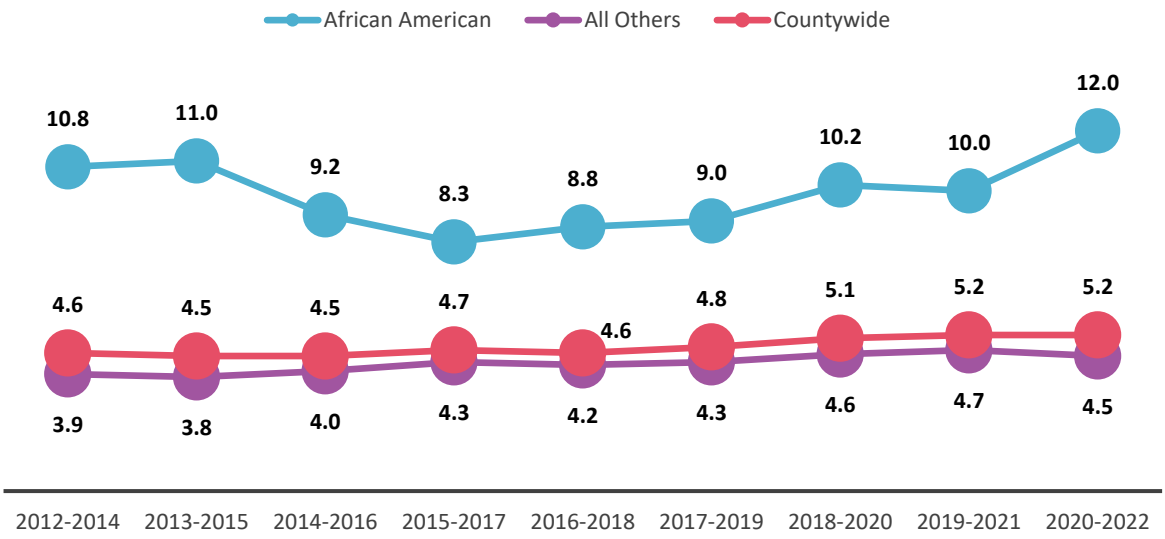
OVERALL INFANT MORTALITY

During the three-year baseline period (2012-2014), African American infants died at a rate of 10.8 per 1,000 births. During 2020-2022, the African American infant death rate was 12.0 per 1,000 births. This reflects an 11% increase compared with the 2012-2014 baseline. African American infants comprised 22% of all infant deaths in Sacramento County during 2020-2022 compared with 24% of infant deaths during 2012-2014.

The rate of African American infant deaths per 1,000 African American births (12.0) increased compared with 2019-2021 (10.0). **African American infants remain were 2.7 times as likely to die compared with all other groups combined**. The disparity between African American infant deaths and all others increased 8% compared with the 2012-2014 baseline.

Multiple factors may influence recent increases and fluctuations. For instance, most current rates include the height of the COVID-19 pandemic in 2020 and 2021. Economic and health concerns as well as shelter-in-place orders in 2020 resulted in fewer births, a slightly elevated number of deaths, and a reduction of the in-person reach of community support services. [42,vii] Structural racism is a likely contributor to the ongoing disparities in infant mortality among African Americans with patterns persisting countywide as well as across the nation.[viii] Because countywide rates (including infant death rates among all other races) have been increasing in recent three-year rolling rates, it may be beneficial to conduct additional research identifying other intersecting characteristics, which may further inform and highlight necessary systems-level, preventative approaches, potentially reducing infant death rates as well as racial disparities.[ix]

Figure 30. Three-Year Rolling Rate of Total Infant Death in Sacramento County, by Race



Source: Sacramento County Public Health (SCPH) Epidemiology Program Data Request. Rate is per 1,000 births.

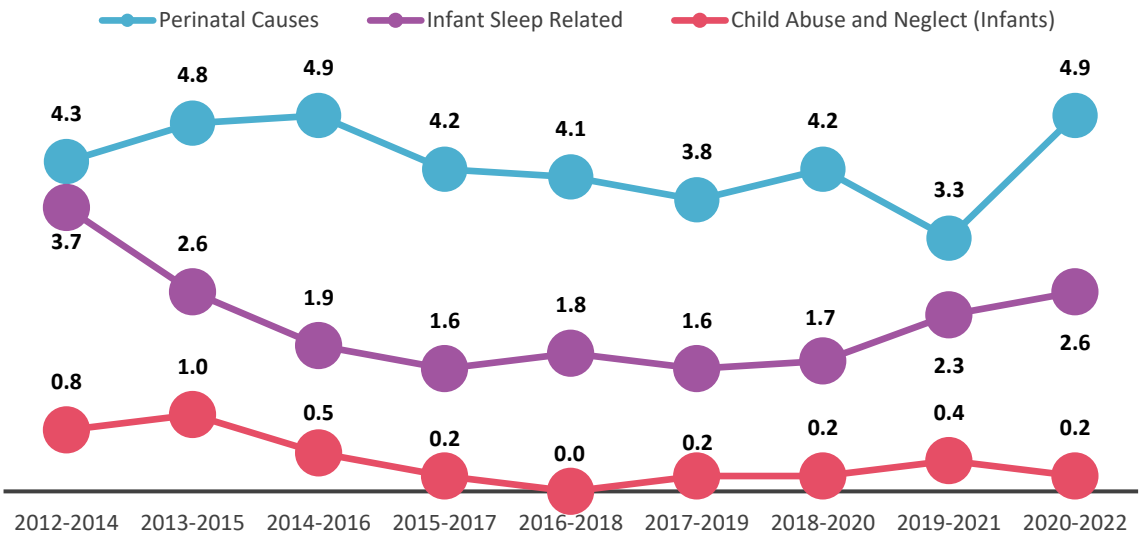
The figure below summarizes infant death rates for each of the three First 5 Sacramento RAACD initiative's focal areas for African American infants alone. Between the 2012-2014 baseline and 2020-2022 (most recent data), infant sleep-related (ISR) deaths had a net decrease of 30% and child abuse and neglect (CAN) deaths (among infants) decreased 76%. Deaths due to perinatal causes had a net increase

[42] While birth rates have been declining nationwide, COVID-related fertility declines may relate to reduced access to partners or intentional delays in childbearing (among those with the means and resources to do so). While the proportion of births to younger people with fewer resources increased, this population was also more vulnerable to COVID-19 which also had impacts on birth outcomes, including increased chances of preterm births and infants being in NICU after birth (Frueh, 2022).

of 14% since 2012-2014. The 2020-2022 rate is comparable to the 2014-2016 peak and exceeds the 2012-2014 baseline value.

As of 2020-2022, CAN homicides exceeded the Blue Ribbon Commission's 2020 reduction goal, whereas infant sleep related deaths and perinatal deaths among African American infants in Sacramento County show worsening trends. Perinatal deaths had an unfortunate spike despite an improvement in the previous rolling rate. Infant sleep related deaths show a slow but continuing trend upward beginning in 2018-2020. The three most recent rolling rates include 2020 and subsequent years impacted by the COVID-19 pandemic. It is possible that undesired trends result, in part, from ongoing disruptions to services and long-term impacts on community health. The increases in countywide perinatal deaths are particularly alarming as the single year rate for 2022 (7.2 per 1,000 African American births) doubled compared with 2021 (3.5 perinatal deaths per 1,000 African American births).

Figure 31. Three-Year Rolling Rates of African American Infant Death: Sleep Related, Perinatal Causes, and Child Abuse and Neglect



Source: 2012 through 2022 Sacramento County Child Death Review Team Reports. Rate is per 1,000 births.

The following sections will further explore countywide infant death rates by RAACD focal area, with comparisons between African American infants and infants of all other races.

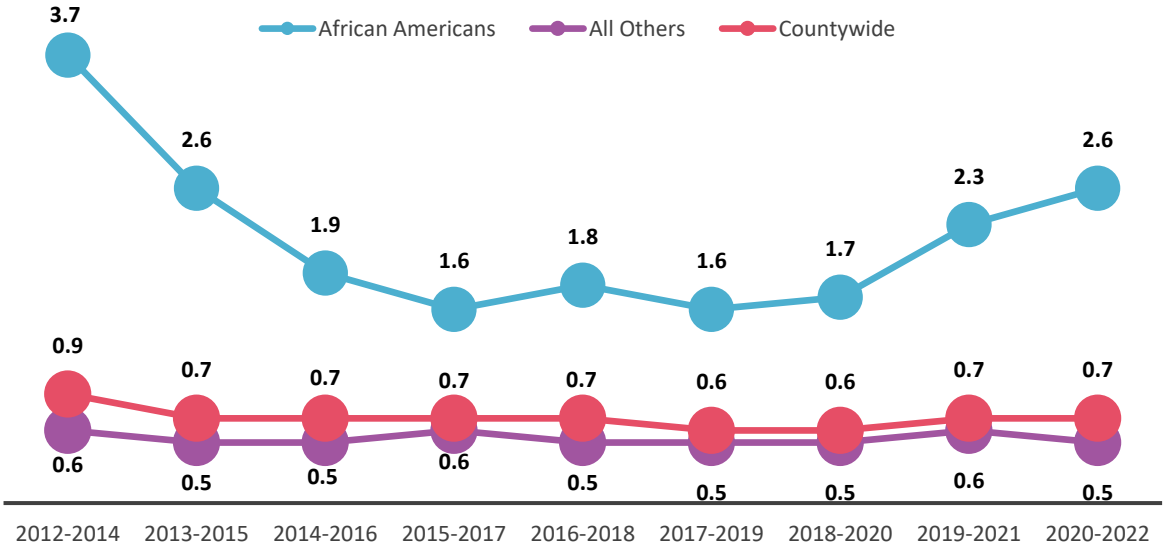
INFANT SLEEP-RELATED DEATHS

The term "Infant Sleep-Related Deaths" (ISR) refers to any infant death that occurs in the sleep environment, including Sudden Infant Death Syndrome, Sudden Unexpected Infant Death Syndrome, and Undetermined Manner/Undetermined Natural Death. Rolling rates of African American ISR deaths occurring in Sacramento County continued to increase following a significant long-term decrease between 2012-2014 (3.7 per 1,000 births) and 2017-2019 (1.6 per 1,000). As of 2020-2022, African American ISR deaths occurred at a rate of 2.6 per 1,000 births. The 2020-2022 rate was slightly higher than the Blue Ribbon Commission reduction goal rate (2.5).

Countywide African American infant sleep-related deaths decreased 32% since 2012-2014. In 2020-2022, African American ISR deaths occurred at a rate of 5.5 times the rate of all other groups.

The disparity gap between African American ISR deaths and all other ethnic groups had a net decrease of 32% compared with 2012-2014. However, in 2020-2022, African American infants were more than five times as likely to die from infant sleep related causes than all other races (2.6 per 1,000 African American births compared with 0.5 per 1,000 births among all other groups).

Figure 32. Three-Year Rolling Rates of Infant Sleep Related Deaths in Sacramento County



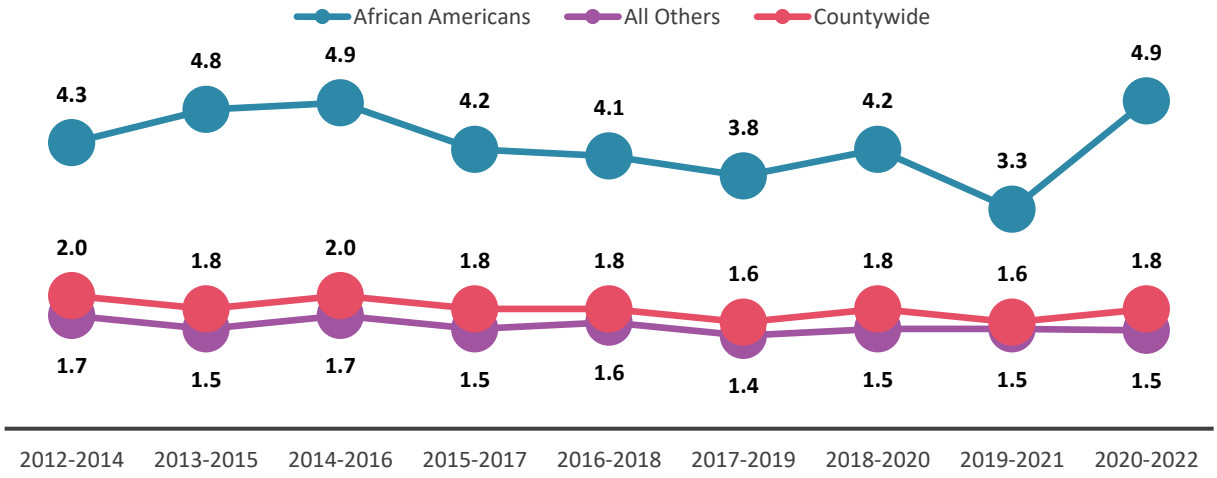
Source: 2012 through 2022 Sacramento County Child Death Review Team Reports. Rate is per 1,000 births.

INFANT DEATHS DUE TO PERINATAL CAUSES

Perinatal causes include deaths due to prematurity, low birth weight, placental abruption, and congenital infections and include deaths through one-month post-birth. During the 2012-2014 baseline period, African American infants died from perinatal causes at a rate of 4.3 per 1,000 births. Despite a promising decrease resulting in the lowest rate for African American infants in 2019-2021 (3.3 per 1,000 births), ISR deaths increased substantially as reflected in the 2020-2022 rolling rate (4.9 per 1,000 births). This rate is higher than the 2012-2014 baseline, and comparable to the peak in 2014-2016.

Since 2012-2014, the disparity gap between African American infants and all others had a net increase of 32%. In 2020-2022, African American infants died from perinatal causes at 3.3 times the rate of all others.

Figure 33. Three-Year Rolling Rates of Infant Death Due to Perinatal Causes in Sacramento County



Source: 2012 through 2022 Sacramento County Child Death Review Team Reports. Rate is per 1,000 births.

Preterm Births

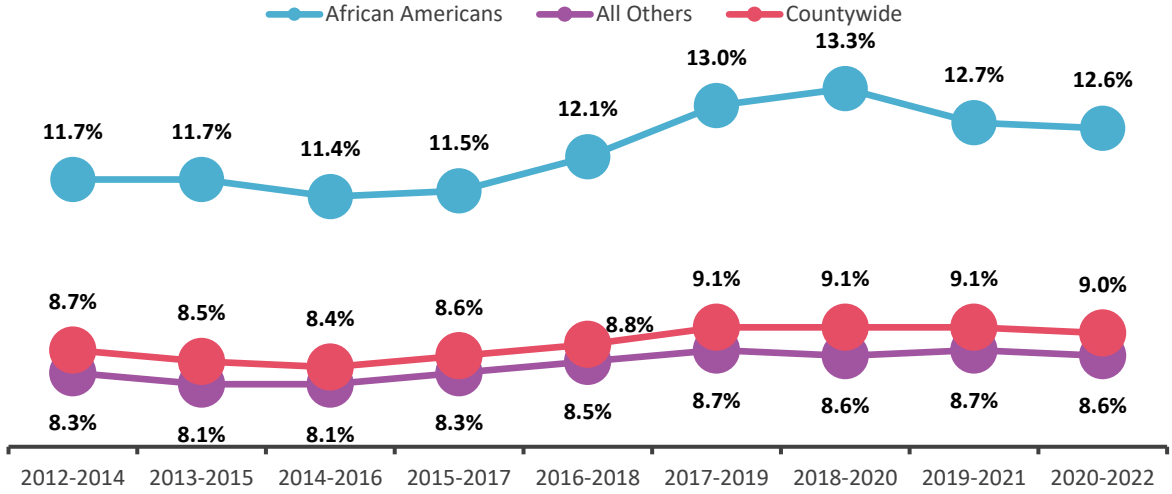
Preterm births include infants born before 37-weeks of gestation. In Sacramento County, nearly 13% of all African American babies born during 2020-2022 were preterm. The percentage of African American births that were preterm (12.6%) was comparable to 2019-2021 (12.7%), lower than 2018-2020 (13.3%), yet higher than the 2012-2014 baseline (11.7%). The proportion of preterm births among infants of all other races and countywide also increased slightly compared with 2012-2014. While alarming, this pattern is consistent with statewide and national concerns. According to Healthy People 2030, preterm births are "getting worse" (10.4% of live births in 2022).[x]

More focused work needs to be targeted in this area to decrease the number of preterm births in the African American community, as well as Sacramento County as a whole. The Healthy People goal is to reach 9.4% by 2030. However, it likely that COVID-19 continues to impact preterm births. COVID-19 infections have been linked to significantly increased likelihood of adverse birth outcomes, including preterm births. Additionally, the COVID-19 pandemic has had a disproportionate impact on communities of color, including increased exposure and health disparities (e.g., structural racism, homelessness, low wage jobs, hazardous environments, less access to health care/COVID-19 testing, and underlying health conditions).[xi]

Additionally, the proportion of preterm African American infants within Sacramento County remained 1.5 times the rate of all other races in 2020-2022. In addition to potential COVID-related barriers, this

substantial gap reflects national discrepancies and may be linked to structural barriers as well as racism-related stress,[xii] highlighting the need for more structural and systems approaches to address the root causes of racial disparities in preterm births and the associated long-term conditions.

Figure 34. Three-Year Rolling Total Percentage of Preterm Infants Born in Sacramento County

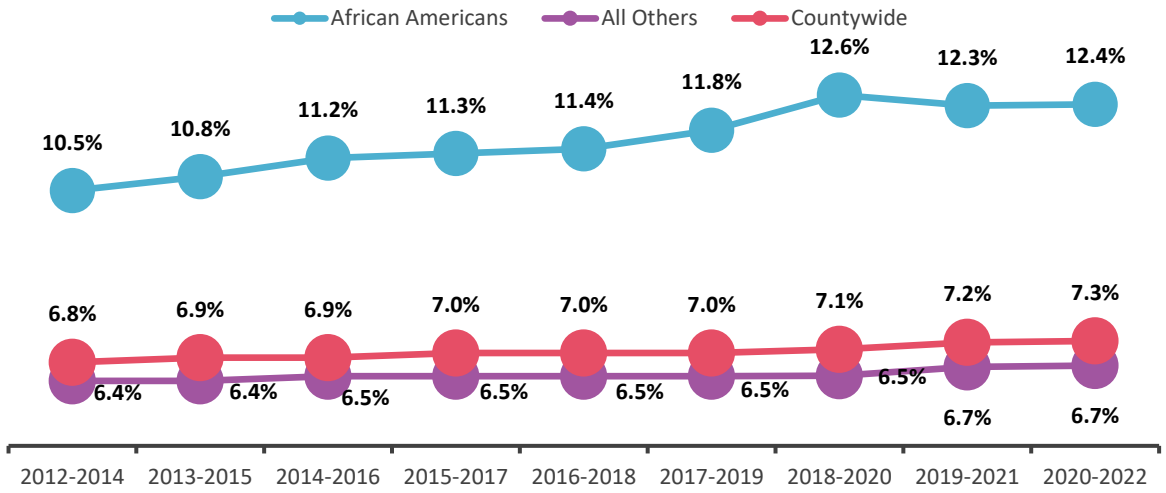


Source: Sacramento County Public Health (SCPH) Epidemiology Program Data Request.

Low Birth Weight

Low birth weight (LBW) newborns are those weighing less than 2,500 grams (5 lbs., 8 oz.). The figure below displays the percentage of African American LBW births between the 2012-2014 baseline and 2020-2022 (rolling total percentages) compared to infants of all other races. The percentage of African American babies born LBW during 2020-2022 is 17% higher than the baseline rolling rate (10.5% in 2012-2014, 12.4% in 2020-2022).

Figure 35. Three-Year Rolling Total Percentage of Low Birth Weight Births in Sacramento County



Source: Sacramento County Public Health (SCPH) Epidemiology Program Data Request.

While increasing trends are concerning, nationwide estimates also show larger proportions of newborns born at a low birth weight in recent years. National Vital Statistics (2024) reported continued increases in LBW births.[xiii] Countywide rates (7.3% overall, 12.4% African Americans) remain lower than national estimates (8.6% overall, 14.8% African Americans).

COVID-19[xiv] as well as persisting racial disparities and the chronic stresses of discrimination and racism are known contributors to health/birth inequities. For instance, research on the negative impacts of racism on mothers and babies indicate that exposure to racial discrimination and segregation during childhood have more negative health consequences than other common contributors (e.g., diet, exercise, smoking, poverty). Similarly, studies commonly found a negative effect of interpersonal discrimination and chronic worry about racial discrimination on preterm birth and birth weight.[xv]

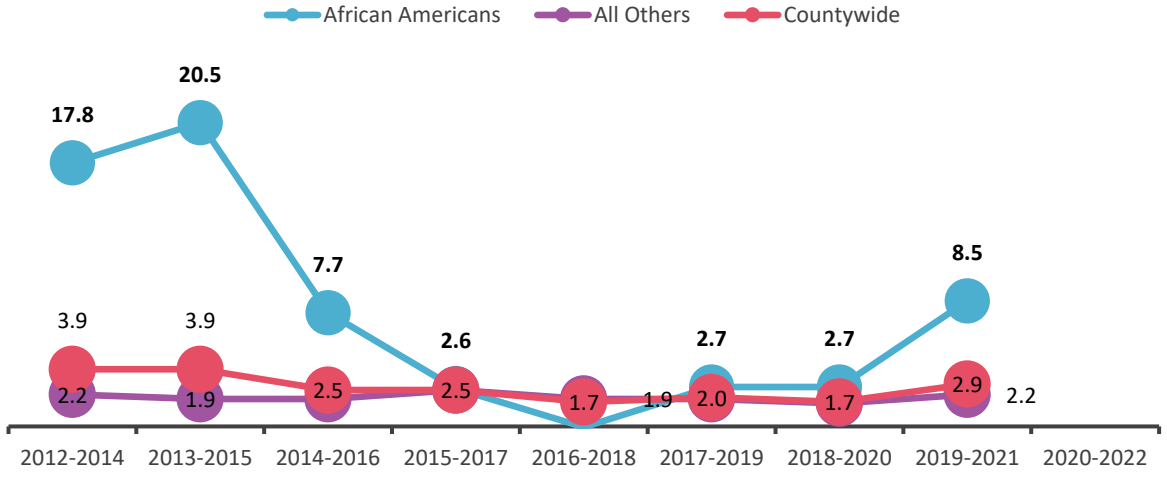
DEATHS DUE TO CHILD ABUSE AND NEGLECT (AGES 0-5)

Among all **children ages 0-5**, African American children died from child abuse and neglect at a rate of 17.8 per 100,000 children during the 2012-2014 baseline period. Due in large part to the broad RAACD initiative efforts throughout Sacramento County,[43] this rate drastically declined, reaching zero African American CAN deaths during 2016-2018. Since then, rates have increased (2.7 per 100,000 in 2017-2019 and 2018-2020, and 8.5 per 100,000 children in 2019-2021). In 2020-2022, rates [placeholder text pending data receipt]. However, despite these increases, rates reflect overall small numbers, with 2.7 per 100,000 representing one child, and 8.5 per 100,000 representing three children. Trends should be monitored and addressed but interpreted with caution.

Since 2012-2014, deaths due to child abuse and neglect (ages 0-5) decreased XX% among Sacramento County African Americans. The disparity gap between African Americans and all other races decreased XX%.

As of 2020-2022, the disparity gap reduced XX% compared with the 2012-2014 baseline. However, African American children remain XX times as likely to suffer a CAN homicide compared with all others.

Figure 36. Three-Year Rolling Rates of Child (0-5) Death due to Child Abuse and Neglect in Sacramento County



Source: 2012 through 2022 Sacramento County Child Death Review Team Reports. Rate is per 100,000 children ages 0-5.

[43] Initiatives include but may not be limited to the Family Resource Centers, the Child Abuse Prevention Center (CAPC), the Cultural Brokers program at the Department of Child, Family and Adult Services (DCFAS), Sierra Health Foundation and the Black Child Legacy Campaign's Community Incubator Leads.

Summary and Conclusions

RAACD strategies continue to have meaningful impact on Sacramento County families. In FY 2023-24, First 5 Sacramento-funded strategies used a range of modalities to promote the health and well-being of African American families and support the reduction of African American child deaths (ages 0-5).

BLACK MOTHERS UNITED

Participants continue to resonate with the support of the BMU program and staff, including valuable peer support, breastfeeding resources, and doula care for Black mothers. Consistent with previous years, more BMU support significantly predicted healthy birth outcomes. BMU clients significantly improved access to protective factors and reduced barriers to healthy birth outcomes. Unfortunately, among the 241 infants born to BMU participants served during 2020-2022, there was one infant death resulting in an infant mortality rate of 4.1 per 1,000 births, which remains substantially lower than the 2020-2022 countywide rate of 12.0 per 1,000 African American births.

FAMILY RESOURCE CENTERS (FRC)

The MAN Arcade Stronger Families, Stronger Generations and SCH Valley Hi Village programs utilized light touch activities, crisis intervention case management, group parenting education workshops, and home visiting with a focus on culturally specific curriculum and strategies to support Black and African American families. FRCs continued implementing the Effective Black Parenting Program and conducting outreach to encourage families to enroll. Participants improved parenting knowledge and skills, protective factors, and access to essential resources for their pressing needs.

SAFE SLEEP BABY

Safe Sleep Baby (SSB) workshops continued to impact providers and caregivers, with significant improvements in knowledge about infant safe sleep, increased safe sleep practices, and access to cribs. In FY 2023-24, more than 1,000 caregivers participated in the one-hour workshop and over 300 community-based service providers and health care workers received training on safe sleep practices and workshop facilitation. Cribs 4 Kids partners distributed nearly 200 cribs to African American caregivers in need of a safe place to sleep their babies, and 93% of African American caregivers reached at follow-up reported only sleeping their child in a crib or Pack-n-Play.

PERINATAL EDUCATION CAMPAIGN

The Perinatal Education Campaign (PEC) merged the Model of Caring campaign onto the Sac Healthy Baby website. The PEC team worked to collect input from medical providers and birth workers to help shape the Model for Caring toolkit content. They developed social media kits, birth storytelling video edits, and flyers/doorhangers for birth workers.

COUNTYWIDE TRENDS

The RAACD initiative contributes to countywide reductions in African American child deaths, particularly among the individuals directly reached. However, most recent three-year rolling rates indicate some countywide trends moving in undesired directions. Countywide, African American infants remain twice as likely to die compared with all other races. During 2020-2022, African Americans were 5.5 times as likely to die due to infant sleep related causes, 3.3 times as likely to die due to perinatal causes, and XX times as

likely to die due to child abuse and neglect compared with all other races. Economic and public health shifts due to the ongoing impact of COVID-19 during this period, as well as ongoing structural, systemic, and institutional racial discrimination, contribute to these disparities and warrant further exploration across systems.

RAACD programs are appropriately positioned to explore the larger patterns in these trends and "scale up" efforts to address them at a county level and reach even more Sacramento families. In addition to direct services and public education, policy/systems change are needed to effect real and lasting change. First 5 continues to advocate for policy and systems change across Sacramento County and the state of California as a whole and has incorporated more deliberate and specific systems-change initiatives and efforts to promote racial equity, diversity, and inclusion in their 2024-2027 strategic plan.

Additionally, now that the Blue Ribbon Commission's target year of 2020 has passed, it is important to revisit the County's long term goals and re-commit to the reduction of African American child deaths, utilizing the insights gained since the last goals were set, incorporating community and systems perspectives which may help identify lingering disparities.

Appendix 1 – Factors Associated with Unhealthy Birth Outcomes

Birth Type	Unhealthy Birth Outcome				Mother's Characteristics						Program Support	
	Low Birth Weight	Birth Weight	Preterm	Gestational Age	Weeks pregnant at entry	1st Trimester Prenatal Care?	# weeks prenatal care began	Socioeconomic barriers at intake	Health risks and pre-existing conditions at intake	Medical conditions developed during pregnancy	# of weekly check-ins	Received Doula Support?
Singleton	Y	4 lb., 14 oz	Unknown	Unknown	8	Y	6	Single, no partner; Income less than $15K; *Pressing Needs:* Food/Nutrition, Transportation	Anxiety; Depression; Prior LBW; Prior Preterm; age 35+; Asthma; Other health risk	Preeclampsia	48	N
Singleton	N	5 lb., 12 oz	Y	36	8	Y	6	Pressing Needs: Transportation, Housing	Other health risk	None	27	N
Singleton	N	5 lb., 8 oz	Y	35	17	Y	5	No high school diploma; Pressing Needs: Dental, Housing	Nutritional deficiencies; Depression; Prior LBW; Prior preeclampsia; Prior Preterm; Other health risk	Preeclampsia; High Blood Pressure	13	N
Singleton	N	6 lb., 5 oz	Y	34	20	N	19	Single, no partner; *Pressing Needs:* Prenatal Care, Food/Nutrition, Counseling, Transportation	Age under 20; Other health risk	Preeclampsia; High Blood Pressure	6	N
Singleton	N	6 lb., 8 oz	Y	34	25	Y	8	None	Nutritional deficiencies; Anxiety; Prior preeclampsia; Prior Preterm; Age 35+; Diabetes; High Blood Pressure	None	17	N
Singleton	N	6 lb., 6 oz	Y	35	26	Y	6	Pressing Need: Prenatal Care	Age 35+	Preeclampsia	14	Y
Singleton	Y	5 lb., 6 oz	N	38	22	Y	9	Unemployed, looking for work; Income less than $15K	Prior preeclampsia	Gestational diabetes; High Blood Pressure	6	N
Singleton	Y	5 lb., 5 oz	N	37	26	Y	7	Unstable housing; No Transportation; Single, no partner; Income less than $15K; *Pressing Needs:* Transportation, Housing	Age 35+; Other Health Risk	None	7	Y
Singleton	N	9 lb., 0 oz	Y	36	30	Y	10	Pressing Need: Housing	None	Preeclampsia	6	N
Singleton	Y	5 lb., 2 oz	N	39	29	Y	-	Income less than $15K	None	None	10	N

Appendix 2 – BMU Correlation, Chi Square, and Regression Details

First, correlational analyses[44] were conducted to identify significant relationships between the factors listed in the table above and the birth outcomes above. Significant correlations mean variables are related to one another, though correlations do not mean that one variable *caused* an outcome. The characteristics that were significantly correlated to birth outcomes are shown in the figure below (variables that were not significantly correlated are not displayed).

Factors that Correlate with Birth Outcomes[45]

Protective/Risk Factors at Intake	Healthy Birth Outcome	Birth Weight	Gestational Age
	(Dichotomous; Y/N)	(Continuous)	(Continuous)
Regular Prenatal Care at Intake		-.130 [t]	
Enrolled in WIC			-.131 [t]
Prior Low Birth Weight Birth	-.223 **	-.156 [t]	-.216 **
Prior Gestational Diabetes			-.220 **
Prior Preeclampsia			-.230 **
Prior Preterm Birth	-.283 **		-.301 **
Has a Child Under One Year of Age	-.247 **	-.203 **	-.221 **
Number Maternal Health Risks at Intake	-.184 *	-.133 [t]	-.175 *
Number of Socioeconomic Risk Factors at Intake	-.167 *	-.139 *	-.133 [t]
Number of Pressing Needs at Intake	-.233 **		-.152 *
Self-reported High Stress at Intake			-.177 *
Number of BMU Check-Ins			.187 **
Received BMU Doula Services	.211 *		.142 *

Source: Health Assessment Form, Pregnancy Outcomes Form, and Exit Form. N = 203, however, sample sizes for each correlation vary due to missing data and/or newer indicators not available for all cohorts within the sample. Statistical significance reported as [t] = $p < .10$ (marginal significance); * = $p < .05$; ** = $p < .01$; *** = $p = .001$.

All dichotomous variables included in the regressions were coded based on how they are presented in the tables (e.g., for the variable "regular prenatal care," 1 = *Did have regular prenatal* care and 0 = *Did not have regular prenatal care*).

[44] Includes Chi-Square test of independence, Point-Biserial Correlation, and Pearson Correlation Coefficient tests.

[45] All dichotomous variables included in the regressions were coded based on how they are presented in the tables (e.g., for the variable "regular prenatal care at intake," 1 = *Did have regular prenatal care* and 0 = *Did not have regular prenatal care*). Significant associations were typically in the expected directions (e.g., more maternal health risks correlated with undesired outcomes) with the exception of two marginally significant variables (prenatal care and WIC enrollment). Since correlations were marginally significant and distribution largely one-sided for these variables, these are likely spurious correlations in this cohort.

Logistic Regression Predicting Dichotomous Healthy Birth Outcome (yes/no).

	B	S.E.	df	p	OR	95% CI
Prior Low Birth Weight Birth	-.394	1.337	1	.768	.675	.049 – 9.263
Prior Preterm Birth	-1.718	1.151	1	.136	.179	.019 – 1.713
Number of Maternal Health Risks at Intake	-.241	.294	1	.413	.786	.442 – 1.398
Has Child Under 1 year old	-1.536	.867	1	.076	.215	.039 – 1.177
Number of SES Risk Factors at Intake	.160	.218	1	.463	1.174	.765 – 1.800
Number of Pressing Needs at Intake	**-.432**	**.202**	**1**	**.033**	**.649**	**.436 – .965**
Received BMU Doula Service	1.233	.666	1	.064	3.431	.930 – 12.658
Constant	**2.664**	**.622**	**18.339**	**.000**	**14.355**	**-**

Note: Statistically significant variables in **bold**; N = 154.

Linear Regression Predicting Continuous Birth Weight

	B	S.E.	t	p	95% CI
Constant	**8.414**	**.610**	**13.804**	**.000**	**7.206 – 9.618**
Regular Prenatal Care at Intake	-1.167	.592	-1.972	.051	-2.336 – .003
Prior Low Birth Weight Birth	-.673	.497	-1.353	.178	-1.655 – .310
Has Child Under 1 year old	**-.999**	**.414**	**-2.411**	**.017**	**-1.818 – -.180**
Number of Health Risks at Intake	.019	.119	.161	.873	-.216 – .255
Total Number of Health *and* SES Risks (combined) at Intake	-.053	.086	-.614	.540	-.223 – .117

Note: Statistically significant variables in **bold**; N = 154.

Linear Regression Predicting Continuous Gestational Age

	B	S.E.	t	p	95% CI
Constant	**39.022**	**.384**	**101.610**	**.000**	**38.263 – 39.782**
Enrolled in WIC at Intake	-.032	.282	-.115	.909	-.591 – .526
Prior Low Birth Weight Birth	-1.082	.771	-1.403	.163	-2.608 – .443
Prior Gestational Diabetes	**-1.862**	**.584**	**-3.187**	**.002**	**-3.018 -- -.706**
Prior Preeclampsia	-.192	.481	-.400	.690	-1.143 – .759
Prior Preterm Birth	**-1.777**	**.684**	**-2.598**	**.010**	**-3.131 – -.424**
Has Child Under 1 year old	**-1.667**	**.554**	**-3.009**	**.003**	**-2.763 – -.571**
Number of Health Risks at Intake	-.010	.169	-.061	.952	-.344 – .323
Total Number of Health *and* SES Risks (combined) at Intake	.144	.121	1.192	.235	-.095 – .383
Number of Pressing Needs at Intake	**-.329**	**.111**	**-2.962**	**.004**	**-.549 – -.109**
High stress level at intake	**-1.051**	**.337**	**-3.118**	**.002**	**-1.718 – -.384**
Number of BMU Check-Ins	**.040**	**.012**	**3.318**	**.001**	**.016 - .064**
Received BMU Doula Service	.302	.293	1.031	.304	-.278 - .882

Note: Statistically significant variables in **bold**; N = 147.

Appendix 3 – Three-Year BMU Birth Outcomes

	FY 2021-22 (N = 71)		FY 2022-23 (N = 67)		FY 2023-24 (n = 66)	
Live Births	71	99%	67	100%	66	100%
Favorable Outcomes						
Healthy birth weight	64	90%	61	91%	62	94%
Full term birth	61	86%	63	94%	60	91%
Healthy birth weight *and* full term	56	79%	59	88%	56	85%
Unfavorable Outcome						
Low birth weight *(< 5 lb, 8 oz)*	7	10%	6	9%	4	6%
Preterm birth *(< 37 weeks)*	8	11%	4	6%	6	9%
Low birth weight *and* preterm	4	6%	2	3%	0	0%
Newborn death	0	0%	0	0%	0	0%
Stillborn	1	1%	0	0%	0	0%

Note: Birth weight and gestational weeks not available for all infants born.

Appendix 4 – Countywide African American Births and Infant Deaths 2012-2022

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
# AA Births	2,078	1,979	1,941	1,901	1,826	1,947	1,817	1,796	1,681	1,714	1,677
# AA Infant Deaths	22	24	19	21	12	14	23	13	18	21	22
AA Infant Mortality Rate *(per 1,000 births)*	10.6	12.1	9.8	11.0	6.6	7.2	12.7	7.2	10.7	12.3	13.1
Three-Year Rolling Rate *(Period end year)*	-	-	10.8	11.0	9.2	8.3	8.8	9.0	10.2	10.0	12.0

Appendix 5 – Technical Notes Related to County Trend Data

Since 2019, representatives from First 5 Sacramento, Sierra Health Foundation, Sacramento County Public Health, and the Child Abuse Prevention Center have met annually to discuss and agree upon core parameters for gathering and sharing RAACD data. The following presents the highlights of these discussions as of fall 2022.

Baseline Year

The Blue Ribbon Commission report cited data from 2007-2011, and set goals based on the change desired after that period. Specifically, 2012 is being used as the starting period for RAACD partners, although implementation began to get underway in 2014 and 2015. Because of the instability of one-year estimates, this report uses the three-year period of 2012-2014 as the baseline period, and tracks change in subsequent, rolling three-year periods relative to that baseline.

Coding of Race

Birth data is based on maternal race indicated on birth certificates and includes individuals who identify as African American alone. Individuals whose race is listed as "Multiracial" are not included in the Sacramento County Public Health's (SCPH) category of African American. Death data is gathered by the SCPH from the coroner's office and is based on the race of the deceased on the death certificate. The race listed on the birth certificate and death certificate may not always match and may not be fully representative of individuals identifying as Black/African American.

Data Sources and Calculated Rates

Partners agreed to use data from Sacramento County Public Health as the source of overall infant death rates, low birth weight, and preterm births and to use CDRT data to track infant deaths by cause. It was also agreed to show trends per 1,000 births, and not 100,000 population, with the exception of 0-5 child abuse and neglect deaths, which remain per 100,000 population.

Measure	Data Source		Measured as:
	Numerator	Denominator	
Low birth weight infants	SCPH	SCPH (total births)	Percentage of Births
Preterm infants	SCPH	SCPH (total births)	Percentage of Births
All Infant Deaths (<1 year)	SCPH	SCPH (total births)	Rate per 1,000 births
Infant Sleep-related Deaths (<1 year)	CDRT	SCPH (total births)	Rate per 1,000 births
Infant Perinatal Condition Deaths (<1 year)	CDRT	SCPH (total births)	Rate per 1,000 births
Infant Child Abuse and Neglect Deaths (<1 year)	CDRT	SCPH (total births)	Rate per 1,000 births
0-5 Child Abuse and Neglect Deaths (< 6 years)	CDRT	County Population (0-5)	Rate per 100,000 children

Three-year rates are calculated as the sum of the totals for each year for the topic of interest (e.g., number of infant deaths) divided by the sum of the total population measure for the three years (e.g., number of births). This is then multiplied by the rate measurement, when applicable. For instance, the rolling rate for infant mortality calculation is:

((# infant deaths Year 1 + # infant deaths Year 2 + # infant deaths Year 3) /
*(# births Year 1 + # births Year 2 + # births Year 3))*1000*

Disparity gaps described in this report reflect the difference between the group with the highest rate divided by the group with the lowest rate. For instance, the disparity gap between infant mortality rates are calculated as:

(African American Mortality Rate / All Others Mortality Rate)

Changes in total rates between single-year or three-year rolling rates are calculated as follows:

(New value-Previous or Baseline value)/ Previous or Baseline value

Calculations for changes in disparity rates between groups are as follows:

((New AA rate – New All Others Rate)-(Previous AA rate – Previous All Others Rate)) /
(Previous AA rate – Previous All Others Rate))

Appendix 6 – References

[i] Sacramento County Child Death Review Team: A Twenty Year Analysis of Child Death Data 1990 – 2009. http://www.thecapcenter.org/admin/upload/final%2020%20year%20cdrt%20report%202012_1%2026%2012.pdf

[ii] Blue Ribbon Commission Report on African-American Child Deaths, 2013. http://www.philserna.net/wp-content/uploads/2013/05/Blue-Ribbon-Commission-Report-2013.pdf

[iii] RAACD Strategic Plan, March 2015. https://www.shfcenter.org/assets/RAACD/RAACD_Strategic_Plan_Report_March_2015.pdf

[iv] RAACD Implementation Plan, September 2015. https://www.shfcenter.org/assets/RAACD/RAACD_Implementation_Plan_2015.pdf

[v] California Department of Public Health. 2024. Breastfeeding Initiation. https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Breastfeeding-Initiation.aspx

[vi] Title IV-E Prevention Services. 2022. "Effective black parenting program." June 2022 https://preventionservices.acf.hhs.gov/programs/402/show

[vii] Frueh, S. 2022. "The pandemic 'baby bust' and rebound." National Academies. June 17, 2022. https://www.nationalacademies.org/news/2022/06/the-pandemic-baby-bust-and-rebound

[viii] Ely, D. M. & A. K. Driscoll. 2024. "Infant mortality in the United States, 2022: Data from the period linked birth/infant death file." National Vital Statistics Reports, 73, 5. https://www.cdc.gov/nchs/data/nvsr/nvsr73/nvsr73-05.pdf

[ix] Burris, H. H. & M. R. Hacker. 2017. "Birth outcome racial disparities: a result of intersecting social and environmental factors." Semin Perinatol. 2017 Oct;41(6):360-366. https://pubmed.ncbi.nlm.nih.gov/28818300/

[x] US Department of Health and Human Services. Healthy People 2030. Reduce preterm births – MICH-07. https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-preterm-births-mich-07/data

[xi] Reyes, M. V. 2020. "The disproportional impact of COVID-19 on African Americans." Health and Human Rights, 2020 Dec, 22(2): 299-307.

[xii] Scommegna, P. (2021, January 21). "High Premature Birth Rates Among U.S. Black Women May Reflect the Stress of Racism and Health and Economic Factors." https://www.prb.org/resources/high-premature-birth-rates-among-u-s-black-women-may-reflect-the-stress-of-racism-and-health-and-economic-factors/

[xiii] Osterman, M.J.K, et. al., 2024. Births: Final Data for 2022. National Vital Statistics Report, Volume 73, Number 2. https://www.cdc.gov/nchs/data/nvsr/nvsr73/nvsr73-02.pdf

[xiv] Wei, S.Q., et. al., 2021. "The impact of COVID-19 on pregnancy outcomes: a systematic review and meta-analysis." CMAJ 2021. April 19, 193, E540-548. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8084555/pdf/193e540.pdf

[xv] Hernandez-Cancio, S. & V. Gray. 2021. "Racism hurts mom and babies." National Partnership for Women & Families, National Birth Equity Collaborative, June 2021. https://www.nationalpartnership.org/our-work/health/moms-and-babies/racism-hurts-moms-and-babies.html

FY 2023-24 Reduction of African American Child Deaths (RAACD) Evaluation Committee Review

Introduction

Overall Goal: Reduce the African American child death rate **10-20%:**

- Infant Perinatal Conditions **23%**
- Infant Safe Sleep Issues **33%**
- Child Abuse and Neglect **25%**
- Third-Party Homicides **48%**

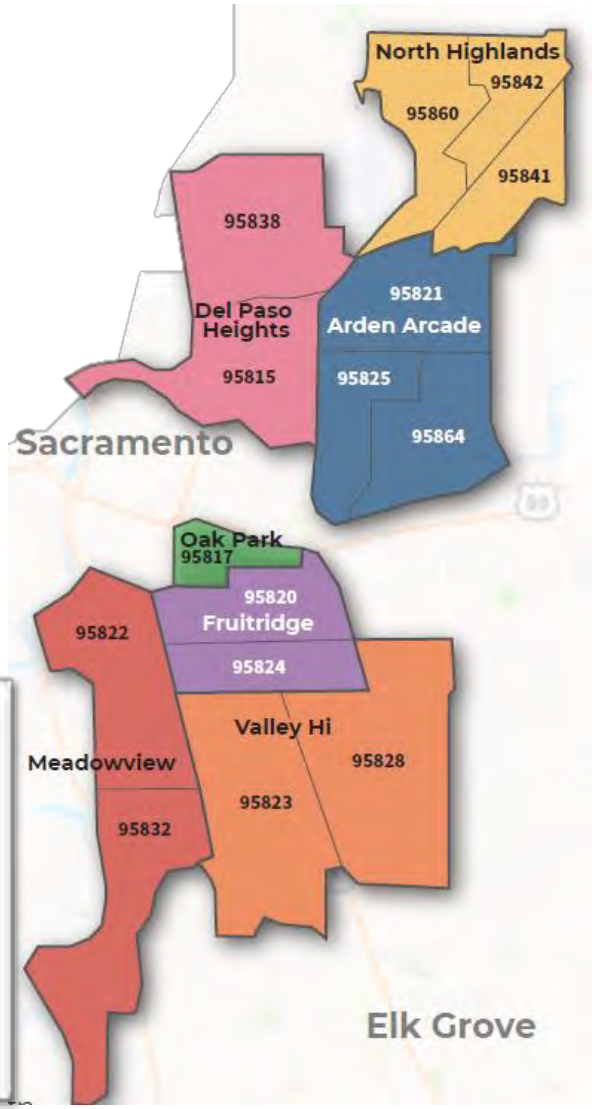
First 5 Sacramento focus

Pregnancy Peer Support Program

Family Resource Centers

Safe Sleep Baby

Perinatal Education Campaign



Pregnancy Peer Support Program

Partner: Her Health First's Black Mothers United program

- **121** prenatal participants + **19** postpartum only
  - 53% lived in one of the seven high-risk neighborhoods
  - One in five (19%) joined during first trimester
- **84%** had at least one **health and/or socioeconomic risk** factor at intake

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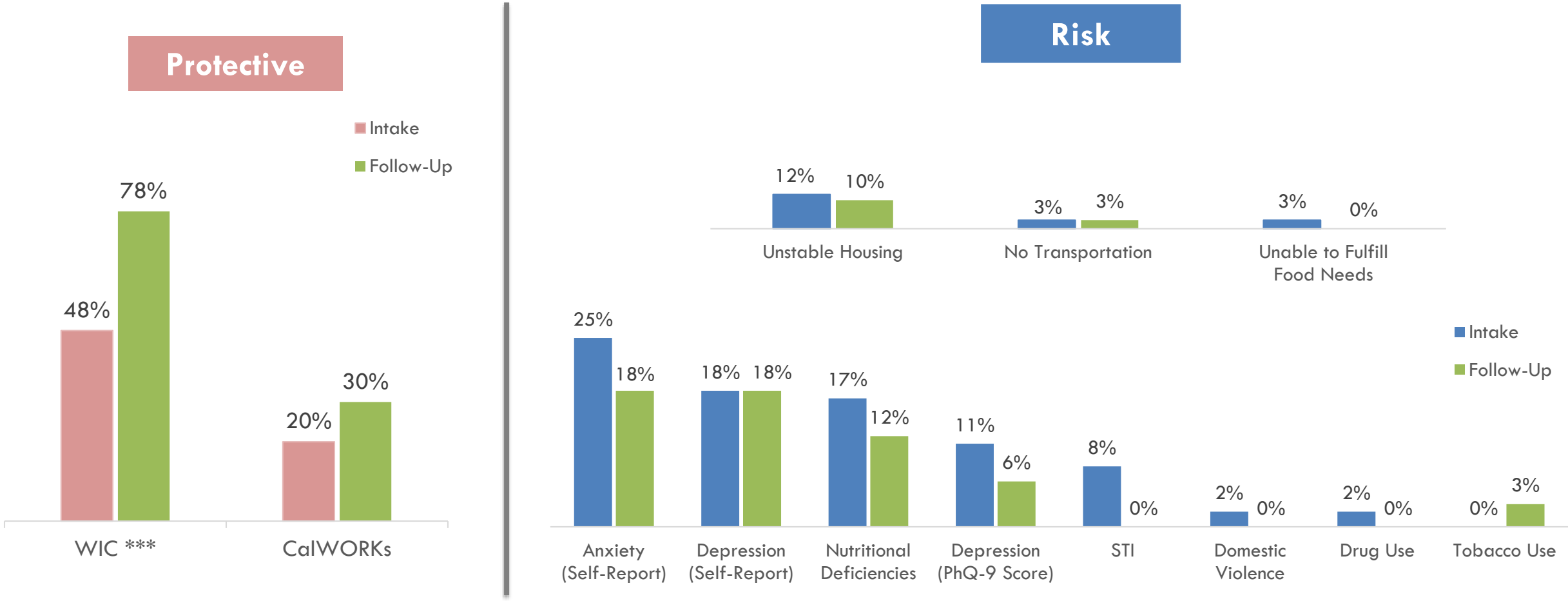
"… I like being in a group setting of moms where everyone looks like me, **I don't feel isolated**. … I still reach out to my pregnancy coach for advice…"

- BMU Participant

Changes in Risk and Protective Factors



Source: Health Assessment (N = 60) and PhQ-9 Assessment (N = 55) Intake and Follow-up Matched Sets. Ns for each item may vary due to missing data/non-responses. Statistically significant change (indicated on column names) reported as * $p < .05$, ** $p < .01$, *** $p < .001$.

FY 2023-24 Birth Outcomes




	All Infants (N = 66)		Twins (N = 2)		Singletons (N = 64)		Served by Doula (N = 26)	
Live Births	66	100%	2	100%	64	100%	26	100%
Favorable Outcomes								
Healthy birth weight	62	94%	2	100%	60	94%	25	96%
Full term birth	60	91%	2	100%	58	91%	25	96%
Healthy birth weight *and* full term	56	85%	2	100%	54	84%	24	92%
Unfavorable Outcome								
Low birth weight	4	6%	0	0%	4	6%	1	4%
Preterm birth†	6	9%	0	0%	6	9%	1	4%
Low birth weight *and* preterm	0	0%	0	0%	2	0%	0	0%
Stillborn deliveries	0	0%	0	0%	0	0%	0	0%
Newborn deaths	0	0%	0	0%	0	0%	0	0%

Longitudinal Outcomes of Pregnancy Peer Support Participants

12-month outcomes of **2020-2022 births** to mothers served by BMU

241 Births
(2020 - 2022)

ONE Infant Death (0.4%)
12-month outcomes

3-Year Infant Mortality:
4.1 per 1,000 births

2020-2022 Countywide:
12.0 per 1,000 (AA)
5.2 per 1,000 (Overall)

Key Takeaway:

Pregnancy Peer Support contributes to **lower infant mortality rates**

> "… I was so blown away by how kind and loving the environment was. **I felt so welcomed and seen for my skin color… They care deeply about the Black community.** They give so much…"
>
> – BMU Participant

Family Resource Centers

Partner: Birth & Beyond – two of nine FRCs receive RAACD funding
MAN Arcade Stronger Families, Stronger Generations; SCH Valley Hi Village Program

- **328** adults and **150** children participated in RAACD-funded activities
- Ongoing implementation of Effective Black Parenting Program (EBPP)

Home Visiting

- 400+ home visits to 67 families
- Participants **increased agreement with Effective Black Parenting behaviors, protective factors, and access to immediate needs**

Parenting Education

- 12 MPAP Caregivers
  29 EBPP Caregivers
- Participants **improved** in **positive parenting knowledge/skills**

Crisis Intervention Services

- 241 services to 191 adults (Level 1 & Level 2 support)
- Case management families **improved in areas of concern** through resources and individualized goal plans

Social and Emotional Learning and Support (SELS)

- **474 "light touch" SELS services** to 170 caregivers and 71 children

“Skye” – Home Visiting

26-year-old Native parent with a multiracial child, seeking support with parenting skills and child development.

Skye enrolled in Effective Black Parenting Program home visiting, received Safe Sleep Baby education, and was connected to Medi-Cal health insurance

“I want her to know as much about her African culture as she can, and **I wanted to be able to learn from Black women.**”

“Imani” – Crisis Intervention Case Management

Mother of four fleeing domestic violence, living in transitional housing. Referred to case management from home visiting.

She was connected to the diaper distribution program, micro-transit, food boxes, holiday gift registries, and leads to access permanent housing.

‘Imani’ is **increasingly independent and self-sufficient**. She is getting **her own place** and has **reliable transportation**. She uses FRC “light touch” support as needed.

Safe Sleep Baby

Partner: Child Abuse Prevention Council

1,086 caregivers trained

- 32% African American
- 61% lived in RAACD-focal neighborhoods

602 cribs distributed by Cribs4Kids Program

- 33% to African American caregivers

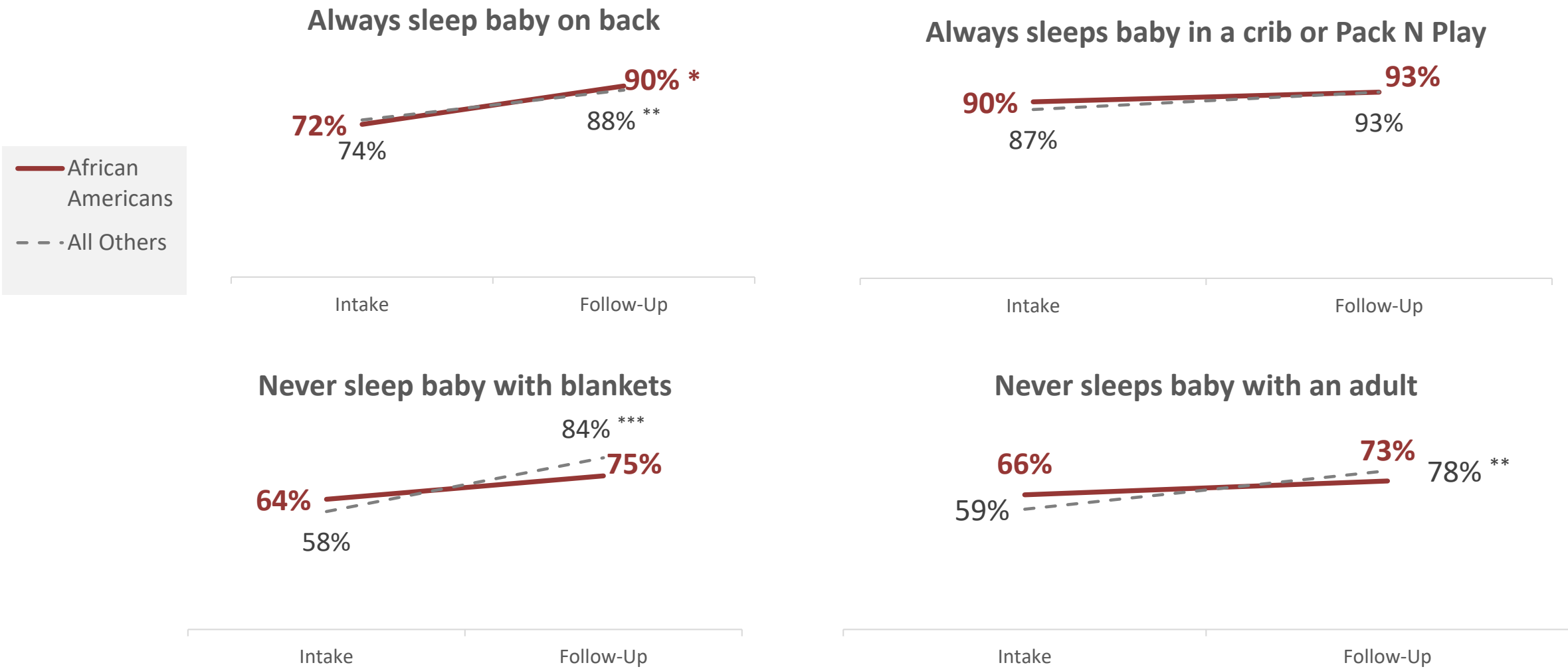
232 community-based service providers and ***70*** health care workers trained

SSB education implemented in ***all*** eight birthing hospital systems in Sacramento County

"… I feel **more confident keeping my baby safe** while she sleeps. I didn't realize it was such an important topic but now I do, and I also have **a safe place for her.**"

- SSB Participant

Infant Safe Sleep Practices

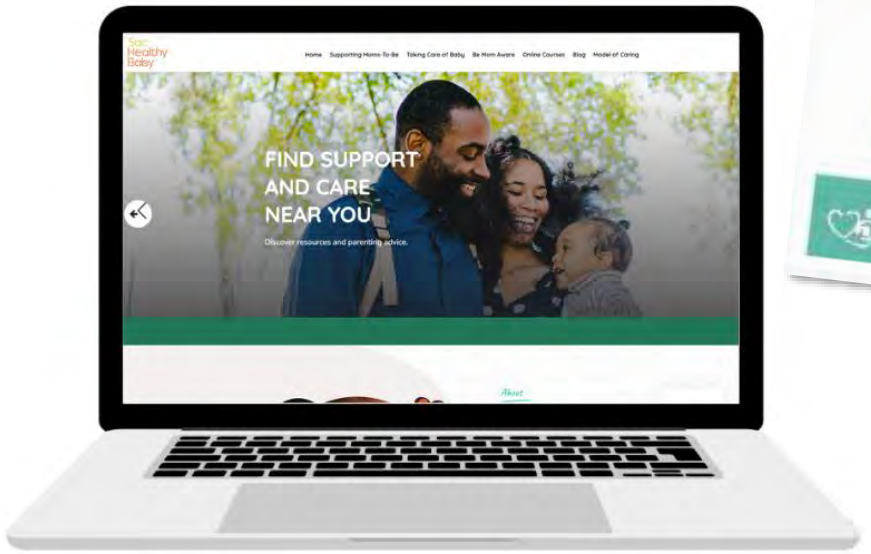


Source: CAPC SSB Intake and Exit Surveys. African American N = 61; All Others N = 184. Statistical significance reported as * p < .05, ** p < .01, *** p < .001.

Public Perinatal Education Campaign

Partner: Her Health First / Dept. of Public Health

- Model of Caring (MOC) campaign further honed to provide **tools for community birth workers** to connect families to resources
- Rebranding and merging MOC onto Sac Healthy Baby (SHB) site
- Developed:
  - Social media toolkit,
  - Edited storytelling videos
  - Engaging images
  - Website content
  - Printable flyers and door hangers



Three-Year Trend Highlights

Between FY 2021-22 and FY 2023-24, participants:

- ✓ Often lived in the RAACD focal areas
- ✓ Gained access to community resources, showed improved protective factors, and increased positive parenting knowledge and skills
- ✓ Had healthier birth outcomes and lower rates of infant mortality compared to countywide
- ✓ Significantly increased infant preparedness and safe sleep practices
- ✓ Received more than 1,500 cribs to safely sleep their babies
- ✓ Engaged with providers at community events, shared their stories, and accessed information via social media/websites

… and more!

> "I know how to protect my baby, which gives me **peace of mind.**"

> "The support is great… I felt **heard and understood** during this birth and pregnancy."

COUNTYWIDE TRENDS

BRC Goal Status as of 2020-2022

2020 BRC Goal:	2020 BRC Goal Status	% Change 2012-2014 to 2020-2022	Disparity Gap 2012-2014 to 2020-2022
10% to 20% reduction of **overall** death rate (ages 0-17)	Goal Exceeded * 30% Reduction	XX% Reduction (ages 0-5)	XX% Reduction (ages 0-5)
At least **23%** reduction of infant deaths due to **perinatal conditions** (ages < 1 month)	Goal Unmet 4% Reduction	14% Increase	32% Increase
At least **33%** reduction of **infant sleep related** (ISR) deaths (ages 0-1)	Goal Exceeded 54% Reduction	30% Reduction	32% Reduction
At least **25%** reduction of **child abuse and neglect** deaths (ages 0-17)	Goal Exceeded * 85% Reduction	XX% Reduction (ages 0-5)	XX% Reduction (ages 0-5)
At least **48%** reduction of **third-party homicides** (ages 0-17)	Not funded or reported by First 5 Sacramento – see BCLC report		

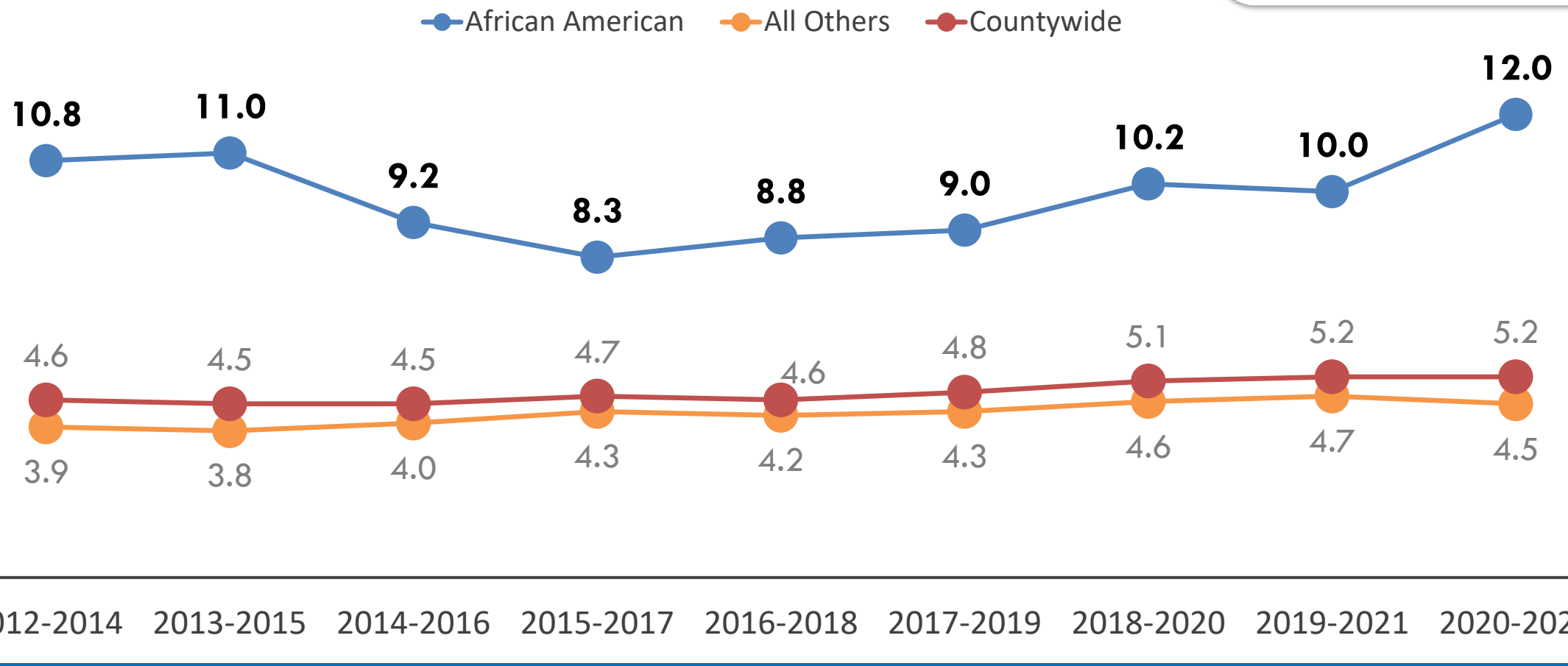
* Not a direct comparison to BRC goals specified for children ages 0-17. Values presented here are for children ages 0-5.

Countywide Trend Data

Since 2012-2014

11% increase (among AA infants)
8% increase in disparity gap

Overall Infant Death (both preventable and unpreventable causes) **- Three Year Rolling Rates**



Source: Sacramento County Public Health (SCPH) Epidemiology Program Data Request. Rate is per 1,000 infants.

Countywide Trend Data

Countywide African American Births and Infant Deaths 2012-2022

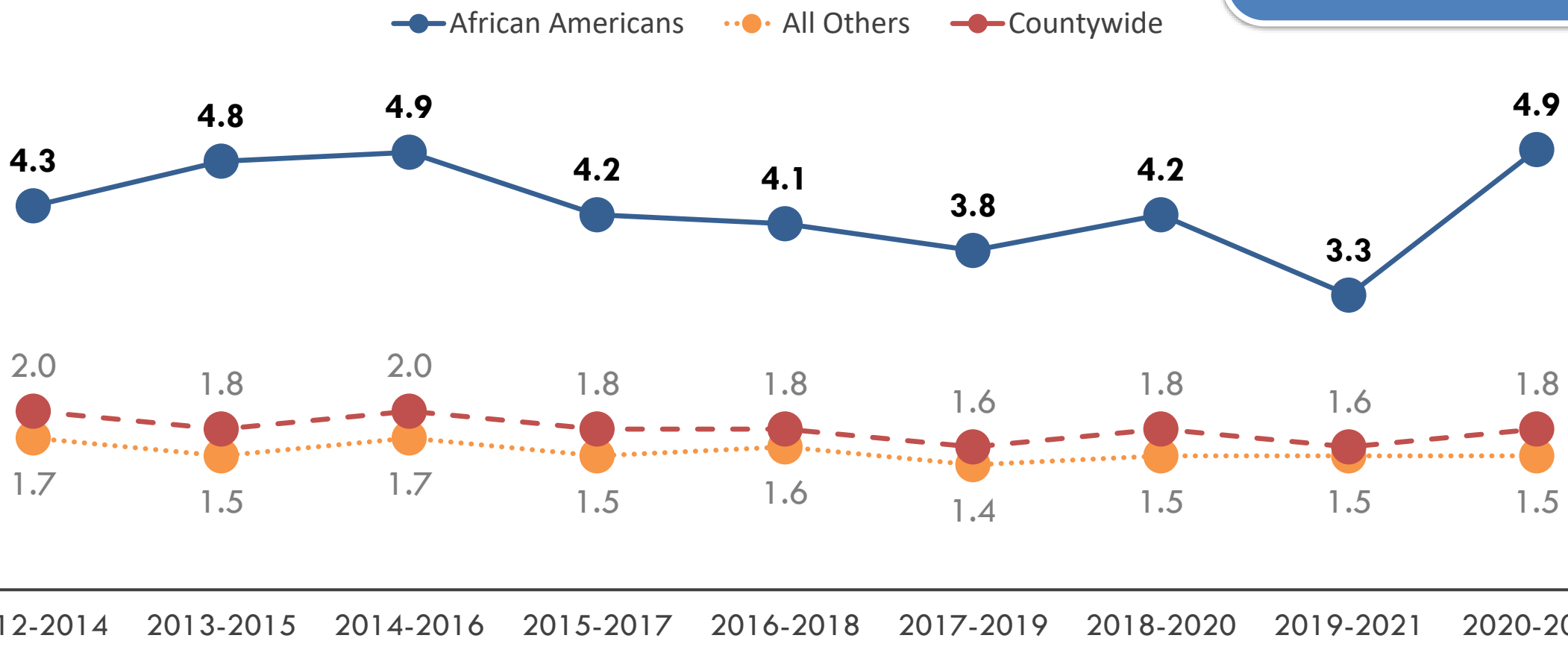
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
# AA Births	2,078	1,979	1,941	1,901	1,826	1,947	1,817	1,796	1,681	1,714	1,677
# AA Infant Deaths	22	24	19	21	12	14	23	13	18	21	22
AA Infant Mortality Rate *(per 1,000 births)*	10.6	12.1	9.8	11.0	6.6	7.2	12.7	7.2	10.7	12.3	13.1
AA Three-Year Rolling Rate *(Period end year)*	-	-	10.8	11.0	9.2	8.3	8.8	9.0	10.2	10.0	12.0

Countywide Trend Data

Since 2012-2014:

14% increase overall (AA)
32% increase in disparity gap

Infant Death Due to <u>Perinatal Causes</u> – Three-Year Rolling Rates



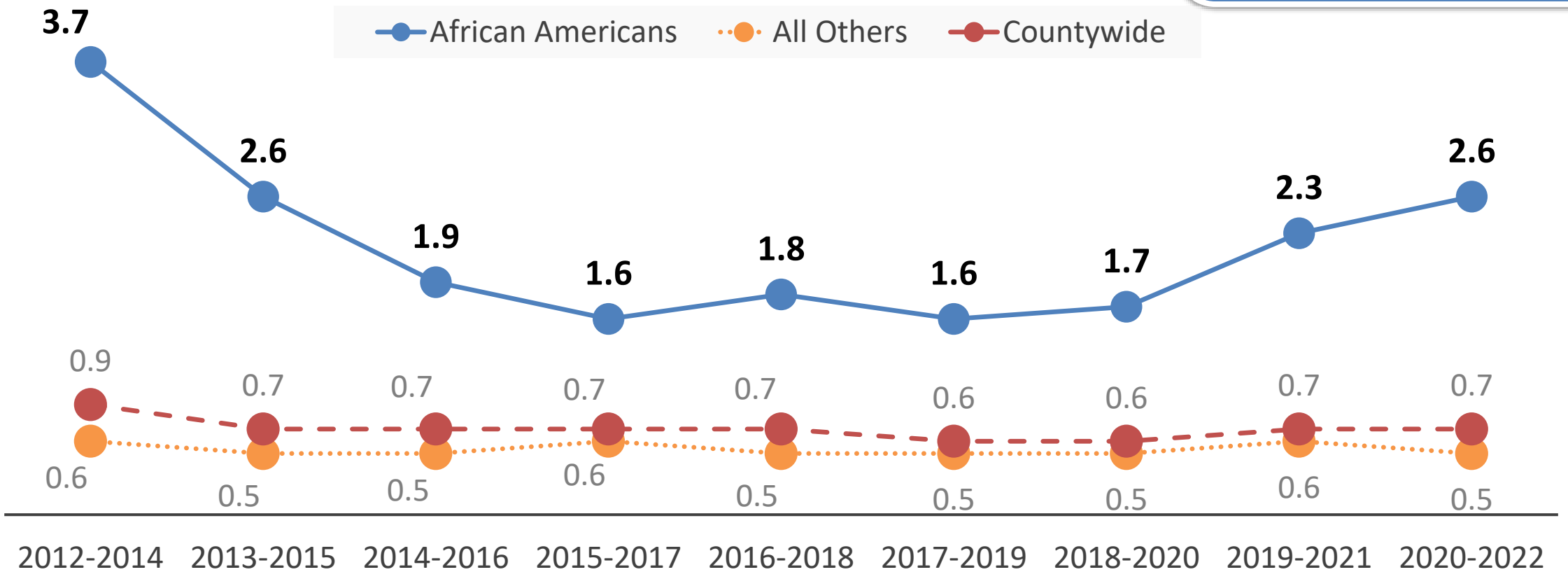
Source: Sacramento County Child Death Review Team Reports 2012-2022. Rate is per 1,000 infants [(three-year sum of deaths / three-year sum of births)*1,000]

Countywide Trend Data

Since 2012-2014:

14% increase overall (AA)
32% reduction in disparity gap

Infant Death Due to <u>Sleep-Related Causes</u> – Three-Year Rolling Rates



Source: Sacramento County Child Death Review Team Reports 2012-2022. Rate is per 1,000 infants [(three-year sum of deaths / three-year sum of births)*1,000]

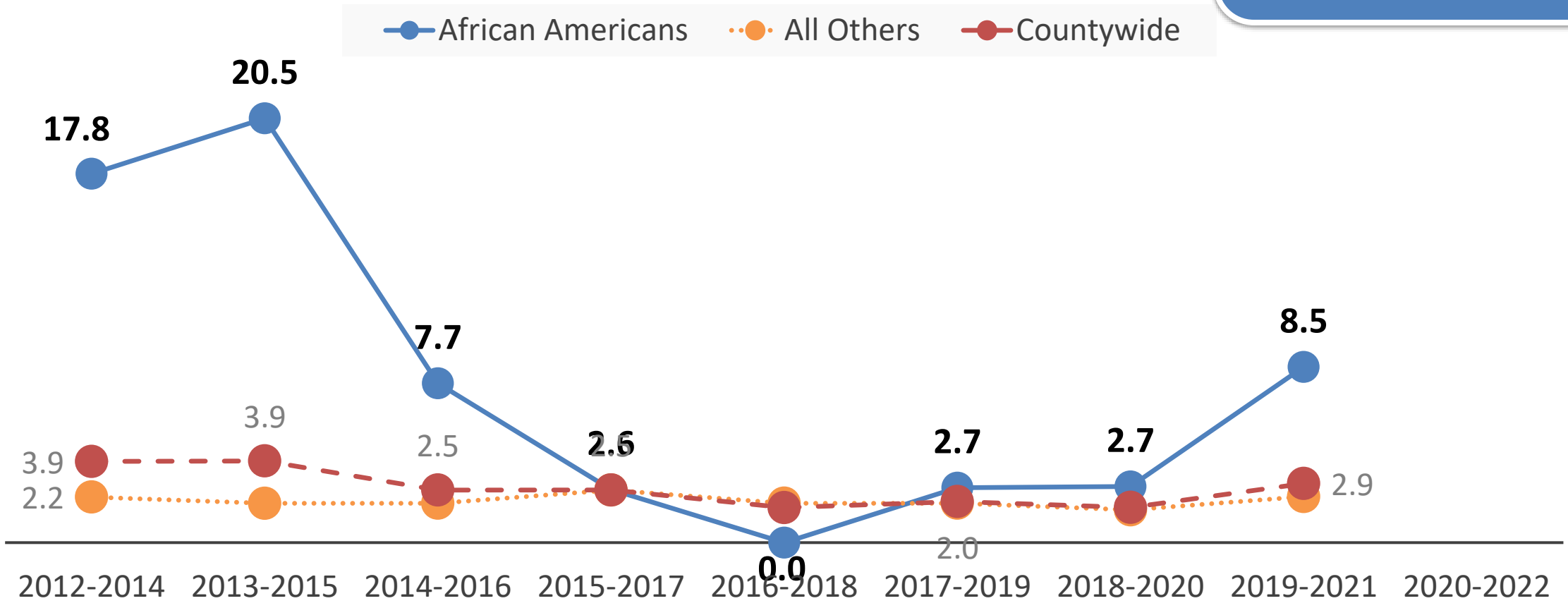
Countywide Trend Data

Child Abuse and Neglect Homicides (0-5) – Three-Year Rolling Rates

Since 2012-2014:

XX% reduction overall (AA)

XX% reduction in disparity gap



Source: Sacramento County Child Death Review Team Reports 2012-2022. Rate is per 100,000 0-17 population [(three-year sum of deaths / three-year sum of population)*100,000]

Discussion