MCH Needs Assessment and its Uses in Program Planning: Promising Approaches and Challenges

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Chapter I
Introduction and Overview

The Title V Needs Assessment, a requirement of the Maternal and Child Health (MCH) Block Grant application, is a critical element of the MCH program planning process. State Title V agencies are required to conduct needs assessments every 5 years and to use the findings of the assessment to identify priorities and to guide resource allocation and program planning.

Despite this long-standing requirement, States have varied widely in the rigor, comprehensiveness, and usefulness of their needs assessments. To gain a better understanding of this variation and to identify promising approaches among the States, the Maternal and Child Health Bureau (MCHB) conducted an analysis and evaluation of the States' Title V need processes. This analysis includes several components:

- A review and abstraction of selected States' 2000 needs assessments;
- A review and abstraction of these States' Block Grant applications and annual reports, to assess the services currently provided by Title V programs;
- A comparison of the needs assessment findings and priorities to the services provided; and
- The development and testing of needs assessment methodologies for Title V programs.

This report presents the findings of these analyses. It is based on a three-step exploration of the process and outcomes of needs assessments in 15 study States. First, the States' 2000 needs assessments were reviewed and abstracted. The abstraction tool, included in Appendix A, was developed by a contractor and is based on a review of the literature and the 2000 Block Grant guidance, describing the structure of the needs assessment. It includes information about the process used to conduct the needs assessment; the quantitative and qualitative indicators of need; the assessment of system capacity; and the priorities selected based on the needs assessment.

Next, the States' 2004 Block Grant applications were reviewed and abstracted, in order to analyze the relationship between the needs assessment findings and the services provided and funded through the MCH Block Grant. These reviews were followed by in-depth interviews with State officials regarding the process of needs assessment, priority setting, and planning and resource allocation. The interview guide used for these discussions is included here as Appendix B.

The 15 study States were chosen based on interviews with representatives of the 10 HRSA Field Offices to determine which States in each region were best positioned to offer lessons, examples, and promising practices to other States. The goal, therefore, was not to identify the "best" needs assessments or to rate the assessments' overall quality; rather, it was to identify geographically and demographically diverse States from across the country that were likely to offer ideas and practices that would be useful to others. The 15 States selected for the study were: Alaska, California, Colorado, Florida, Iowa, Kansas, Minnesota, New Jersey, New Mexico, Oklahoma, Puerto Rico, Rhode Island, Virginia, Washington, and Wisconsin. However, three of these—Alaska, Minnesota, and Puerto Rico—were unable to participate in the last phase of the study (the follow-up interview) because of bureaucratic reorganizations, staff changes, and other factors. Therefore, the findings presented here are primarily confined to the remaining 12 States.

While States have made great progress in the development of their needs assessments and many have promising practices to offer, many components of the needs assessment are consistently challenging. This report reviews a number of these issues, summarizing our findings across the study States and highlighting those States that reported innovative solutions to these challenges. The next chapter describes the structural aspects of the needs assessment process, including establishment of leadership, involvement of stakeholders, inclusion of local-level needs assessments, and coordination with other systems within the State. The following chapter examines specific components of the needs assessment, including data sources, data analysis methods, assessment of capacity, and establishment of priorities. Chapter IV discusses how the findings of the needs assessment are applied in planning and policymaking, and finally, the report concludes with a summary of the lessons learned by and recommendations of State officials regarding the needs assessment process.

CHAPTER II
The Needs Assessment Process

While a strong substantive analysis of needs and resources and a clear linkage of priorities to current needs comprise the core of a needs assessment document, the key to a successful outcome that garners support for MCH needs is the process established to carry out needs assessment. In other words, the process is as important as the product. Granted, a continuous focus on how the needs assessment is conducted and who is involved may complicate the seemingly straightforward process of producing a needs assessment report. However, the literature and the experience of the Title V States we interviewed shows that the following five process elements can make the needs assessment findings more comprehensive, applicable, and acceptable to the families and communities they will ultimately affect.

- ***Clear leadership, responsibility, and oversight.*** The needs assessment should be guided by a clear vision that encompasses the full scope of the needs assessment process, from the identification of indicators to data collection and analysis to the application of findings. This leader or leadership team should also possess the organizational authority to command resources and to marshal data from both public and private-sector sources.

- ***Expertise***. The needs assessment should have access to internal staff or external consultants with appropriate expertise in data analysis and epidemiology.

- ***Community involvement.*** The findings of a needs assessment are unlikely to be accepted by those they affect directly—consumers, providers, and other stakeholders—if these constituents were not included in its development. The community can be involved in a needs assessment at all stages, including providing data on needs and capacity (often through surveys or focus groups), responding to needs assessment findings, and selecting priorities based on these findings.

- ***Creating a local-level process to inform the State-level assessment.*** While the State is ultimately responsible for the overall planning, design, implementation and monitoring of the performance of a statewide MCH system, local health authorities or communities—where much of the States' Title V and other MCH funds and services are administered—are often best equipped with the information to assess local needs and plan local systems of care. Hence, the incorporation of available local-level assessment information is key for statewide MCH planners to be able to tailor resources based on local needs.

- ***Coordination with other systems.*** MCH does not operate in a vacuum, and the Title V Block Grant cannot possibly fund all of the programs and services necessary to meet the needs of pregnant women, children, and families. Therefore, it is critical that the Title V

agency work in concert with the other agencies and systems that serve these populations both in assessing priority needs and planning coordinated programs to address them. Examples of such programs and systems include Medicaid and SCHIP, the education system, early intervention, juvenile justice, and welfare and other family support services.

Few of these process elements were described in the States 2000 and 2004 updated needs assessment reports. We learned most about the processes States used in the development of their 2000 needs assessments and the process plans they have for 2005 through the follow-up intensive telephone interviews.

A. Clear Leadership, Responsibility, and Oversight

Several States described the use of a leadership or management team to oversee their needs assessment process. For example, in **Oklahoma**, an MCH/CSHCN Leadership Team oversaw the State's needs assessment. In **Virginia**, the process was led by the Management Team of the Office of Family Health Services, which oversees the MCH and Preventive Health Services Block Grants. Since the 2000 MCH needs assessment, many states have established an ongoing needs assessment team within the Title V agency that annually reviews needs and priorities and works together to develop a plan for the more comprehensive 5-year needs assessment in 2005. For example, beginning in January 2004, a team from **Florida's** Division of Family Health Services developed a step-by-step Title V Needs Assessment workplan with clear assignments of roles and responsibilities for the 5-year needs assessment, including how the State advisory group and other stakeholders' views would be incorporated into the process.

Wisconsin had a distinct and well-defined needs assessment process. A Needs Assessment Coordinator oversaw the planning and coordination of the process, and a Needs Assessment Planning Team was established, comprising 12 Bureau of Family and Community Health (BFCH) and DPH Regional Office staff and managers.

The team refined the needs assessment design, reviewed and reworked the interview outline, and field-tested the outline with DPH staff not involved in the process.

Through a series of the key informant interviews they incorporated a variety of perspectives in the definition of needs and priorities, including county health department directors, the Milwaukee city health director, nine Milwaukee municipal directors, and Tribal Health Center directors.

The areas of concern raised in these interviews shaped the organizational structure of the needs assessment.

B. Technical Expertise

States' 2000 needs assessments rarely described the technical resources used to conduct data analyses, although a few mentioned the use of both internal and external sources of support. **Colorado's** 2000 needs assessment referred to the use of an MCH Information Specialist to assist in the analysis an interpretation of data. **New Jersey's** 2000 assessment described the use of the State's Center for Health Statistics and the MCH Consortium's Data Work Group. The **Kansas** Title V agency, which depended on technical expertise of an outside consultant group for its needs assessment analyses from 2000 to 2003, has recently hired in-house staff with epidemiological expertise and plans to conduct most, if not all, of the data analysis and interpretation of the data internally, using outside experts only to assist staff and stakeholders in setting priorities.

C. Community Involvement

All States recognize that involving key stakeholders in the MCH needs assessment process is beneficial to their goals. State officials report that they strongly believe that the involvement of diverse perspectives—such as those of consumers, providers, representatives of public and private organizations with potential resources, MCH researchers, elected officials, and advocates for women and children—enables the process of identifying needs setting priorities to be more collaborative and responsive to the public and other stakeholders. The involvement of stakeholders also educates the community and builds a constituency among providers, consumers and others involved in improving the well-being of mothers and children.

The involvement of outside stakeholders in States' Title V needs assessments has varied in the past. Most collected at least some information from consumers or providers through one-time special data collection efforts for the 2000 needs assessment. All study States reported that consumers and stakeholders were at least involved in the review of the MCH needs assessment document or reviewed a summary of the data to provide input on which needs which be Title V priorities. Most State officials thought this was an area of needs assessment

process that they could improve upon for 2005. The major avenues for stakeholder involvement in State needs assessments included the following:

- ***Focus groups and surveys.*** One approach was to solicit the opinions of families, consumers, and advocates on the needs of their constituents. **Iowa's** 2000 needs assessment described a survey of advocates on MCH priorities in the State, and **New Mexico** and **Puerto Rico** conducted focus groups of adolescents and families of children with special health care needs. While this approach can be effective in gathering information about the opinions and perspectives of consumers and advocates, it does not allow for their ongoing participation in the process or their contribution to the selection of methods or priorities.

- ***Task forces on emerging MCH issues***. **Florida** is one of several States that has developed statewide issue-focused workgroups or task forces addressing emerging issues, such as oral health care, obesity, and mental health. Florida Title V officials indicated that rather than bring these stakeholders into the Title V needs assessment process, they send Title V agency staff as representatives to these task forces and will be incorporating the findings and reports from these special task forces into their Title V needs assessment.

- ***Community/Regional Meetings.*** In the past, **Rhode Island** and **Wisconsin** have held listening sessions around the State, which included representatives from the State and Regional Public Health Departments, WIC, current grantees, coalitions, and other interested parties. During these sessions, they discuss the needs of the MCH populations, issues related to statewide projects, and lessons learned. Wisconsin officials have also interviewed the directors of the local public health and tribal health departments to ascertain their views on the needs of the MCH populations. **Iowa's** CSHCN program conducts regional meetings with local stakeholders, including providers, foundations, educational agencies, and policy makers. Iowa officials indicated that the regional meetings have proven effective in identifying emerging needs and priorities at the regional level as well as providing information on potential resources with which the State can work collaboratively to address unmet needs. For the 2000 needs assessment, the State of **Washington** conducted five regional meetings with facilitated discussions of service system assets, gaps, and impacts of policy on the MCH population. The information from these meetings was incorporated into issue papers used in the final selection of statewide priorities.

- ***Advisory Groups.*** Several States established Advisory Councils to guide the conduct of or provide input into the Title V needs assessment, often including family or consumer representatives. **Colorado** relied upon an Advisory Council on Health Programs for Women and Children, which includes two parent representatives, for advice in selecting measures and determining priorities based on needs assessment findings. **Alaska** formed an 18-member Maternal, Child, and Family Health Advisory Committee, including both professionals and parents, to oversee the needs assessment. **Virginia** used an Advisory Committee on Children and Families, made up of consumers and representatives of community organizations, to review needs

assessment data. **Iowa's** Statewide MCH Advisory Council meets quarterly to provide input throughout the annual needs assessment and program planning process. This Advisory Council includes parents, providers, county officials, State legislators, other divisions of the Iowa Department of Health, and State agencies serving children and families. In **New Mexico**, consumers are intimately involved in the needs assessment process through working groups in every health district in the State. Depending on how these advisory or workgroups are used, this route allows outside stakeholders to give input at various points in the needs assessment process and to offer interpretations of early needs assessment findings.

- ***Steering Committees.*** A still higher level of involvement is the inclusion of families or consumers on steering committees that guide and direct the needs assessment process at every stage. For example, in 2000 **Minnesota's** MCH Advisory Task Force, which included consumer and community representatives, worked with an internal work group at every stage to develop the vision and operational plan for the needs assessment. They reviewed available indicators and identified those with highest priority for inclusion in the needs assessment, and they identified gaps in available data. They also collected, analyzed, and displayed data that might be included in the final document.

Many States reported soliciting input from a range of perspectives. In their most recent needs assessment, for example, **California** officials involved a variety of stakeholders in a Title V planning group, held interviews with stakeholders, and conducted surveys of providers and parents of children with special health care needs.

At the same time, a few States advised that involving stakeholders at the State or local level in the MCH needs assessment and planning process must be done with caution. Their involvement may raise unrealistic expectations if the State does not have the capability to address the needs or problems raised. However, another State suggested that involving stakeholders during a time of limited resources is critical so that the stakeholders are involved in a process that is designed to reach agreement on priorities for expenditure of limited public funds.

D. Creating a Local-Level Process to Inform Statewide Assessment

Most of the study States are playing an important role in supporting local needs assessments and planning by providing their local or regional health agencies with guidelines, access to data, and technical assistance for conducting local level needs assessment. These public entities are asked to involve consumers, providers and other stakeholders in the needs assessment process, with some States more successful in this effort than others. Examples of the types of local entities that are asked to conduct needs assessment include:

- ***Local perinatal consortia.*** The development of local perinatal systems of care often provides an opportunity to establish and nurture local-level coalitions, which in turn offer an opportunity to conduct local needs assessments. **Florida** provides a consumer-focused local needs assessment model through its *Healthy Start Prenatal and Infant Coalitions*. Each of these coalitions, supported with Federal and State funding, comprises consumers, providers, and other local stakeholders and is responsible for developing local MCH leadership and systems planning. Their funds are used to build and sustain the coalition, conduct the planning process and provide or oversee services to address the priority needs they have identified. In **Virginia,** as well, Regional Perinatal Councils are required to conduct needs assessments to document the demographics of their MCH population, the regional perinatal service capacity, health risk and outcome indicators, and qualitative information gathered from a community-level Fetal and Infant Mortality Review process funded by the State.

In **Iowa,** local Title V contractors—who receive over 50 percent of the State's Federal and State MCH funding—are required to help lead a participatory and comprehensive local needs assessment process, titled the Community Health Needs Assessment (CHNA). To conduct this assessment, the local Title V contractors—often the local public health agency—are asked to partner with a variety of local stakeholders, including the local boards of health, hospitals, community organizations, health centers, social service providers, schools, faith-based organizations, businesses and citizens. While the local organizations are not mandated by law to conduct these needs assessments, they receive incentive bonuses to conduct the process and are held accountable for the performance measures and action steps they outline in a 5-year plan that is the result of the needs assessment.

As part of the CHNA, each locality must identify 5 MCH-related priorities. To assist communities in identifying priority needs, the Iowa Department of Public Health makes available a population-based data file, the Community Health Indicator Tracking System, as well as regional consultants who provide technical assistance on needs assessment and planning. State guidance reflects a comprehensive approach to community needs assessment. Each community is encouraged to couple the quantitative health indicator data with locally generated information of a more qualitative nature on health needs, to conduct an assessment of the strengths and gaps in local capacity, and to inventory the community assets that will be brought to bear to address the priority health issues they identify.

- ***General MCH consortia.*** In **New Jersey** the State Title V agencies fund regional consortia of providers to develop regional systems of care based on regional needs. Each of the Consortia conducts regional-level planning and needs assessment which is reported up to the State level and rolled into the State needs assessment and Block Grant application.

- ***County health departments.*** In many States, county health departments or other local health jurisdictions are required to conduct assessments of need in their communities. ***California*** provides data and extensive technical assistance in needs assessment to the State's 61 local health jurisdictions (58 counties and three cities) through the University of California at San Francisco's Family Health Outcomes Project (FHOP). FHOP produced a detailed guidance document for the local health jurisdictions to use in developing their needs assessment. This document includes a detailed outline for the assessment report and a list of indicators to be included; in addition, the data with which to develop these indicators is provided by the State. In the past, local jurisdictions were asked to gather these data themselves, but State officials felt that they would get more consistent indicators if the data were provided to them. ***Minnesota*** is another State that included local-level needs assessments in its statewide assessment; the state's Community Health Service Agencies were required in 2000 to conduct needs assessments as part of their biannual planning process, and the needs identified through this process were added to the MCH Indicators Menu for the statewide needs assessment.

As part of the State MCH needs assessments, in each of these examples, the Title V agency works to incorporate the local-level assessments into a statewide picture of the services available and current MCH needs, and uses the local information to target and tailor technical assistance and training. However, some States cautioned that it is difficult to systematically present and incorporate the local assessments because they contain a large amount of qualitative information on needs and system capacity. To remedy this for the 2005 needs assessment, one of these States was considering the use of qualitative analytic software to analyze the content of the local assessments.

E. Coordination with Other Systems

A few of the study States described how an integrated approach to planning across State agencies has helped garner and maintain support for MCH programming. For example, in **Rhode Island**, the director of the Title V agency participates in an executive-level interagency body called the Children's Cabinet. The Cabinet, which was created by legislative mandate and reports to the Governor, is composed of the directors of each State

agency serving children and families along with a representative of the State's largest private children's advocacy and resource organization (RI Kids Count). The Cabinet members work together to plan and monitor State policies and legislative initiatives affecting children. They have established a common set of goals and performance measures for all State agencies working to improve the health and welfare of children. The Title V director indicated that his agency's involvement in the Cabinet is critical to improving MCH in Rhode Island and the goals and priorities developed by the Cabinet drive MCH policy and program planning in the State. Their active participation in the Cabinet has increased the profile of MCH issues and systems and has helped the health department to think "out of the box" of public health. Their participation has also built support across both public and private agencies and in the State legislature for the maintenance of existing MCH systems and services, and has increased support for seed money toward the development of new infrastructures for emergent MCH health needs.

Another example of the integration of State MCH needs assessment into a broader planning process comes from **Iowa**. In this State, the MCH needs assessment process is tied to the goals and actions steps outlined in *Healthy Iowans 2010*, a State companion to *Healthy People 2010*. Because State MCH staff and stakeholders have been involved in documenting the State's MCH needs and defining priority MCH-related goals for *Healthy Iowans 2010*, the State's Title V MCH priorities have always been consistent with and drawn from this broader State public health planning document. At the same time, the State Title V leadership in Iowa, which directs an ongoing MCH needs assessment process, is incorporating issues that have emerged since the first publication of *Healthy Iowans 2010* into the revised version to be released in 2005.

Virginia's Title V agency works collaboratively in a State-level interagency planning committee focused specifically on MCH issues. The committee comprises representatives of the State Medicaid agency, Title V agency, Social Services and Mental Health that meet quarterly to address MCH issues that cut across program lines. They have worked together on a volunteer basis to successfully alleviate barriers to Medicaid enrollment for pregnant

women. The group is now examining how the State can improve screening for substance abuse, domestic violence and maternal depression by private providers.

These examples illustrate how a systematic needs assessment process that has clear roles and leadership, includes staff with technical analytic expertise, involves diverse community stakeholders, and that is integrated with other local and State planning efforts for the MCH population may greatly enhance the potential for the needs assessment findings to be translated into program planning for the development of an effective MCH system.

There are two broad substantive component areas that are essential to any needs assessment: assessment of needs and the capacity of the system to meet identified needs, and establishment of priorities. In the following chapter, the contractor identified criteria for a successful assessment in each component area, analyzed the abstracts of 15 States' 2000 Title needs assessments in accordance with these criteria, and reviewed new directions or methods that under consideration by the States for their 2005 needs assessments.

CHAPTER III
The Components of a Needs Assessment

A public health needs assessment does not stand alone; rather it is a critical step in a larger process of program planning and evaluation. As Stevens and Gillam (1998) note, "the purpose of needs assessment in health care is to gather the information required to bring about change beneficial to the health of the population."

Within this broader framework, acknowledging that the components of a needs assessment cannot be separated from the processes used to develop it and the presentation and application of its findings, in this chapter we focus in on the needs assessment process itself, particularly three components:

- ***Collection and analysis of information on health needs.*** The first component of a successful needs assessment is the collection and analysis of information on the extent of health problems using data from a variety of sources. The data should be drawn from a range of health indicators for the three priority MCH populations: pregnant women, mothers, and infants; children; and children with special health care needs. Ideally such indicators should include both quantitative and qualitative measures, include State-level data as well as more geographically or subpopulation-specific targeted data when available, and be drawn from the most up- to-date data sources. The analysis should include point-in-time data and trend analysis and

- ***Capacity assessment.*** Complementing and essential to the analysis of the population's needs is an assessment of the capacity of the system to meet those needs. Ideally, this includes an analysis of the availability, accessibility and quality of existing resources—both internally to Title V and throughout the systems of care serving mothers and children—as well as an effort to uncover resources, both individual and organizational, that can be brought to bear to address the identified needs.

- ***Priority setting.*** The final step in the assessment process is the establishment of priorities among the multiple needs or problems identified and the presentation of those priorities to stakeholders, both those who have been involved in the needs assessment process and those not involved who can have a positive impact.

The following sections of this chapter discuss these three broad components of needs assessment. In each section, criteria for successfully carrying out each component are identified, based on the literature and lessons learned from the contractor's abstraction of the study States' Title needs assessment and planning documents and follow-up telephone interviews

with most of these States. Also included are examples drawn from the experiences of the States that may be useful or applicable to other State and local MCH needs efforts.

A. Assessment of Health Needs

1. Indicators of Need

One of the elements of a successful needs assessment is the use of a range of health indicators of the three priority MCH populations: pregnant women, mothers, and infants; children; and children with special health care needs. In addition, crosscutting measures of the health of the population as a whole can reveal needs that affect MCH populations. These health indicators can expose the strengths and weaknesses of a population and reveal health issues that need to be addressed. In order to achieve this, a thorough needs assessment should include the following criteria:

- Indicators related to the 18 national performance measures, as well as measures of demographics, health status, and outcomes;
- Qualitative measures of health status, especially from the perspective of consumers, in order to identify the perceived needs of a population;
- A variety of measures beyond the traditional MCH indicators, to provide a more in-depth picture of the health status of a population; and
- Indicators that are specific to the health of the State MCH population and do not stray from the purpose of the needs assessment, so that the analysis of needs and capacity is focused.

The indicators commonly reported by States are displayed in Table 1 below. Very few States addressed all of the above criteria in their needs assessments; more commonly, States were thorough in particular areas. Although none of the States included data on all 18 of the national performance measures, twelve States did address at least two or more. The most commonly addressed were "the rate of birth for teenagers aged 15 through 17 years" and "the percent of very low birth weight infants among all live births," each measured by nine States. Also common were "percent of 19- to 35-month-olds who have received the full schedule of age-appropriate immunizations" and "percent of children without health insurance," each measured by eight States. "Percentage of mothers who breastfeed their infants at hospital

discharge" was measured by seven States, and "the rate of suicide deaths among youths 15-19" and "percent of infants born to pregnant women receiving prenatal care beginning in the first trimester" were each measured by six States.

Many of the needs assessments included demographic data to provide an overall view of the State's population. Some of the statistics that were commonly mentioned by States include: population characteristics, poverty rate, Medicaid and/or SCHIP eligibility, insured rate, and Head Start enrollment. Every State also included typical health status indicators for the MCH population. Some of the frequently mentioned indicators for pregnant women, mothers, and infants include: rate of tobacco, alcohol, or drug use before or during pregnancy; prevalence of domestic violence during pregnancy; rate of birth defects (especially neural tube defects); and rate of LBW/VLBW births. Some common health status indicators for children include: occurrence of overweight/obesity; youth alcohol, drug, and tobacco use; seatbelt use among youth; and the prevalence of weapons and violence in schools. States included far fewer indicators of health status for CSHCN. Some that were measured include: asthma occurrence and hospitalization rates, common conditions/diagnoses, severity of conditions, ability to perform age-appropriate activities, and availability of specialty providers.

Every State also included outcome measures as indicators of need in their assessments. The number and type of outcome measures varied widely among states, and very few states included outcome measures for CSHCN. Although many States included outcome measures for pregnant women, mothers and infants, there was little commonality among states in the measures that were chosen. A few of the most common include infant mortality rate, maternal mortality rate, and perinatal mortality rate. The outcome measures for children were slightly more homogeneous among States and include: child and teen death rates, injury-related death rate, adolescent homicide rate, motor vehicle crash death rate, and total number of drowning deaths. Some of the outcome measures for CSHCN include asthma death rate, infant mortality rate by birth defect, and the percentage of births affected by fetal alcohol syndrome.

Table 1. Indicators Commonly Reported in State MCH Needs Assessments			
	Pregnant Women and Infants	**Children**	**CSHCN**
Performance Measures	Percent of VLBW infants among all live births Percent of mothers who breastfeed at hospital discharge Birth rate for teenagers aged 15-17 years	Percent of 19- to 35-month-olds who have received a full schedule of age appropriate immunizations Percent of children without health insurance Rate of suicide deaths among youths aged 15-19 years	**no more than one State provided data on any one CSHCN performance measure*
Demographic Measures	Female population by age and race/ethnicity Fertility rate Live birth rate	Number of children by age group Percent of children at various poverty levels Percent of children enrolled in Head Start	Number of CSHCN
Health Status Measures	Rate of LBW births Percent of women using alcohol, tobacco, or drugs before or during pregnancy Percent of women subject to domestic violence before or during pregnancy	Percent of youth using alcohol, tobacco, or drugs Percent of youth involved in fights at school Percent of overweight/obese children	Number of children born with birth defects or congenital anomalies Asthma rate Asthma hospitalization rate
Outcome Measures	Infant mortality rate Maternal mortality rate Perinatal mortality rate	Child and teen death rate Injury-related death rate Adolescent homicide rate	Asthma death rate

Seven States included qualitative measures, although most included data for only one or two indicators. **Florida** included five qualitative health indicators, most of which were measured through consumer feedback. Two Florida indicators were measured through consumer focus groups (the factors affecting poorer pregnancy outcomes for black women and possible medical reasons for racial disparities in infant mortality), and two were measured through a consumer survey (stability of CSHCN health, and overall rating of the health status of CSHCN). The **Wisconsin** needs assessment included key informant interviews of county health department directors, tribal health center directors, and the director of the Milwaukee City Health Department. These interviews enabled State officials to obtain qualitative data on health care access, child care availability, dental access for children, and the increasing number of special needs children in the State.

Many States moved beyond general population data and typical MCH health indicators in their needs assessments, and also used a variety of interesting and original indicators to measure the health status of their MCH populations. For instance, the **Alaska** needs assessment included a measure of the percentage of women receiving breast exams or pap smears, the percentage of WIC participants with anemia, and the percentage of mothers who binge drink after delivery. **Colorado** included the percentage of women with inadequate weight gain during pregnancy, the percentage of mothers who put their infants to sleep on their backs, and the percentage of WIC clients who are classified as obese. The **Iowa** needs assessment included the percentage of safety seats that are properly installed, and **Minnesota** included several interesting indicators such as the percentage of adolescent pregnancies that end in abortion and the percentage of parents who read or tell stories to their children three or more days a week. The **New Jersey** needs assessment included the percentage of pediatric cases of vaccine-preventable illness, as did **Virginia**, which also included the rate of non-induced pregnancy terminations and the proportion of women eating more than five servings of fruits and vegetables a day.

Overall, the **Rhode Island** needs assessment addressed all of the criteria mentioned above. It included half of the national performance measures, as well as a qualitative measure of the knowledge, attitudes, and practices of adults with regard to their relationships with their

teenagers, obtained through a statewide telephone survey of parents. Other interesting Rhode Island indicators were: the prevalence of open neural tube defects, the type of contraception used by women at family planning clinics, the percent of children who did not visit a dentist in the past year, reasons for childhood hospitalizations, and children's use of safety seats, safety belts, and bicycle helmets. A number of indicators for CSHCN included: the rate of babies born with birth defects, the ten most frequent congenital anomalies among newborns, and the number of children hospitalized for brain-related injury (and of those, the proportion requiring institutional or professional at-home care).

The **Kansas** needs assessment included an array of indicators and addressed all of the above criteria except for qualitative measures. Kansas addressed almost all of the national performance measures. Their variety of indicators included: the percentage of children from WIC households who are overweight, the rate of safety equipment use among children, and the percentage of CSHCN patients who had to travel more than 100 miles to receive services. The indicators chosen focused on the MCH population without clouding the assessment with an excess of generalized data.

2. Data Collection and Analysis Process

Key to the construction of a successful Title V needs assessment is the identification and use of available data sources to describe the elements of MCH needs. Also important is the development of additional sources of data when need can not be adequately analyzed and presented with what is most readily available. The critical components of the data collection and analysis process include:

- **Use of State level data as well as more geographically targeted level data when available.** Some indicators and situations are best described on the State level or do not tend to vary much across local areas. In these cases, State-level data are completely appropriate. However, some indicators often vary by region or locality. Because both types of situations exist within States, the data used to conduct the needs assessment should attempt to include data at the local level.

- **Use of both quantitative and qualitative studies (focus groups and key informant surveys) as data sources**. Different types of needs are best explored

and described using different types of data. For example, incidence and prevalence can best be described using quantitative data. Programmatic impact can best be captured using qualitative studies. Because both of these types of information are necessary for a thorough needs assessment, it is important that both types be used.

- **A means of identifying unmet data needs and collecting primary data to fill those data gaps (e.g., special key informant surveys or focus groups).** The needs assessment should present a detailed picture of the MCH needs of a State. As part of the process it is then important to determine the degree to which needs can be adequately described with what is available. When it is determined that needs cannot be adequately described, the needs assessment process should describe a process by which the data can be developed to adequately describe and evaluate the need. This will allow a final needs assessment to be complete and thorough.

- **Identifying and analyzing appropriate/relevant data available from other State agencies and MCH-related organizations.** While it is easiest to work completely within the State Health Department, other State agencies and offices collect MCH data as well. It is important, in order to paint the most complete picture of MCH need and capacity, to work with and analyze data from other State agencies and organizations working within the State who address MCH issues.

Most of the study States were able to use a combination of State level and more geographically targeted data. Several States (e.g., **Colorado, California, Florida, Iowa, Minnesota,** and **Oklahoma**) were able to use State-level data from national data collection efforts such as PRAMS, the BRFSS, the YRBS, and the Youth Tobacco Survey. Many States used State Health Department data for their needs assessment that was captured on the county or health district level. States also had access to or developed specialized State-level data collection efforts that were able to report generalizable data on a more local level. In **Colorado**, a State marketplace analysis was conducted, while in **California** exclusive breastfeeding was reportable on a sub-State level because the results were taken from their Maternal and Infant Health Assessment Survey. In **Florida**, the KidCare survey provided local level data and the same was true in **Oklahoma** from the Toddler Survey.

While all needs assessments reflected the use of quantitative data, some needs assessment documents relied very little on qualitative data. For the most part, however, needs assessments reflected a combination of quantitative and qualitative sources. In **Florida**, for example, in addition to the quantitative data, information and results from Healthy Start Coalition service delivery plans, the Family Voices Survey, and a key informant survey on State MCH needs were incorporated into the needs assessment. **Kansas** conducted interviews and **Minnesota** included results from an Urban Institute family survey, while **New Jersey** incorporated data from FIMR teams and the Family Voices survey. **Iowa** conducted focus groups on children's mental health care needs. **New Mexico** used interviews and focus groups pertaining to transition services for youth with special health care needs for the needs assessment and **Washington** utilized results from focus groups with parents of children with special health care needs. **Oklahoma** conducted focus groups around the State with 125 recipients of assorted Title V services.

Oklahoma uses a wide range of both National and State-level quantitative data sources in its needs assessment, including:

- Pregnancy Risk Assessment Monitoring System
- Youth Risk Behavior Survey
- Behavior Risk Factor Surveillance Survey
- Consumer Assessment of Health Plan Survey (both adult and children's section)
- Youth Tobacco Survey
- Oklahoma Uniform Crime Report
- Reportable OSDH Injury Surveillance System (contains information on burns; traumatic brain injuries; traumatic spinal cord injuries; and drownings)
- Community Assessment Tool for Children with Special Health Care Needs (CATCH
- National Immunization Survey
- Oklahoma Toddler Survey (surveys a sample of State resident mothers with children two years of age).
- First and Fifth Grade Health Surveys (population-based surveys developed and operated by the Assessment and Epidemiology Division within MCH)
- Health Provider Survey (survey of all licensed health care providers in selected counties to identify barriers that may affect the use of health care services by participants in the Medicaid managed care system)
- Drug Use Needs Assessment Survey (focused on questions pertaining to domestic violence and injury)
- Maternal Serum Alpha-fetoprotein screening data
- OK Birth Defects Registry

Wisconsin represented a bit of an anomaly. They used some quantitative data but very little. The quantitative data they presented was chosen to illustrate the concerns expressed in key informant interviews that were conducted in order to find out what needs should be focused on.

Many States used data from sources other than their health department. Some of these were governmental and some were extra-governmental. Predominant among other departments was education, often the focal point for the collection and analysis of YRBS (middle and high school) data. Additionally, **California** reported using Family Voices data as well as Police Record Reports. **Florida** used the Florida KidCare survey as well as well as the Family Voices survey; **New Jersey** also used the Family Voices survey as a source of data. **Rhode Island** used KidsCount data, while **Iowa**, working with the Department of Social Services, utilized the results of newly enrolled SCHIP families regarding dental care access. In **Kansas**, data were obtained from KS Dept of Human Resources, the KDHE Injury Prevention Program as well as from Medicaid claims, the State departments of Education, Office of Judicial Administration, Social and Rehabilitative Services, and Transportation.

Kansas's data were also obtained from the Kansas Hospital Association and the physician licensure database. **Minnesota**, in addition to using public safety data, worked with the State planning agency as well. They also obtained data from Abbott Labs and the Urban Institute. **Oklahoma** worked with

The **New Mexico** needs assessment included a wide variety of data sources, both quantitative and qualitative. Many of the common State-level sources were used, such as the New Mexico PRAMS, Vital Records, and the YRBS, but a number of State-level sources from a variety of agencies and organizations were used as well. These included: a telephone survey by the NM Health Policy Commission, a Medical Home Practice Standards mail survey of physicians, the Double Rainbow Project Family Survey (statewide), the New Mexico School Survey (NMSS), and Hospital Inpatient Discharge Data (HIDD) from the New Mexico Health Policy Commission. Qualitative data from two sources were also collected for the needs assessment. One was a series of MCH needs assessment workshops in which the management teams from each of the four Public Health Division Districts and selected MCH partners were asked a series of questions about local needs. The other qualitative data source was a series of focus groups and key informant interviews regarding transition services for youth with special health care needs. Other surveys included:

Medical Home Practice Standards mail survey—addressed to physicians, this survey included questions on the practice of accessible, family-centered, comprehensive, continuous, coordinated, compassionate and culturally competent care for CSHCN. It was used to identify practice strengths and weaknesses in these areas.

Double Rainbow Project Family Survey—a 1999 statewide family survey used to identify ways to improve access to early intervention and health service systems in NM. The results identified a number of service barriers for CSHCN.

NMSS—a 1997 sample representing 72 percent of the state's public school children grades 7-12. It measured demographics, substance use/abuse, mental health measures such as self-esteem and depression, violence, adult involvement such as rule setting and mentoring.

HIDD—collects discharge data from community and selected specialty hospitals. The measures from this survey that were used in the needs assessment were non-fatal injuries, pregnancy morbidity, and asthma hospitalizations.

the Health Care Authority as well as the Department of Public Safety, while **Virginia** used reports obtained from the Department of Social Services as well as the State police.

3. Identifying New and Innovative Data Sources

In discussing their plans for the Title V 2005 needs assessment, State officials expressed confidence about their ability to analyze quantitative data and enthusiastic about new quantitative and qualitative data sources available to them, including a new emphasis in some States on gathering information from consumers and providers. Major new sources of note included:

- **New national surveys with State components.** Two modules of the State and Local Area Integrated Telephone Survey (SLAITS) are now, or will soon be, available for analysis on the State level: the National Survey on Children with Special Health Care Needs (NSCSHCN) and the National Survey of Children's Health. Many States discussed analyzing the NSCSHCN to address critical questions (and several National Performance Measures) about systems of care for CSHCN, a capacity they have not had in the past. Colorado and New Mexico also mentioned using the National Survey of Child Health, a more general survey about child health and well-being, although this data set is not yet available at this writing.

- Other States, such as Colorado, Washington, and New Mexico, discussed having access to the Pregnancy Risk Assessment Monitoring System (PRAMS) for the first time, or now having data from multiple years, allowing for trend analysis. Oklahoma and Washington also mentioned the Youth Risk Behavior Survey as a new data source in their States.

- **State-level surveys.** A number of States described new sources of State-level survey data that will be available for 2005. The California Health Interview Survey, to be conducted every 5 years by UCLA, will have information on chronic conditions and risk factors for 55,000 respondents, and will provide a rich resource for needs assessment data. Oklahoma has a new oral health survey and a survey on care received by Medicaid eligibles. In Iowa, the Department of Public Health, in conjunction with the Child Health Specialty Clinics and the University of Iowa Public Policy Center, will be conducting the Iowa Child and Family Household Health Survey. This large, comprehensive State telephone survey is designed to evaluate the health status, access to health care, and social environment of children in the State. In Florida, new Geographic Information Systems (GIS) mapping capabilities will allow for better analysis of needs at the local level.

- **State surveillance data.** Several States have improved their public health surveillance systems, providing new sources of population-based data on important health conditions. For instance, Colorado will have oral health surveillance and hearing screening data available, and Washington will have birth defect surveillance data.

- **Linked State data**. Finally, several States described newly-available linked databases that will allow for more detailed analysis of perinatal and program data. These include new linked birth record data in Wisconsin, and the linkage of SSDI data in Oklahoma. In Florida, data linkages will allow for Medicaid, WIC, and Healthy Start flags within vital records. In addition, Florida and Kansas are using the Perinatal Periods of Risk approach to conduct in-depth analysis of their fetal and infant death rates.

A number of States also hope to utilize data from other programs to assess the needs of their MCH populations, although accessing such data can be problematic due to confidentiality concerns. One State plans to use Food Stamp Program data, while another has tried to access Medicaid/SCHIP data without success.

4. Capacity Assessment

For strategic program planning, a state's assessment must examine not only the trends and emerging health issues among the maternal and child health population, but also include an assessment of the services and resources that are available and needed to help the Title V agency address those issues. A comprehensive analysis of MCH capacity should answer five assessment questions:

- **What resources and services are available to serve the State's MCH needs?** This would include an inventory of services provided by Title V and other public and private agencies, at all levels of the MCH pyramid and ideally a quantitative assessment, of the extent of available services relative to the population needs.

- **What factors affect the accessibility or quality of available MCH services**? This would include an assessment of barriers to service accessibility as well as needed changes to services that could improve their accessibility. Such an analysis should include analysis of the perspectives of multiple stakeholders including the end-users of MCH services (e.g. local health departments who utilize information from State databases, public and private providers who need training and information, and consumers of services)?

- **What is the community-level MCH capacity?** This would include both the incorporation of local service capacity assessment into the State assessment as well as an inventory of available resources and assets at the community level that could partner with MCH, such as voluntary organizations, providers, community leaders, and community institutions.

- **What environmental factors are impacting the MCH population's service needs and the agency's resource allocation decisions?** Such factors may include changes in State demographics, expansions of Medicaid, State budgetary limitations, welfare reform, and the shift of the publicly insured population to managed care arrangements.

- **What is the internal capacity of the Title V agency?** An internal capacity assessment involves an internal look by the agency at its strengths and needs in order to carry out the needed MCH functions. The ideal internal capacity assessment includes an examination of following: the health department's management, legal authorities, infrastructure, financial and staffing resources, inter and intra-organizational relations, the cultural competency of its staff and services, and other organizational resources.

While none of the State documents reviewed addressed all of these five components of capacity assessment within the needs assessment portion of their block grant application, they each addressed at least one. The strength of the States' capacity assessments fell primarily in their analysis of the availability of health care and related enabling services for the target MCH populations.

Overall, these assessments were weak in assessing the needs for core public health services and their internal capacity to carry out these functions. Further, while several States appropriately linked their analysis of capacity to their ability to address their identified priority health needs, most did not. Hence, the goal of capacity assessment -- i.e., to analyze the ability of the current MCH systems and services to address the MCH's population's service needs at all levels of the MCH pyramid, was often overlooked in the Title V Year 2000 needs assessments.

The sections below provide a flavor of the types of capacity assessment, the relative depth of these analyses, and examples of data sources that were used when analyzing MCH capacity in the States.

5. Assessing Availability of Resources and Services

The majority of States' needs assessments included some level of analysis of the availability of health providers and direct health care services for specific MCH target populations. As illustrated in Table 2, the states varied considerably in the number of services and types of providers that were the focus of their assessment.

a. Direct Health Care Services

Nine States analyzed the availability of primary care providers (physicians and/or allied health professionals) and mapped or listed the federally designated health professionals' shortage areas (HPSAs) within their State. The availability of dentists to serve low-income children was a significant capacity indicator in six State needs assessments. These States measured dental provider availability using one or more of the following measures: the proportion of dentists and clinics providing some Medicaid dental services for children, the number of dentists serving children at outpatient dental clinics, and federally designated Dental HPSAs.

To identify areas of the State with an inadequate supply of MCH providers, **Virginia** used more up-to-date information than is provided by the Federal HPSA designations and focused their analysis of supply specifically on MCH providers. For example, to assess the availability of perinatal providers, the State compared the number of perinatal providers to the extent of perinatal needs using data supplied by regional perinatal planning councils. In addition, the State assessed the availability of ob/gyns to Medicaid clients, using Medicaid claims data to determine the proportion and distribution of ob/gyns accepting Medicaid payments.

Virginia also used a unique approach to assess the availability of general pediatricians and geographic variations in their availability. Using local level data available from the American Academy of Pediatrics data, the needs assessment measured the ratio of practicing primary care pediatricians to the child population.

The majority of States also examined the number of MCH services available through one or more types of institutional providers or service settings. When writing up this part of their needs assessment, most States simply described the size of the service capacity, as measured by the number of particular services or clinic sites and in some cases the numbers of clients receiving a particular type of service. However, only a few States looked at the geographic distribution of services and analyzed areas with gaps in services. Fewer still had data comparing the amount of available services to the size of the population in need of those particular services.

As illustrated in Table 2, seven States focused their service capacity assessment on the availability of specialty and subspecialty services for CSHCN, a population group for which assurance of comprehensive coordinated service is a key performance measure for State Title V agencies. Four States looked at the availability of a primary care, medical home for CSHCN, an important measure of service availability for CSHCN. In **California**, availability of a medical home was able to be assessed as a proportion of all CSHCN in the State system, based on service data input into the CSHCN program database. The other three States based their findings on the availability of a medical home using data from surveys and focus groups with parents of CSHCN.

Because the majority of States have moved away from the provision or administration of direct primary care services for the MCH population, only four States' needs assessments assess the supply (number and geographic distribution) of publicly subsidized outpatient primary health care services for the MCH population. These States happen to be ones that partner with community health clinics and free clinics for the provision of direct MCH primary care services.

A smaller number of States assessed the availability of several other types of direct health services. For example, two States assessed the availability and accessibility of high-risk neonatal intensive care services and birth centers, based on the geographic distribution of those services and data on the proportion of VLBW infants who were delivered at high risk neonatal intensive care facilities. Three States looked at the existing service capacity to provide mental health services for children. Two States analyzed the availability of publicly subsidized family planning services for low-income women and teenagers. This was measured by comparing the number of women receiving subsidized family planning services to the population in need, using a standardized formula developed by the Alan Guttmacher Institute to determine the size of the population of women in need. Other States examined capacity by looking at genetic services and school health services.

Eleven of the needs assessments identified remaining gaps in health insurance coverage and benefits for women and children and selected improving access to health care services as a

priority need. Given the recent implementation of SCHIP in 2000 (when these needs assessments were submitted), most of the documents reviewed included a discussion of recent expansions in eligibility for public insurance programs, the specific eligibility criteria for Medicaid, SCHIP and other State child health insurance programs, and how children identified as having a special health care need were covered in these programs. Most States included available data on the number and rate of uninsured children. One State, **Washington**, looked specifically at the uninsurance rate among CSHCN.

Iowa, Rhode Island, New Jersey, New Mexico, Colorado, Washington and Virginia looked not only at the size of the newly eligible populations but also calculated the number of eligible women and children not enrolled in public insurance programs. They also emphasized the need for new or improved efforts to link these women and families to insurance programs.

b. Enabling Services

In addition to monitoring insurance coverage for women and children and providing outreach to promote enrollment in public insurance programs, many of the States are still providing case management or enabling/supportive services. These come though local health departments and grants to other public or private organizations for targeted services to high-risk groups. The size of the programs and various types of services provided in the States were described in six States' needs assessments.

Rhode Island's Title V needs assessment provides a comprehensive and well-organized analysis of the availability of an array of direct and enabling services, including primary care providers and services for women and children, family planning, mental health care for children, dental care for low-income children, WIC, school breakfast program, child care, and shelter and advocacy programs for children witnessing domestic violence.

Rhode Island's needs assessment examined the State's capacity to offer dental services for children and comprehensive services for CSHCN and their families. The State analyzed multiple indicators of capacity, including the availability of practicing dentists by locality, federally-designated Dental Health Professional Shortage Areas, and the accessibility of dentists specifically for low-income children. The latter indicator was assessed from two sources: a survey of all private dentists in the State regarding their willingness to accept children insured by Medicaid and staffing data from the network of community health centers and hospital dental that are required to accept public insurance and offer sliding scale fees for uninsured families.

Rhode Island also examined the availability and accessibility of the array of services needed for CSHCN. Based primarily on multiple surveys of caregivers and data from State screening and tracking programs for children at risk of developmental delay and disability, the State identified gaps in the availability of services and linkages for children in the early intervention programs when they enter school. Survey results also revealed limited accessibility to dental and mental health services for CSHCN, support services for CSHCN and their families, and the need for assurance of a medical home for these children that can coordinate, communicate and provide appropriate referrals from primary to specialty and subspecialty services.

Eight of the State needs assessments examined the availability and unmet need for family support services to families of CSHCN, including respite care, service coordination, case management and parent-to-parent networks. This measure of capacity was usually assessed descriptively with data on the number of each type of service available and number of clients served, supplemented with information from parent surveys regarding the perceived availability and unmet needs for family support. **Minnesota** included an assessment of the size of the unmet need for crisis respite care services, based on the average number of families on the waiting list for respite care services.

Four States included an assessment of the capacity of the WIC program using data on the numbers and proportion of the eligible population unable to be served in the most recent year. One of these States, **Washington,** also noted the number of children receiving health and nutrition screening services at Head Start and State-funded early childhood programs.

c. Population-Based Services

Documenting capacity and unmet needs for population-based services is a more difficult task compared to that for direct or enabling services because there are less data available on the size of the population reached and the population in need. In fact, the needs assessments reviewed provide little analysis of the existing capacity in population-based services. Instead, most include a listing of many population-based services they provide or contract out for, such as lead screening, newborn biochemical screening, newborn hearing screening, injury prevention programs, oral health education and screening programs, SIDS public education, and folic acid education campaigns. Only in a few cases are data provided on the numbers reached or unmet need for population-based services, for example in the area of childhood immunizations.

While not analyzing the capabilities or reach of existing population-based services, many States have identified priority health needs that could be addressed through enhanced population-based services. For example, based on extensive survey data showing limited use of dental services by low-income children, **Florida** identified the need for expanded publicly funded dental screening programs for children. Similarly, using key informant and parent

survey data, **Minnesota** and **Rhode Island** identified the need for enhanced early identification and tracking systems for infants and toddlers, special education services for school-age children with disabilities, and transitional services for adolescent CSHCN. In light of alarming indicators regarding substance abuse among pregnant women and domestic violence in **Puerto Rico**, the Commonwealth's needs assessment identified a need for new population-based screening services for substance abuse among pregnant women and other public awareness, screening and intervention programs to address the issue of domestic violence. **Minnesota's** needs assessment highlighted data on poverty, hunger and homelessness as risk factors associated with poor health and mental health problems for the MCH population. Minnesota identified a need for new population-based health education approaches that focus on promotion of healthy community conditions and family support to address the underlying causes of poor health outcomes, and raise awareness of mental health problems and resources.

d. Infrastructure-Building Services

While all State Title V needs assessments - at least briefly - mention their involvement in infrastructure building services, only nine States (**New Jersey, Minnesota, Iowa, Kansas, Florida, Colorado, Rhode Island, Washington, and Virginia**) incorporated any analysis of their capacity and unmet needs in this important core MCH public health function. Each of these States looked at their data collection systems and ways in which the quality and types of information collected can be improved. They looked at ways to integrate or link multiple datasets for assessing the MCH's populations needs and examining causal associations between client characteristics and their health status and outcomes. Many also looked at the need to build local infrastructure for data collection and analysis, as well as local planning.

The second most commonly examined infrastructure-building service was the State's quality assurance functions. **Florida, California, Washington, Minnesota, Virginia and Iowa** examined one or more of the following aspects of quality assurance: standards of care, quality monitoring and quality improvement efforts, and performance-based contracting and accountability. These six States and **Rhode Island** also looked at the need for training of

health care providers and in some States there was a focus on health and safety training for childcare providers**.**

New Jersey, Kansas, Rhode Island, Minnesota, and Washington identified the need for the State to continue, expand or initiate consumer engagement, at the community level and in Statewide quality review and planning functions. While several States discussed the need for broad consumer participation and engagement, many focused more specifically on the inclusion of communities of color, new immigrant groups, and on supporting parent-to-parent networks with families of CSHCN.

6. Assessing Accessibility and Quality of Available Services

The majority of States did not assess the accessibility and quality of available services. Of the group that did, the most information was available on accessibility and quality of services for CSHCN. **Florida**, **Minnesota**, **Virginia** and **Washington** incorporated extensive information in their needs assessment on access issues for CSHCN. These included the accessibility of: primary care, specialty services, appropriate tertiary care, and assistive technologies in various geographic regions of the State, as well as parents' perceptions of provider attitudes and quality of the primary care and care coordination services available to their children. Data from local capacity assessments provided a rich source of data for **Florida** to assess factors affecting the accessibility of prenatal and pediatric care. **Iowa** conducted a special needs assessment to examine factors affecting the accessibility of mental health services for children. The cultural competency and accessibility of MCH services to minority and multicultural groups was the focus of qualitative data collection efforts in **Iowa**, **Florida Wisconsin**, **Minnesota**, **New Mexico** and **New Jersey** and **Virginia**. **Minnesota**, **New Mexico** and **Virginia** conducted surveys of service providers at publicly funded clinics and consumer focus groups on the issue of cultural competency and ways to improve accessibility of MCH services for families from other cultures, including communities of color.

7. Examining Structural and Environmental Factors Leading to Change in Title V Capacity Needs

The environmental factors and policies with the most effect on Title V in recent years were the expansion of Medicaid and SCHIP and the shift to managed care and their potential effect on Title V services and health care. Seven States looked at the changing role of Title V as most Medicaid eligible women and children have been required to participate in a managed care arrangement. Capacity-related issues raised include: the need for ensuring MCH interests are addressed in State Medicaid contracts with managed care organizations, potential legal controversies regarding population-based MCH data collection and monitoring in a managed care environment, involvement of local health departments as contractors in the provision of primary care, the State's continued role in quality assurance and monitoring, the continued need for assurance of care coordination for CSHCN, the need to focus on enabling and population-based services to reduce racial disparities in healthcare access and outcomes, and the need to improve cultural competency of the existing system serving women and children.

Several States also discussed the changing demographics of their MCH population as a result of recent influxes of immigrants from many different parts of the world. Given that the new immigrants were coming from many cultures and speak many different languages, these States highlighted the need to focus on improving the multi-cultural competency of staff. Secondly, they focused on the importance of using multi-cultural competency as a standard in designing and reviewing the quality of direct, enabling and population-based MCH services.

8. Assessing Internal Organizational Capacity

The definition of capacity assessment in public health includes and internal organizational assessment, that includes an assessment of a health department's management, legal authorities, infrastructure, staffing, inter and intra-organizational relations, its cultural competency and other organizational resources. While the tools for assessing MCH internal capacity are still in the developmental stage, we assessed the extent to which internal organizational needs were documented as part of the needs assessments and thus could be used to inform the strategic planing process and decisions about allocation of resources.

As noted in the section above on infrastructure-building services, most of the States examined their internal capacity for data collection and data analysis. Specific enhancements to State data systems and capacity included the need for infrastructure changes to allow MCH link databases and to make data more available and usable by local health departments and researchers. A few States discussed the need for specialized data collection efforts including PRAMS, maternal mortality reviews, fetal and infant mortality reviews, child mortality reviews, and special surveys to allow the State to better assess concerns such as domestic violence, perinatal substance abuse, and youth-risk and health-promotion behaviors.

Several States identified specific gaps in internal staff capacity, e.g. in the area of monitoring the quality of care for CSHCN in managed care, in MCH epidemiology, and staff, interpreters and resources to conduct outreach, translate materials and adapt culturally specific health assessment or treatment approaches.

Finally, while most States provided long lists of Title V agency partnerships and advisory committees, only a few States assessed the weaknesses or gaps in their collaborative relationships. For example, **Washington** and **Minnesota** cite the need for Title V to enhance its role, in collaboration with the Department of Education, for the planning and assurance of transitional services for adolescents with special health care needs. **Virginia** cites the need for improved coordination between the Departments of Health and Mental Health, Mental Retardation and Substance Abuse Services as well as the need for improved coordination and integration of various public and private systems of care for CSHCN.

9. New Directions for States' Capacity Assessment

While capacity assessment was not a focus of many States' needs assessments in 2000, it is of growing interest to many of the study States. For instance, in Rhode Island, the Title V agency is looking more closely at ways to measure the capacity of systems to provide a medical home for all children. In addition, since 2000 all of the study States have received State Early Childhood Comprehensive Systems (SECCS) Planning Grants funded by MCHB.

States have used these grants to assess capacity at the system level using a variety of data sources, including primary data collection (interviews and focus groups) with stakeholders, resource mapping, program and provider data, and other State and local data sources. Several State officials told us that they would be incorporating these findings into their 2005 needs assessment. Some States are also beginning to look at the capacity of the existing systems to provided needed oral health care for children, particularly uninsured children and those with public coverage.

Internal capacity assessment has taken on a greater importance as State Title V agencies continue to evolve from providers of direct service to the public health functions of education, infrastructure building, assurance and monitoring. Many of the study States have or are planning to utilize the recently revised and streamlined Capacity Assessment for State Title V (CAST-5) tools in this effort. Florida and Colorado, for example, were pilot States for the complete set of revised CAST-5 instruments, and California, New Jersey and Virginia have used or are planning to use a number of the revised CAST-5 tools for their 2005 needs assessment. Colorado officials particularly appreciated being able to select the modules of the tool that were the most useful to them; their analysis highlighted needs in the areas of data capacity and staff capacity in particular.

While CAST-5 provides a useful tool for assessing internal capacity, many States reported assessment of capacity across the system as a whole to be a challenge. Washington State officials noted that, since their agency does not provide direct services, they have no influence on the capacity of the system to serve patients. In addition, although they were able to discuss issues such as the effect of environmental changes such as managed care and welfare reform on access to care, they did not have clear measures of the accessibility, availability, and affordability of services. California officials also noted that they relied on anecdotal reports regarding access to providers, particularly for CSHCN, in the absence of quantifiable measures. New Mexico has access to a number of traditional capacity indicators due only to the unfortunate fact that a majority of their counties are designated as health provider shortage areas.

Table 2
States' Assessment of Supply and Availability
Of Direct Health Care and Enabling Services for MCH Populations

ST	Direct Health Care Providers and Services										Enabling Services		
	Primary Care Providers	Dentists serving low-income children	Primary care services for women and children	Specialty and sub-specialty services for CSHCN	Medical Home for CSHCN	Neonatal intensive care and birthing centers	Mental Health Services for Children	Family Planning	School Health	Insurance Coverage and Outreach	Case management/ supportive services for women and/or children	Family Support services for CSHCN	WIC
AK													
CA				X						X	X	X	
CO		X	X	X						X	X	X	
FL	X			X	X	X	X	X		X	X	X	X
IA	X	X		X	X			X		X			
KS	X	X					X						
MN				X						X		X	
NJ										X	X	X	
NM										X			
OK													
PR				X						X	X		
RI	X	X	X	X			X		X	X		X	X
VA	X		X	X			X	X	X	X	X	X	X
WA	X	X	X	X		X		X		X		X	X
WI										X			

B. Setting Priorities and Putting It All Together

The next step in the development of a successful needs assessment is synthesizing the findings of the various analytical efforts into a unified, coherent statement of the State's MCH priorities. This is a complex task, as it involves balancing and integrating information from various sources, along with the less empirically-based preferences and priorities of a wide range of stakeholders. The presence of the following elements may help to simplify this task.

- ***Local participation***. The needs assessment should utilize input from local constituencies, including local health agencies and consumers, in identifying priorities. Consumer, advocacy, or local provider organizations may offer insight into regional or local issues that affect the populations they know best.

- ***Defined methodology***. The needs assessment should include a specific protocol and set of criteria for ranking and prioritizing the needs identified by the assessment.

- ***Integration.*** The capacity assessment analysis should be integrated with the assessment of needs. Analyzing the needs in the context of the system capacity, and vice versa, will reveal the gaps in the system that contribute to needs going unmet, and will highlight the areas of need that can be addressed most successfully through systems changes.

- ***List of priorities***. A comprehensive list of priorities should be included in the needs assessment document. Health status and outcome goals, quantitative and qualitative capacity assessment goals, and internal capacity assessment goals should also be included.

Few of the State needs assessment documents reviewed incorporated all of these criteria. The first, the use of local-level input, was discussed in several of the assessments reviewed. For example, the Montana State Needs Assessment work group conducted special surveys to assess State, local, private health, education, and social work providers' as well as consumers' opinions concerning priority MCH needs for children with special health care needs and for the larger MCH population. They included the results of these surveys in the final prioritization process. Similarly, in Wisconsin, local health department directors were asked, "What new needs have emerged as a priority over the last 5 years?" This information was tabulated, compared to prior years' results, and ranked according to the frequency the priority was mentioned. The resulting priority needs were arranged in a table,

marked according to the type of service, and the MCH population affected. For example, the first priority, dental access for children, is recorded as an enabling service involving children and CSHCN.

Several States described the use of a specific protocol and a series of criteria to guide the selection of priorities. In general, the criteria used reflect the *impact* of the health issue (including prevalence rates, total numbers of people affected, and effect on morbidity and mortality, and the economic impact of the problem); its *susceptibility to intervention* (including the existence and feasibility of interventions to address the issue and the existence of known risk factors for the problem); and *practical concerns* about monitoring and addressing the need (including the ability to track and measure the indicator and the availability of resources to address the problem). The processes and criteria used by several of the study States to select priorities are described in more detail below.

- The **Washington** Needs Assessment included an extensive priority development process. A Steering Committee was established and included representatives of the Office of Maternal and Child Health (OMCH), the local assessment coordinator for the Department of Health (DOH), and a representative of the local health jurisdictions (LHJs) throughout the State. The committee developed the plan for assessing needs and system capacity and setting priorities based on these findings. This plan included facilitated discussions at five regional meetings of LHJs to identify local priorities, the findings of which were incorporated into issue papers used in the State's final "prioritization retreat."

  The State held four of these retreats, each including experts from DOH, the LHJs, State universities, advocacy groups, parents, other State agencies, and other stakeholders. The first three retreats focused on the specific priority populations of mothers and infants, children and adolescents, and children with special health care needs. At each retreat, participants were presented with needs assessment findings and asked to rank the health indicators according to the Hanlon-Pickett prioritization method. This method involves rating the size and seriousness of each health issue, the effectiveness of available interventions, and the State's political, economic, and logistical ability to address the issue in order to assign a priority level to each indicator. These initial retreats produced a set of seven to ten ranked priority health needs for each population.

  Finally, a retreat was held in November 1999 to distill these three priority lists into a single list of 15 State priorities for OMCH using a similar process. From this list, the final list of ten priorities for the Block Grant was chosen. The criteria used to make this final selection included:

- the prevalence of the problem both in terms of rates and absolute numbers of people affected
- the seriousness of the issue in terms of morbidity and mortality
- the economic impact of the issue and the extent of resources available to address the problem

Finally, the participants at the retreat decided to prioritize issues that were precursors to other problems, in order to focus on preventing the problems that were farthest "upstream." Using these criteria, the final list of ten priorities was selected.

- The State of **Iowa** used a quantitative approach to prioritizing Maternal and Child Health problems or needs that gave equal value to the views of all persons involved in the needs assessment process, and they also used consensus decision-making at various stages of the process. The process began by the creation of two separate planning groups for the MCH population overall and for CSHCN. Each planning group identified a list of potential MCH goals or needs, based on available data. A subset of both groups then jointly developed a set of criteria to prioritize MCH goals or needs. The criteria chosen were:

  - Degree to which goal is reachable by known interventions.
  - Degree of health consequence of not addressing goal.
  - Degree of non-Title V State and national support for addressing the goal.
  - Degree of current demographic disparity regarding goal.
  - Degree to which other local providers or service consumers identify goal as a need.

  The planning group members then individually scored each problem in the pool for each of the five criteria (based on a three-point scoring scale for each criterion). Then the group's grand total scores were added up for each problem and the problems were numerically ranked. The MCH Planning Group gathered to discuss the quantitative results and decide by consensus if there were any changes needed and if other considerations needed to be taken into account in determining the final list of priorities.

  The CSHCN planning group utilized a second, primarily qualitative process. A group of 14 key regional and central office staff engaged in a brainstorming exercise to identify specific areas of CSHCN services that needed improvement, based on the quantitative data and their own expertise and experience. The group then used a two-stage voting process to prioritize the new pool of capacity needs in each level of the MCH Pyramid. To finalize the list of five CSHCN priority needs, after the voting process the group discussed the results to determine if any additional factors needed to be considered and a consensus process resulted in some changes to the vote-determined list.

- The **Kansas** Needs Assessment had a thorough and intuitive approach to setting the State priorities. Preliminary priorities were chosen through a Joint State Needs Assessment Steering Committee, consisting of 15 key decision-makers representing State agencies parents of children with special health care needs, local health departments, private, not-for-profit agencies, as well as academics. The proposed priorities were presented to a Resource Committee at a prioritization retreat held in May of 2000. This retreat included 35 representatives of various State programs, organizations, and interests. Retreat participants selected nine overall priorities relevant to primary care, Maternal and Child Health, cross-cutting, and infrastructure issues. They were subsequently presented a week later at a video-conference for immediate feedback from 20 local health departments and via mail to stakeholders. The Needs Assessment plan included a list of criteria used to select priorities. They should:

    - Have a positive impact on health outcomes;
    - Be trackable and measurable;
    - Have a relatively small number of identifiable risk factors; and
    - Be susceptible to a finite, manageable set of program activities, services or interventions

A few States effectively integrated the capacity assessment analysis with the assessment of priority needs. The **New Jersey** Needs Assessment workgroup did a very thorough job merging these two concepts throughout their document. Throughout the capacity assessment analysis, including direct health care, enabling, population-based, and infrastructure building services, they include the service structures that are in place to target the nine State priorities. For example, targeting the improvement of access and utilization of preventive and primary care health services (priority need #1), the State depicts the expansion of enabling services such as NJKidCare, a service system supplementing Medicaid within the State. Other programs including Healthy Mothers/Healthy Babies programs, HealthStart, and Healthy Start are also in place to reduce the barriers to health care.

As required by the Block Grant guidance, all of the States included a list of priorities developed through the needs assessment process. The States' priorities varied in scope and specificity: some were broad, overarching priorities while others applied to a specific issue. Most of the States' priorities can be categorized into three broad areas: (1) health status; (2) access to care; and (3) capacity. Table 3 below shows the priorities that were most commonly mentioned by the study States.

Table 3 MCH Priorities		
Health Status	**Access**	**Capacity**
Support, educate, strengthen families	Improve access to early and high quality health services for MCH and vulnerable populations	Improve the coordination of health care services including CSHCN
Reduce disparities in health status	Improve access to adequate prenatal care	Improve the communication among parents, public, private, community based organizations, advocates, stakeholders in MCH issues and solutions
Promote healthy behaviors among pregnant women and parents	Improve access to oral health care for children	Improve infrastructure for transition services for CSHCN
Improve oral health status	Reduce disparities in access to health care	Improve program evaluation and population assessments for MCH and CSHCN
Improve prevalence rate of family violence/child abuse	Improve access to substance abuse treatment and mental health care	Improve upon MCH public health information/surveillance, epidemiological capabilities, and community assessments
Improve unintended pregnancy/adolescent pregnancy rate	Improve access to high quality health care for CSHCN	
Improve mental health status		
Decrease rate of tobacco/alcohol/drug use		
Improve nutritional status/level of fitness		
Reduce rates of infant, child, female morbidity/mortality		
Improve rates of unintentional/intentional injury		
Improve levels of safety in child care		
Improve the health, safety, development of teens		
Reduce the rate of low birthweight infants		
Improve quality of parenting skills		

A needs assessment must not be seen simply as a document, but as a step in a process of systems development. The needs assessment should ideally result in the development of alternative interventions to address the priorities and the selection and implementation of appropriate and viable interventions, the allocation of resources and development of systems to support those interventions, and the establishment of a performance measurement system to evaluate the impact of the chosen approaches.

The next chapter focuses on how the study States have applied the results of their needs assessment, with specific examples of what contributed to their successes in applying needs assessment priorities to program planning, as well as the factors that pose challenges to the States who wish to shift resources to new priorities and emerging needs.

Chapter IV
Putting Needs Assessment Findings into Practice

A major product of the needs assessment process is the list of 10 priorities that is submitted to MCHB on Form 14 of the Title V Block Grant Application. While these are a required element of the block grant, States vary in their approaches to measuring and using the priorities for planning and resource allocation, a critical step in their ability to put the findings of the needs assessment into practice. This chapter discusses the study States' strategies for measuring their progress on the priorities, through State and national performance measures, and allocating resources based on their priorities. The information is derived from a review of their 2004 Title Block Grant Applications and from the follow-up in-depth telephone interviews conducted with the State officials about their past efforts to establish priorities, how they have measured and evaluated performance on their priorities in the past, planned changes for 2005, how their budgets and staff resources breakout by MCH priority areas, and overall how they put their needs assessment findings into practice to shift, target or refocus program resources.

A. Identifying and Measuring Priorities

Section IV.B. of the Block Grant application asks States to link their priorities to specific State-identified or national performance measures. In practice, these are linked with varying degrees of precision; for example, Colorado attached a table listing the State's priorities and the specific State and national performance measures associated with each. California, on the other hand, divided its priorities according to the four pyramid levels and listed the national and State performance measures that addressed each level, but did not specifically link the measures to the priorities. Florida and Rhode Island each listed at least one national and one State performance measure for each priority (although Florida had one priority with no measures), while New Mexico linked its priorities to the levels of the MCH Pyramid but not to any specific State or national measures.

Some priorities lend themselves to measurement through the National Performance Measures more easily than others. For example, many States identified priorities relating

to reduction of adolescent pregnancy or birth rates (National Performance Measure 8) or oral health (National Performance Measure 9). Priorities related to perinatal care are generally mapped to National Performance Measures 15, 17, and 18, while those relating to systems of care for CSHCN link to Measures 2 through 6.

However, many States listed at least one priority that was not reflected in the set of national performance measures, and several had more than one. The types of priorities that were not linked to national performance measures included the following:

- Reducing overweight among children, addressing physical activity and nutritional habits (Colorado, Iowa, Kansas, Virginia, New Jersey).
- Reducing substance abuse (alcohol, tobacco, and drugs) (Colorado); Decreasing tobacco use (Washington); increasing access to mental health and substance abuse services for women and children (Kansas).
- Establishing an integrated system of comprehensive mental health services for children (Iowa).
- Decreasing family violence (Washington).
- Ensuring surveillance capacity for CSHCN (Washington).
- Reducing the incidence of infections during pregnancy (Florida).
- Improving State MCH data and epidemiological analysis capacity (Florida and Virginia).
- Reducing racial and ethnic disparities in health status among pregnant women and children (Iowa, Kansas, Virginia).

In cases where no national performance measure addresses a priority, States generally developed or applied their own performance measures. For example, Washington's priority of decreasing family violence is measured through an indicator of the percentage of pregnant women who are screened for domestic violence at prenatal visits. Colorado's priority on reduction of overweight in children is associated with a State performance measure addressing the proportion of WIC children who are obese. Florida's priority on reducing the incidence of infections during pregnancy is measured through an indicator

tracking the percentage of pregnant women screened by Healthy Start, the State's program for high-risk pregnant women. In all of these examples (as in others found in other states), however, the State performance measure focuses on a subset of the population included in the priority goal, subsets for which State-level data are more readily available than for the population as a whole.

This analysis illustrates the complexity of monitoring and measuring progress on the issues that are important to State MCH agencies. The national performance measures focus on the traditional concerns of MCH: developing and maintaining systems of care for CSHCN, immunization, injury prevention, oral health, and perinatal health. To a large degree, data sources for these indicators are available to the States, and new sources—such as the National Survey of CSHCN—have been developed as a result of the importance of these indicators.

An area of particular interest in the States is the development of quantifiable measures to assess the quality of children's care. Some examples include:

- ***Florida*** has developed a set of performance indicators to track local progress toward the six national goals for CSHCN. The State staff have piloted and are now implementing a tracking system at local and regional Children's Medical Services (CMS) agencies to quantify the availability, accessibility and quality of services for children enrolled in the CMS network. They have also developed population-based measures using existing hospital, screening and early intervention data systems to assess the effectiveness of special needs screening and follow-up services for all children in the State. These data will be used to complement information available from the National Survey of CSHCN, which provides information on families' experiences and perceptions of the service and support systems for CSHCN.

- ***Rhode Island's*** Title V agency is working with the State pediatrics associations to identify indicators that can assess whether children have a "medical home." To this end, they are developing and testing measures to quantify the extent to which care for children is accessible, family-centered, continuous, comprehensive, compassionate, culturally effective, and coordinated.

In developing their priorities, however, States have expanded this list of concerns to include mental health and substance abuse, obesity, violence, and health disparities and some have begun to include concerns about MCH data infrastructure as a priority along with individual health issues. These new priorities reflect the critical issues that affect children and families and are appropriate priorities for State MCH agencies. As the list of priorities becomes more varied, however, the challenge of measuring progress toward these goals increases. State-level population-based data on these issues is rarely available, so States rely on proxy measures, often based on program data (such as WIC or Florida's Healthy Start program). These provide information on subpopulations, often those in greatest need of services. While this information is useful, it does not address the status of the population as a whole.

Some States have gone a step further and established priorities that reflect the MCH agency's role in systems development and infrastructure-building. These do not lend themselves to quantitative measurement, so States have developed qualitative indicators for them or left them without performance measures. For example, Kansas's priority to "increase data infrastructure, epidemiological capacity, and products of analyses for improved State and community problem-solving" is monitored through a qualitative assessment of "the degree to which the MCH program addresses data capacity." Florida's similar priority, to improve State MCH data and epidemiological analysis capacity, is not associated with any national or State performance measures.

Most of the States interviewed said that the performance measures they report for Title V are their primary indicators for annual assessments of needs and progress on their priorities and they ues these data also to report on performance for internal State planning purposes (often supplemented with additional measures reported only to the State). At the same time, some State MCH officials cautioned against over-reliance on quantifiable performance measures in States' assessment of progress toward MCH goals and priorities and for State program planning. They indicated that a focus on performance measures relies primarily on quantifiable health status measures that can measure only broad—and sometimes long-term—changes. They suggested that other qualitative or capacity

indicators should be tracked on an ongoing basis to gain a better understanding of the factors contributing to changes in health status or health access measures and thus assess what aspects of the system need to be expanded, curtailed or improved.

B. Allocating Resources Based on Priorities

In the block grant application, activities and accomplishments are organized around the performance measures, *not* the State's priorities. Therefore, priorities that are not linked to a performance measure do not have a logical place in the application unless States choose to list additional activities. Moreover, if States have not clearly tied their priorities to the performance measures, it can be difficult to determine whether activities are being conducted and funds allocated to address the priorities.

The MCHB form limits the States to 10 priorities, and most report that this limit does not present a problem. In fact, officials in Colorado felt that if anything, they had too many priorities, not too few; other States, such as New Jersey, listed fewer than 10 priorities. Of the study States, only New Mexico and Rhode Island reported that they had created additional priorities. Of the two additional priorities, one ("reduce medical services funding gaps for children in NM, i.e. children who are non-Medicaid eligible, children with orthopedic/rehabilitative needs, and children in need of catastrophic medical funding such as organ transplants") did have activities associated with it, while the other ("establish infrastructure in NM to support the development of a system to respond to genetic breakthroughs and their implications") does not.

Aside from the absolute number of priorities, the breadth and generality of the priorities that are chosen affects how easily they can be measured and linked to programs. Some States developed broad priorities, so as to assure that all of their programs and funds could be demonstrably linked to the priorities; others crafted specific priorities, so as to be able to measure progress; and still others focused on new or emerging issues, so as to draw resources to new areas. However, each of these approaches has drawbacks as well. For example, one of Colorado's priorities is "reduce overweight, addressing physical activity and nutritional habits." While this is specific and measurable, it is not linked to

any of the national performance measures, and State officials reported that they have not succeeded in allocating resources to address the priority. Other priorities are cast more broadly, such as Washington's first priority, "improve access to comprehensive prenatal care." This easily encompasses a range of programs, so it can clearly be shown that resources are being applied to the issue. Florida officials reported that casting their priorities broadly made them easier to measure as well; New Jersey, on the other hand, eliminated one of their priorities ("improve access to and utilization of preventive and primary care health services") because it was too broad and difficult to measure.

In addition to the 10 MCH priorities reported to MCHB, Rhode Island's MCH agency uses a second set of priorities that are developed annually as part its broader strategic planning efforts with all divisions in the State health department and across State agencies participating in the Governor's Children's Cabinet. These priorities are what Rhode Island's Title V director considers its high profile priorities for maternal and child health. They focus more broadly on child development, children's readiness to learn in school, family security, and family stability--priorities that are clearly affected by multiple agencies, have a broad array of potential indicators, and whose achievement would require coordination of services across agencies. As discussed in Chapter II, the Title V agency has works in collaboration with other State agencies serving children and families and RI Kids Count to develop performance measures for these priorities, that include health, socioeconomic, behavioral and educational outcomes and risk factors. They have also most recently developed "system indicators" designed to assess child access and system capacity in achieving these broad priorities.

To further examine the study States' allocation of resources to their priority issues, we extracted from the 2004 Block Grant applications information about the programs and services implemented by the State Title V agencies and their association with both the States' priorities and the levels of the MCH Pyramid. In many cases, the association between program activities and the priorities was tangential; the activities were described in the context of the State and National Performance Measures, and the measures were

linked to the priorities, but the activities are rarely discussed in the context of the priorities.

Overall, in most States, one-half to two-thirds of the MCH activities described in the Block Grant fell into the "infrastructure-building" category, while fewer than 10 percent were classified as direct services. Nearly all activities could be associated with one of the ten priority needs; for most States, 10 percent of activities or fewer were not related to any of the priorities (in one State, however, 38 percent of activities were not related to any of the priorities.) Likewise, nearly all of the priorities had at least one activity associated with them; only two States had priorities with no associated activities. Our analysis confirmed State officials' reports that broader priorities could encompass a greater number of activities. For example, Oklahoma's priority to "decrease adverse pregnancy outcomes" covered 22 percent of the State's activities, and Minnesota's goal of "promoting family support and healthy community conditions" covered 21 percent. In contrast, more specific priorities generally only had one or two activities listed, such as Florida's priority to "improve the State's maternal and child health data capacity and capacity for epidemiological analysis," or California's goal of "continuing to expand the CCS statewide automated case management and data collection system, CMSNet, to improve tracking and monitoring services outcomes for CSHCN," each of which represented one activity.

Several States reported that including an issue as a priority can provide justification for allocating resources to a program that might otherwise not receive funding. Washington, for example, intentionally focused their priorities on issues that the State has traditionally not had the resources to address, such as oral health, mental health, nutrition, and systems of care for CSHCN. State officials felt that including these issues as priorities would raise their visibility and help to justify the allocation of new resources to these issues. To some degree, this has been successful: the State MCH agency has hired staff with responsibility for mental health and nutrition when positions have become available. Iowa reported taking a similar approach, including in their priority list only "emerging issues" rather than those for which the State maintains ongoing programs. While most of

the State's MCH funding is based on historical allocations, the remainder can be devoted to these new issues.

In addition to their efforts to use priorities to direct funding decisions on the State level, several States reported using the priorities to guide contracts with and workplans of local health jurisdictions.

- In ***Virginia***, the Title V agency has translated its MCH priorities into "investor targets" for its regional health districts, who receive the majority of State Title V and State MCH funds. Investor targets were developed as a quantitative measure for the State to use to determine the success of its investments in local health. Each investor target is tied to a State MCH priority. Each local health department is asked to select three investor targets in its annual contract with the State and to commit to achieving measurable goals toward each. Annual allocations of funding from the State to the districts are, in part, tied to documented performance on these targets.

- In ***Iowa***, each local board of health is required to conduct a Comprehensive Health Needs Assessment and Health Improvement Plan every 5 years. They must document local needs, select local health priorities and develop local action plans for each selected priority. The local boards, which receive Title V funds, must include at least 5 MCH-related priorities, action plans and performance measures that are tied directly to the State's priorities, and in selecting performance measures for these MCH priorities they must draw from the list of Title V national and State Performance Measures.

In Wisconsin, the work plans of local public health departments are determined based on the needs assessment findings as well. Other States also direct most of their funds to local health agencies, but the allocation of these funds is not driven by the priorities. In Washington, for example, local health jurisdictions' work plans are based on the 10 essential public health services, not on the MCH Pyramid or priorities.

Despite these efforts, rational planning can frequently be stymied by the competing demands of political realities and bureaucratic intransigence. In the real world, MCH agencies cannot completely revamp their budgets each year, or even every 5 years, regardless of the data and reasoning behind their stated priorities. Existing positions and programs are generally continued unless there is a pressing reason to terminate them, and

funding for new positions and programs can be difficult to find. In addition, a substantial proportion of MCH funds are often passed on to local health jurisdictions, whose decisions about allocating these funds may or may not be linked to the State's priorities. Therefore, new programs or positions can only be established when new funding or staff slots become available. Several States reported taking advantage of retirements and resignations to redirect their staff positions and assure that newly-hired staff have the skills needed to build the MCH infrastructure. Kansas, for example, reported revising position descriptions to include data expertise and computer literacy whenever vacancies occurred.

Even more frustrating to State officials is the role of political considerations in the allocation of funds and development of programs. Officials in one State reported feeling constrained even about mentioning programs or issues that might cause controversy, such as adolescent pregnancy prevention, even when these were listed as State priorities. This clearly hampered the State's ability to address these priority needs. Officials in another State reported that the priorities of the Governor's office routinely pre-empted those identified through the needs assessment, leaving MCH officials frustrated. A third State specifically mentioned the challenge of funding programs for adolescents, who are less politically appealing than pregnant women and young children.

Overall, States reported that they can be successful in allocating resources to their priority needs when they can show both a clear need, through needs assessment data, and program success, through evaluations. Having access to sources of funding outside of the MCH Block Grant is helpful as well, as is having staff and involved stakeholders who are passionate about the issues. And while political constraints can hamper progress toward some priority objectives, others can find crucial support from gubernatorial Children's Cabinets and advocacy groups concerned with children's and families' issues.

C. Analysis of Budget Information

To further assess States' ability to allocate funds to their priority issues, we requested from each State information from their most recent budget on funding allocations by program, arrayed according to the State's priorities or the performance measures (which could then be mapped to the priorities). Only three States were able to provide this information, indicating that while the priorities are important, and the performance measures provide the context for the discussion of activities, these structures are rarely used in the analysis of resources and their allocation.

Table 1 below shows the distribution of expenditures by priority in the three States that submitted budget information. (As the table shows, these three States presented their expenditure information in varying levels of detail.)

Table 1.
Analysis of 3 States' MCH Expenditures by Priority Area

Priority	State A				State B			State C*
	Title V	Federal	State	Other	Title V	Federal	Other	Total
1	8.5%	2.5%	0.2%	0%	0.6%	0.8%	0%	1.8%
2	0%	1.1%	0.6%	0.2%	"addressed by every program"			42.9%
3	3.7%	0%	0%	0%	3.5%	0%	0%	0%
4	4.6%	8.2%	1.0%	0%	41.6%	5.8%	39.1%	0%
5	8.0%	20.4%	77.4%	13.8%	43.4%	44.1%	44.5%	9.8%
6	7.0%	1.3%	0.2%	0%	0.8%	43.1%	11.8%	4.2%
7	7.6%	1.9%	3.3%	0%	5.1%	6.2%	4.6%	7.1%
8	0%	0%	0%	0%	5.0%	0%	0%	0%
9	37.2%	16.4%	8.5%	17.5%	0%	0%	0%	25.7%
10	11.2%	2.6%	0.5%	0%	0%	0%	0%	0%
None	12.0%	45.4%	8.3%	68.4%	0%	0%	0%	8.5%

Notes: If a program was linked to more than one priority, the budget was divided evenly among all associated priorities. WIC expenditures are excluded in all three states.
*Funding for statewide programs only.

Some priorities received large proportions of MCH funding. In State A, Priority #9 (having to do with outreach for MCH programs) received funding from all sources, while priority #5, regarding family support, received the largest proportion of funds, primarily State funds. In both States B and C, priorities regarding access to and quality of health services were associated with the bulk of resources.

Others received much smaller percentages of allocated funds. Some of the priorities in these States that received no funds or small proportions of funds included issues such as dental disease, childhood obesity, health and safety in child care, parenting skills, substance use, and injury prevention. (It should be noted that one of the priorities listed here that has no funds attached addresses the nutritional status of children and families, but this table does not account for WIC funds.)

In addition, one of the three States devoted a large proportion of its available funding to programs that were not linked to any of the State's priorities. These primarily included infrastructure-related and administrative activities.

Although this analysis is by no means exhaustive, it does illustrate the challenge of associating MCH agencies' expenditures with their priorities, especially since this analysis is not required as part of the block grant application. In addition, it shows that although the States' priorities address a wide range of MCH issues, their actual activities and expenditures may be focused on more traditional MCH programs and services.

Chapter V
Challenges and Lessons Learned

As this review of the process and content of Title V needs assessments shows, the study States varied widely in their approaches to needs assessment how and to what degree they address each of the elements of health needs and capacity assessment, and the areas of focus of the assessment. States also vary considerably in the degree to which their reported MCH priorities drive program planning and the allocation of resources within their Title V programs and MCH programs overall. Despite this variation in State documents and experiences, the review of State documents and interviews with State MCH officials regarding Title V needs assessment and planning reveal a number of consistent themes. States face common challenges as they try to integrate needs assessment into their program planning efforts and their experiences reveal lessons for all State and local MCH needs assessments. They also have made important suggestions regarding the guidance and tools they receive from MCHB on needs assessment.

A. Challenges

The challenges State Title V agencies faced as they approached the needs assessment process in 2000 and many face again in 2005, include the following:

- Moving beyond traditional indicators and data sources. Despite the range of needs and issues faced by women, children, and families, many of the States' needs assessments relied on data from traditional sources (such as Vital Statistics) to produce traditional indicators (such as mortality rates and birth outcomes). Indicators of health care access and quality, psychosocial risk factors, nutrition, oral health, and other issues of critical importance to maternal and child health were much less common, presumably because data on these indicators are less accessible.

- Using qualitative data most effectively. While many States conducted focus groups of consumers and families, particularly families of CSHCN, the findings of these groups were not always clearly reflected in the needs and capacity assessments. Qualitative information can and should be used to amplify, enhance, and explain quantitative findings, but combining the two sources of data appeared to present a challenge to many States.

- Incorporating local findings into State needs assessments. Similarly, many States described local-level needs assessment processes, but relied on State-level data sources for their indicators of need. It was not clear how the local assessments of need contributed to the State assessment, beyond the identification of local priorities.

- Assessing capacity, especially at the system level. The most challenging aspect of the process for most States was the assessment of capacity. While most State officials expressed that they would like to perform such assessments, many appear to lack the financial and/or human resources to do so. For example, in 2000 rather than examining the capacity of the overall system serving children and families—including Medicaid, SCHIP, Early Intervention, and special education, as well as public- and private-sector MCH services—many States simply reported the number of children served through Title V-funded programs. This does not describe capacity (as it is not clear whether these programs could serve more clients), nor does it address the capacity of the full range of resources available to MCH populations. By the time States began preparing for their 2005 Title needs assessments, revised CAST-5 tools were available to the States. While these tools received a positive reception in many States, some found them still overly complex, and others simply reported that their budgets and lack of staff with expertise in this area prevented them from assessing capacity thoroughly and systematically.

- Marrying needs and capacity assessment. The integration of the needs and capacity assessments can provide a powerful analytical tool. This analysis can reveal areas of significant unmet need (those with high need and low capacity), areas of greatest opportunity to intervene (high need and high capacity), and areas of excess capacity (low need and high capacity). Perhaps due to the structure described in the Block Grant guidance, most States' needs and capacity assessments were distinct, and the findings of the two were not integrated.

- Translating identified priorities into resources and system changes. Many officials interviewed felt strongly that the MCH needs assessment and the resulting priorities are beneficial when justifying programs or funding, or when seeking new resources. However, one of the consistent themes found across States is the influence of political issues on the ideal of program planning and resource allocation based on identified priorities. Most States are forced to contend with political pressures that affect MCH functions. In many States, new administrations bring with them new State-level priorities and funding decisions, and restructuring and budget cuts in a number of States have led to a reduction in both the human and monetary resources that are available for States to address the needs of their MCH populations. Some States are reduced to providing the bare minimum of services while they are forced to decide where they can absorb budget cuts. While this can be

frustrating, it does not appear to diminish MCH officials' commitment to conducting thorough and useful needs assessments.

1. States' Recommendations for Title V Needs Assessment Guidance and Tools

Most States have similar needs and suggestions for making the Title V process and tools more useful. Most of the themes that arose during the interviews involve the timing and process of the needs assessment, the barriers to performing capacity assessment, and the effect of political constraints on program planning and resource allocation. In addition, several State officials had suggestions regarding the guidance and tools they receive from MCHB on needs assessment.

Some MCH officials also offered constructive comments about the needs assessment cycle in their States. Many States, including Florida, New Jersey, New Mexico, Oklahoma, and Rhode Island reported performing ongoing needs assessment. As one MCH director noted, "any State with a good epidemiology program should do ongoing needs assessment." Similarly, Washington officials felt that it would be helpful to them to have a more regular needs assessment cycle; they would like to make it a systematic part of their work, not a process that they undergo only once every 5 years for the Block Grant. Officials in that State would like to receive their needs assessment tools sooner so that they can begin needs assessment earlier in the cycle. Wisconsin is one State that does perform needs assessment only once a year (unless there is an initiative that requires additional needs assessment); however, they define it as "integral" to their work.

While many of the State officials interviewed felt that the guidance they receive from MCHB is a useful template, several suggested improvements. Some felt that more specific guidance that clearly spells out the information required, with examples and models of effective approaches, would be useful. In California, State officials noted that they have begun to give more directive guidance to their local Health Departments for their assessments, and they would like the same from the Federal government.

In contrast, other State officials felt that it was important that the guidance allow for variation across States. New Mexico officials, for example, felt that while a blueprint of the requirements is helpful, each State is different and should ultimately be allowed to do what is best for them. They would, however, like more guidance on how to incorporate qualitative and policy information (such as laws, regulations, and resources) in their analyses. Colorado officials also felt that the needs assessment guidance should be more general because the Block Grant represents only one element of their planning process.

Finally, several others also noted that the guidance could be "more succinct," and two noted that it would be useful to have the guidance earlier in the needs assessment cycle so that the assessments could be more effectively integrated into the agency's day-to-day work. Despite any concerns that States may have regarding the Title V Guidance, most found the regional training sessions to be very helpful. Officials felt that they were an excellent format for learning new skills, sharing information, and inspiring new ideas for the needs assessment process.

2. Lessons Learned

While the needs assessment process presents a number of challenges to States, several lessons can be learned from their experiences in producing the 2000 Needs Assessment. In general, the needs assessment can be most effective if it is seen as a process, not a product, and if the assessment itself is an element in a broader strategic planning effort. Thus, Title V agencies should plan for the process as a whole, from the development of indicators to the identification of priorities, and designate clear sources of leadership, responsibility, and oversight for this process.

Just as important as high-level leadership is the involvement of a range of individuals with diverse perspectives and expertise throughout the process. This includes not only the perspectives of community-based stakeholders and consumers, but also the contribution of experienced and creative analysts who bring knowledge, interest, and new ideas about data sources and indicator development.

A third lesson is the importance of a systems approach to the assessment process. The needs of children and families do not limit themselves to one program or funding source, and the assessment of needs and capacity should likewise take a broad view of the systems that serve the MCH population. This approach will help to assure that the capacity assessment in particular takes account of all of the resources available to address MCH needs.

Finally, as has been discussed earlier, the findings of the needs assessment must be linked to the identification of priorities and allocation of resources. This is the final, critical step in the planning process and should involve consistent criteria and be based on the empirical findings of the assessment efforts.

In summary, States are committed to the process of needs assessment for the MCH target populations, but need ongoing assistance, particularly in assessing both their own internal capacity and that of MCH systems. In addition, while needs assessment is clearly an important part of the MCH planning process, it is evident that translating the priorities that emerge from these assessments into resource allocation decisions is a significant challenge. This could be addressed on the Federal level with guidance that incorporates the priorities more explicitly into the structure of the Block Grant application, perhaps including a specific format for linking priorities to performance measures and program activities. Overall, however, many States appear to have taken seriously the conduct of a comprehensive needs assessment and the development of their priorities, and use them as consistently as they can, within the budgetary, bureaucratic, and political constraints that they face, to shape systems of care for children and families.

Appendix A: Needs Assessment Abstraction Tool

Maternal and Child Health Needs Assessment and Block Grant Abstraction Forms and Interview Template

State:

I. Overall Description of Needs Assessment:

- Purpose of NA.
- How will it be used?
- Who (what agencies and at what level) will use the assessment information?

Definitions:

- How does State define "need"?
- How does the State define "capacity"?

Organization of the Assessment – State Level:

- Identify the agency, person, and title of person(s) responsible for the development and conduct of the NA.
- What data analysis and epidemiological capacity was available to the process?
- Were outside consultants used? If so, describe purpose and type of consultation.
- Was an intra-departmental or inter-agency group formed to oversee the assessment?
- What conceptual framework or organizing principles were used to organize the NA?

Organization of the Assessment – Local Level:

- What, if any, local county health departments, Councils, Regional Planning Groups were involved in the NA process?
- How were they involved in the NA process?
- What is their role in using the NA information?
- How were consumers involved in the needs assessment process?

II. Data Collection and Analysis Processes

A. Major sources of quantitative data:

- Why and how were they selected?
- What sociodemographic variables were used to stratify data?

B. Major sources of qualitative data:

- Why and how were they selected?
- What sociodemographic variables were used to stratify data?

C. Analysis

- How were quantitative and qualitative findings analyzed and synthesized?
- What trends are analyzed and what data are limited to one year?
- What data are unavailable?

Template Table 1: Needs										
I. Priority Population	**Quantitative Findings**					**Qualitative Findings**			**Overview**	
	Indicator	*Data Source*	*Year(s)*	*Analyses*	*Stratification variables*	*Indicator*	*Data Source*	*Analyses*	*Synthesis of Qualitative and Quantitative Data*	*Unavailable Data*
Pregnant women, mothers, and infants	*Demographics*									
	Health Status									
	Performance Measures									
	Outcomes									
A. Children	*Demographics*									
	Health Status									
	Performance Measures									
	Outcomes									
CSHCN	*Demographics*									
	Health Status									
	Performance Measures									
	Outcomes									
Cross-cutting										

Template Table 2: Capacity			
	Infrastructure Findings (institutional capacity) (note data source where available)	**Human Resource Findings (provider capacity) (note data source where available)**	**Qualitative Findings (access, other assets & resources)**
Infrastructure-building services			
Population-based services			
Enabling services			
Direct health care services			
Collaboration mechanisms			
System-building efforts			

Survey Follow-up Questions
V. Priority Setting
• How were priorities determined? • Was the same process used for CSHCN and MCH? • How were consumers involved in the process of setting priorities? • What data were used? • Were priorities linked to funding allocations? - Women, pregnant women, infants? - Children? - CSHCN? • Were resources allocated to all of the priorities identified? If not, why not? • Was the needs assessment document presented to key stakeholders? If so, which aspects were most helpful in garnering needed resources and partners?

VI. Financing	Agency-Program	Population	Service
A. Support for MCH – Public Sector B. Support for MCH – Private Sector			

LIST OF STATE'S PRIORITY NEEDS

Appendix B: Telephone Interview Guide

Title V Needs Assessment Interview Guide:
Follow-up Telephone Interview with State MCH Directors

A. I would like to begin with a broad overview question, to get your experience and your perspective generally on how helpful the Federal Title V Needs Assessment Requirement is:

Please tell me how the Title V Needs Assessment process and final product are really used in your State.

B. More Detailed Questions on State MCH Needs Assessment Process

1. Are your State's MCH planning efforts coordinated with broader State PH planning efforts?

   1.a. (If yes) Please describe in detail how they are coordinated (timing, process, content, what needs assessment and planning tools are used for both at the State and/or community level)?

2. Is your State's MCH needs assessment an ongoing process? On what kind of schedule (every year, two years, five years)?

3. Since the 2000 Needs Assessment, how often and in what years has the State modified its list of State MCH priority needs?

   3a. Does the State currently have State MCH Priority Needs in addition to those reported on Form 14 of the Title V Block Grant Application?

I have reviewed the 2004 updated Needs Assessment and the text you included on the process for updating and analyzing data. I would appreciate being able to include a little more detail on this process.

4. Can you please describe the steps you used to assess needs and determine State MCH priorities in your most recent MCH Needs Assessment?

5. Was it the same for CSHCN? If not, how did the steps differ for determining CSHCN needs?

(If different processes were used for MCH and CSHCN, for questions 6-9 obtain different responses regarding each process)

6. How were consumers involved and at what stage or stages of the needs assessment process were they involved?

7. How were any other stakeholders involved and at what stage or stages of the needs assessment process were they involved?

8. Did you incorporate capacity assessment into your most recent needs assessment?

   8a. (If yes) What methods did you use to assess State capacity to meet identified State needs?

9. Did the process involve any community level needs or capacity assessments?

   9.a. (If yes) Please describe this process and how this was incorporated into the State MCH needs assessment.

D. Translating State MCH Priorities into Program Planning and Resource Allocation Decisions

10. How are the State MCH priorities linked to your annual program planning process for the Title V agency?

11. How, if at all, are these priorities used in any broader Department of Health and/or interagency State planning process for mothers and children?

12. What is the process you undergo each year to make resource allocation decisions for the MCH agency's budget (i.e., Title V dollars and State funds not tied to Federal mandates)?

13. How are the selected MCH priorities utilized or factored into this process?

14. Have you been successful in allocating increased resources (public, private or in-kind) to identified State priority needs/goals?

14a. (If yes) To what factors do you attribute your success in translating the needs assessment process into increased resources for priority MCH needs?

15. Which priority needs did not receive increased resources?

15a. To what factors do you attribute this (internal and external agency)?

16. Please estimate, if you can, the proportion of Federal and State MCH agency funds that is allocated for FY 2004 to activities that focus on your MCH priority needs?

17. What proportion of the MCH agency's staff resources in 2004 would you estimate go toward activities focused on the current State priority needs?

(If answers to 13 or 14 do not equal to at least 50 percent)

18. What internal or external stakeholders or factors prevented you from allocating the majority of resources on State MCH priorities?

E. State Performance Measurement

19. While we know States must report progress on State and National Performance Measures, please describe any other ways that you routinely assess progress on addressing your State's MCH priority needs?

F. Overview of MCHB Title V Needs Assessment Requirement

20. Please explain how your State uses the Federal Guidance for the 5-Year Title V Needs Assessment as a framework for planning and developing your 2005 State's MCH needs assessment and priorities?

20a. If so, how is it most helpful and how could it be more helpful?

21. Does the Title V Needs Assessment Guidance and form for reporting priorities provide a useful outline or format for reporting your State's MCH needs assessment process and content, and the resulting program priority areas?

21a. Do you have any suggestions for ways to make either of these more helpful?

G. Looking Ahead to the 2005 Needs Assessment

22. What data sources will you be analyzing for the upcoming 2005 Title V needs assessment that were not available for the 2000 Title V Needs Assessment?

23. How have you begun or plan to assess local/State capacity for this assessment? Have you considered using CAST-5 as a tool for the capacity assessment?

24. So far what has been, or what will be, the role of stakeholders, including consumers, in the needs assessment process?

25. Do you foresee using different processes this year than in the past to follow-up on the results of your needs assessment for program planning, allocating resources, and monitoring progress?

H. Budgetary Information***

From a detailed review of your 2004 BG Application, I have compiled the list of each of the activities you list that address one or more of your 10 MCH Priority Need areas.

For our report, we now need to document the primary funding source and the amount of Federal and State expenditures budgeted for each of these activities in FY 2004; We will then need to compare the these budgeted expenditures to the total budget (Federal and State dollars) for MCH activities in your State.

After we talk on the phone, I will ask you to send or provide me budget information/details that would enable me to conduct this analysis.