Review of the Title V 5-Year Needs Assessment Process in the States and Territories

FINAL REPORT

Appendix: Sample Needs Assessment Process Tools from the States

Prepared for
HRSA/MCHB

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Review of the Title V 5-Year Needs Assessment Process in the States and Territories

APPENDIX

California -- 1

Connecticut ------------------------------------27

Louisiana --32

New Hampshire----------------------------------43

Virginia ---68

Washington -------------------------------------71

CALIFORNIA

California MCH Five Year Needs Assessment

Guidelines & Indicator List for MCAH Jurisdictions

State of California Department of Health Services, Maternal and Child Health Branch
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Maternal and Child Health Community Health Assessment and Local Plan Development Guidance
August, 2003

I. Background

The Federal Maternal and Child Health (MCH) Bureau requires all states receiving Title V Block Grant funding to submit a statewide needs assessment every five years. The MCH population that this assessment process addresses includes: (1) pregnant women, mothers, and infants up to age one; and (2) children (including adolescents).

California is unique among the states in terms of its size and diversity of population, geography, and maternal and child health needs. Therefore, the State MCH Branch depends on receiving input from all of its 61 local MCH jurisdictions in order to produce a comprehensive analysis that describes the State's various public health issues and unmet needs, some of which may be specific to a given area. The purpose of this document is to help your local MCH jurisdiction to produce a succinct yet thorough needs assessment and action plan for meeting those needs.

Your local assessment is to be completed under the direction of the MCH Director in collaboration with the Health Officer, MCH program coordinators, and all appropriate public and private organizations. The local MCH community needs assessment report for the next five year cycle (2005-2009) must be submitted to the Family Health Outcomes Project by **June 30, 2004.**

After completion of the needs assessment, each jurisdiction is responsible for preparing an action plan that maps out the steps to address the identified needs. Your progress toward those goals will be monitored as part of the justification for program activities in the annual MCH Application for Allocation. Supplemental guidelines for the action plan will be forthcoming. The action plan is due **June 30, 2005.**

II. Guidelines and Technical Assistance

The Family Health Outcomes Project (FHOP) will provide you with health status indicator data to minimize the local jurisdiction data collection burden and to ensure standardized reporting and analysis. In order to support the completion of your five year needs assessment, FHOP will:

- Serve as the contact to respond to questions and provide technical assistance related to the five year needs assessment and action plan;
- Provide feedback on draft assessments and plans;
- Provide on its website standardized data for the indicators that the jurisdictions are required to review;
- Provide on its website the revised Developing an Effective Planning Process: A Guide for Local MCH Programs (March 2003). The guide provides a step-by-step process of community assessment and plan development;
- Provide updates in the FHOP newsletter on newly available data and assessment tools;

Page 170 of 224

- Continue to provide training relevant to the assessment and planning process.

FHOP contact information

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III. The Planning and Assessment Process

The five year needs assessment document should not exceed 32 pages, plus any additional priority problem analyses and appendices. We urge MCH Directors and staff to refer to and use the FHOP website frequently during the process in order to access data, the planning guide Developing an Effective Planning Process: A Guide for Local MCH Programs (March 2003)*, and other helpful materials and tools.

See the attached MCH Five Year Needs Assessment Report Outline for the required report content and format. We recommend preparing the report, as much as possible, as the assessment process proceeds and produces data and decisions.

*Developing an Effective Planning Process: A Guide for Local MCH Programs (March 2003) is referred to throughout this guidance as "the planning guide." Where a "Chapter" is referred to, it is a chapter of the planning guide.

MCH Five Year Needs Assessment Report Outline

The following is an outline of the recommended content and format for the MCH Five Year Needs Assessment Report. Voluminous narrative reporting is not encouraged; rather, use tables and bulleted information wherever appropriate. Suggested page limits are included. The planning guide[1] chapter references are included to provide additional guidance as needed. In some sections a paragraph is included to describe the planning process that would contribute to the content of the section.

The report should have seven sections:

I. Summary/Executive Report
II. Description of the MCH Community Health Assessment Process
III. MCH Planning Mission Statement and Goals
IV. MCH Community Assessment
V. Priority MCH Problems/Needs in the Jurisdiction
VI. Preliminary Problem Analysis for the Identified Local Priority Problems
VII. Appendices

Section details:

I. *Summary/Executive Report (1-2 pages)*

This section should include:

A. Purpose of the assessment
B. Description of the assessment and prioritization process
C. Mission and goals agreed upon by the planning group
D. Highlights of the assessment findings
E. Priority MCH problems/needs

II. *Description of the MCH Community Health Assessment Process (1-3 pages)*
Reference: Chapter I

This section should:

A. Describe the planning group/how it was recruited/selected
B. Describe what or how partnerships/collaborations were used
C. Briefly describe the planning processes
D. Describe how community input was obtained

Process: Convene a planning group to conduct an inclusive assessment and planning process. Local jurisdictions are required to obtain public input into its MCH assessment, including input from citizens and family members. The jurisdiction may obtain this input in several ways. A broadly representative planning group or collaborative of stakeholders that includes consumers and advocates is recommended to meet this requirement. Alternatively, the local MCH program

[1] Developing an Effective Planning Process: A Guide for Local MCH Programs (March 2003) is referred to throughout this guidance as "the planning guide." Where a "Chapter" is referred to, it is a chapter of the planning guide.

Page 172 of 224

may be able to partner or build upon other collaborative efforts to assess community needs. See Chapter I for guidance about forming and facilitating a planning group and for alternative options.

III. *MCH Planning Mission Statement and Goals (1 page) Reference: Chapter I*

This section should:

A. Briefly describe the process for developing the Mission and Goals
B. Present the MCH Mission and Goals

Process: The planning group should review any previous mission and goals and establish the current MCH mission and goals to guide the work of the assessment.

IV. ***MCH Community Assessment* (25 page maximum) *Reference: Chapter II***

This section should include:

A. Community health profile (2-5 pages) Reference: Chapter II

1. The profile should include indicators of the overall population's socio-demographic status, health status, health risk factors, and access to health and social services. It provides the context in which MCH population health needs will be identified and will highlight factors (e.g., geographic, political or social) that need to be considered when responding to health problems.
2. Some jurisdictions may be conducting an assessment of community assets to identify the resources and strengths within a community. If a community assets assessment has been done, summarize the findings. Alternatively, if your local Public Health Department is implementing the "Mobilization for Action through Planning and Partnership (MAPP)" planning process you may wish to use the process and data specific to the MCH community profile in this section.
3. See Chapter II for guidance on content and the FHOP website for community health profile examples.

B. Community resources assessment (1-4 pages) Reference: Chapter II

1. For each of the two MCH populations: 1) pregnant women, mothers, and infants up to age one; and 2) children (including adolescents):
   a. Identify concerns regarding access to health care and health-related services from the perspectives of financial access, cultural acceptability, availability of prevention and primary care services, and availability of specialty care services when needed.
   b. Assess and describe the availability of care. Discuss, as appropriate, shortages of specific types of health care providers, such as primary care physicians, nutritionists, public health or visiting nurses, etc. This should not be a list of providers and services, but rather should identify gaps and needs. A table, chart or map of the resources can be included as an appendix. See Chapter II for guidance on content and the FHOP website for examples.
   c. One way to do this would be to update the previous MCH Five Year Needs Assessment "Health Services Systems Profile" or a description of community resources recently done in the county for another purpose. Alternatively, if your local Public Health

Page 173 of 224

Department is implementing the "Mobilization for Action through Planning and Partnership (MAPP)" planning process you may wish to use the process/data specific to the MCH community resources assessment in this section.

C. **Review the State required MCH indicators (See Appendix A) (2-7 pages)**

1. Provide a list and a discussion of the required indicators (Appendix A) that you identify as local MCH problem areas based on quantitative and qualitative analyses.
   a. Quantitative Analysis. For each indicator, review the data available under *California MCH Data* on the FHOP website for the jurisdiction. Using this data:
      i. For each indicator, compare your local values with the standards provided, which will be the Healthy People 2010 goal and/or Statewide data. Include a test for statistical significance (as small number limitations allow). Complete and include, in an appendix to this section, the required form comparing local data to Healthy People 2010 or Statewide data. (The required form will be available on the FHOP website in August.)
      ii. Analyze the data for significant differences among subgroups or trends over time. In the report, comment on the significance of observed trends and any differences observed in age or racial subgroups for each required indicator. At least five years of data are required to assess trends. Refer to FHOP's new guidelines <u>Do We Have a Trend? A Beginner's Guide to Analysis of Trends in Community Indicators</u> that is posted on the FHOP web site under Reports/Guidelines. This document describes how to review indicator data over time, use an EXCEL function to select an appropriate trend line, and determine the significance of a trend. In the fall, FHOP will begin to post EXCEL tables that contain updated information for the required indicators overall and for age and race/ethnic subgroups where possible and relevant, along with rates and confidence intervals. For the major summary indicators (e.g. infant mortality, LBW) trend graphs with confidence intervals will be produced. In addition, FHOP's EXCEL data templates can be used to analyze indicator data and produce graphics for those indicators not included in the FHOP tables, or for subgroups in the tables for which trend graphs were not produced. **NOTE** that counties with fewer than 10 cases over three years for any of the indicators should not use the templates for those indicators and will not be able to adequately assess trends. These counties can use raw numbers and case review or qualitative data to describe the situation in the county regarding these areas
      iii. Indicators that are significantly worse than the standard, or that have significant downward trends, should be included in the list of MCH problems from which the planning group selects the local priority problems. If available, data from other sources, such as locally conducted surveys, can also be considered in the quantitative analysis.
   b. Qualitative Analysis

i. Include a review of any qualitative data collected from individuals and organizations with an understanding of the health needs of the community and the barriers to obtaining better public health. Report the results of qualitative needs analysis methods and describe how these results confirm, conflict with, or enhance the results of the quantitative analysis.

D. Optional Topics (1-4 pages) Reference: Chapter II

1. Provide a list and discussion of additional MCH indicators or topics, such as those listed at the end of Appendix A, that you identify as local problem areas as a result of the local community planning group's process or other method (see Chapter II). Include a summary analysis for each identified area. Include identified issues in the list of MCH problems.

E. Assessment of MCH capacity (1-4 pages) Reference: FHOP Website

1. Provide a summary description of your local MCH program capacity. Determine the capacity of the local MCH program for carrying out the core MCH activities. These include the ability to:
   a. monitor local MCH population health status;
   b. diagnose and investigate MCH problems in the community;
   c. inform, educate and empower people about MCH issues;
   d. mobilize community partnerships to identify and solve MCH-related problems;
   e. develop policies and plans that support MCH related health efforts;
   f. link women and children to needed health and social services;
   g. evaluate the effectiveness, accessibility and quality of MCH population-based health services.
2. Assess the cultural competency of your MCH program.
3. Briefly describe current issues in the public and/or private health care sector that have an impact on the MCH program's roles.
4. We recommend using the tool provided on the FHOP website (available in September) to assist your assessment. If your local Public Health Department is implementing the "Mobilization for Action through Planning and Partnership (MAPP)" planning process you may wish to summarize the process/data specific to the MCH capacity assessment in this section.

F. Identification of the Problems/Unmet Needs of the Local MCH Population (1-3 pages) Reference: Chapter II

1. Synthesize the findings from sections A-E above.
   a. This should include assessment of major morbidity, mortality, health and other related risk factors, protective factors, gaps and disparities.
   b. Identify major problem areas within the MCH population as a whole and for significant sub-populations. Where possible, examine issues by race/ethnicity, age, health insurance status, type of health insurance, socioeconomic status and/or subcounty geographic area (zip code or census).
   c. Identify the unmet needs/problems of:
      i. pregnant women, mothers, and infants;
      ii. children, including adolescents.
   d. Present major findings in a bulleted or other summary format.

Page 175 of 224

Process: Generally, MCH staff will develop the community profile, the community resource assessment and the local MCH capacity assessment. We recommend that where possible you begin with previous MCH profiles or assessments or those recently done in the county for another purpose. Staff (this may be in conjunction with a workgroup of the planning group) should review the State's list of required MCH indicators and optional indicator/assessment areas. For each required indicator, review the jurisdiction's data as described above. The results of the analysis of the indicator data should be reviewed by the planning committee and included in the local assessment report. The planning group may identify additional MCH indicators relevant to local problems/needs or conduct assessments such as surveys to assist in assessing community health and health systems status. Both quantitative and qualitative data may be collected. Refer to Chapter II for a complete description of the process of identifying and selecting indicators and for tools that may assist you. The results of the analysis of the data compiled should be organized in a user friendly presentation to be reviewed by the planning group and a summary of significant findings and decisions based on these findings included in the assessment report as outlined above.

V. Priority MCH Problems/Needs in the Jurisdiction (1-2 pages) Reference: Chapter II and its Appendix II-I

This section should:

A. *Provide the final list of priority problems that will be addressed in the five year plan. Use clearly and plainly stated phrases, such as "The infant mortality rate for minorities should be reduced" or "Reduce the barriers to the delivery of care for pregnant women."*

B. *Briefly describe the process and rationale used to set priorities among the unmet needs/problems identified*

Process: Set priorities among identified health problems. Present the health problem and service delivery data to the local planning group and have the group select the problems/needs that MCH will address as priorities during the next five year cycle. Use an inclusive process to set 2 to 7 priorities among the identified problems, as appropriate to the size and resources of the jurisdiction. Take into account your MCH program's capacity to achieve selected priorities. To set priorities among the identified problems, use an objective, systematic method such as the suggested prioritization process and tool included in Chapter II, and Appendix II-I. These priorities will receive targeted efforts for improvement and will be addressed in the action plan, the second component of the MCH assessment and planning process (due June 30, 2005).

VI. Preliminary Problem Analysis for the Identified Local Priority Problems. (2-3 pages for each priority problem) Reference: Chapter III

This section should include:

A. A preliminary problem analysis for at least one identified priority problem. If time and resources permit, prepare a preliminary analysis for each of the priority problems. For each problem analysis done include the following:

1. A brief statement of the problem and a preliminary problem analysis diagram. The diagram should identify direct precursors (causal factors), secondary precursors (personal, family, institutional and social risk

factors) and tertiary factors (societal factors, systems issues, policies) that contribute to the observed poor outcome or condition as identified in the staff group or a planning group subcommittee designated to review the data

2. Provide a list of the additional data/information the group identified as needed to understand the contributors to the problem or to identify effective interventions (i.e., additional data about the population most affected by or at risk for the problem or research about potential intervention points in the causal pathways and interventions) If there is a data collection/research plan include it as an appendix to this section

B. If your group is able to compile the additional data and research and continue with the process during this assessment year, summarize the result of the problem analysis process. In this case, include the final problem analysis diagram showing the selected causal pathway or pathways and intervention points for which interventions will be developed. Include a summary explanation. If the group does not get this far along in the process, it will be included in your next year's report/plan.

Process: The planning group should be involved in developing a preliminary problem analysis for at least one of your priority problems. Refer to Chapter III to review the components of the facilitated problem analysis process. With your planning group, use the assessment data to draft the problem analysis diagram. Where data are not available, brainstorm other factors from the planning group member's experience or from review of research and best practices literature. Develop a plan to complete the data collection and to do a literature or web review of the problem, its precursors, and potential interventions. This will give you a head start on the planning activities you will have to complete in the next funding year.

VII. Appendices

Include appendices as indicated above and any other materials that you wish to be reviewed

Required Indicators

Indicator	Source
Birth	
1. Number of births & fertility rates	Birth file
2. Number and teen birth rate per 1,000 females	Birth file
a) age 12-14	
b) age 15-17	
c) age 18-19	
d) age 15-19	
3. Number & percent low birth weight (live births)	Birth file
4. Number & percent very low birth weight (live births)	Birth file
5. Number & percent preterm births (less than 37 weeks gestation)	Birth file
6. Number & percent of births occurring within 24 months of a previous birth	Birth file
a) entire population	
b) age 12-19	
7. Number & percent of teen births to women who were already mothers	Birth file
Death	
8. Perinatal death rate	Fetal Death & Death file
9. Neonatal deaths (#) and death rate (per 1,000 live births) *[birth - <28 days]*	Death file
10. Post-neonatal deaths (#) and death rate (per 1,000 live births) *[>=28 days - 1 year]*	Death file
11. Infant deaths (#) and death rate (per 1,000 live births) *[birth - 1 year]*	Death file
12. Deaths (#) and death rate per 100,000	Death file
a) age 1-14	
b) age 15-19	
Prenatal/postnatal care	
13. Number & percent prenatal care in first trimester (live births)	Birth file
14. Number & proportion of women (age 15-44) with adequate prenatal care (Kotelchuck index)	Birth file
15. Percent of women exclusively breastfeeding at the time of hospital discharge	Genetic Disease

Health	
16. Percent of children and adolescents without health insurance (age 0-18)	CHIS
17. Percent of children without dental insurance (age 2-11)	CHIS
18. Percent of children who have been to the dentist in the past year (age 2-11)	CHIS
19. Percent of children and adolescents youths who are overweight	CHDP
a) age 5-11	
b) age 12-19	
20. Rate of children hospitalized for asthma per 10,000 children	OSHPD
a) age < 4	
b) age 5-18	
21. Rate per 1,000 women aged 15-19 with a reported case of chlamydia	STD Branch
22. Rate of children hospitalized for mental health reason per 10,000 children	OSHPD
a) age 5-14	
b) age 15-19	
Injuries	
23. Number and rate of hospitalizations for all non-fatal injuries, by age group	OSHPD
a) age <=14	
b) age 15-24	
24. Rate of non-fatal injuries due to motor vehicle accidents	OSHPD
a) age <= 14	
b) age 15-24	
Other	
25. Number of children living in foster care	DSS
26. Percent of children in poverty (age 0-19)	Census 2000 DOF
27. Percent of women 18 years or older reporting intimate partner physical abuse in the last 12 months	California Women's Health Survey

Optional Topics

MCH jurisdictions may want to consider including a discussion of other maternal and child health topics in your needs assessment reports. Examples of optional topics are shown below. FHOP is investigating data availability for some of these optional topics; if and when these data become available, jurisdictions will be notified. If your jurisdiction has done research or surveillance on these or other topics that are locally important, a discussion of the findings would be very helpful to the State in its Statewide assessment.

1. Percent of children/adolescents who report at least 20 minutes of physical activity 3 or more days per week.
   Note: The California Department of Health Services Physical Activity Guidelines for Children, Youth and Adults recommends that "Elementary school children should accumulate at least 30-60 minutes of age and developmentally appropriate physical activity on all or most days of the week," and "Adolescents should engage in at least 60 minutes of moderate to vigorous physical activity per day on most days of the week. Thirty minutes of physical activity per day should be viewed as a minimum. One hour per day represents a more favorable level."
2. Number & percent of children 19 to 35 months of age who have received full schedule of age appropriate immunizations.
3. Incidences of vaccine-preventable diseases.
4. Indicators of mental health problems, e.g., suicide, depression, etc.
5. Rates/issues regarding perinatal substance abuse.
6. Rates/issues regarding gestational diabetes.
7. Issues regarding oral health, such as rates of sealant application in children, access to dental care, rate of children who have seen a dentist prior to starting school, etc.
8. Indicators of youth resiliancy, such as a close relationship with a caring adult, high expectations, and opportunities for meaningful participation.
9. Others?

Data Source Glossary
CHIS: California Health Interview Survey
OSHPD: Office of Statewide Planning and Development
DSS: Department of Social Services
DOF: Department of Finance

Tool Used Title V Agency Internal Capacity Assessment

10 MCH Essential Services and Public MCH Program Functions (Detailed List)

1. Assess and monitor maternal and child health status to identify and address problems.
   A. Develop frameworks, methodologies, and tools for standardized MCH data in public and private sectors.
   B. Implement population-specific accountability for MCH components of data systems.
   C. Prepare and report on the descriptive epidemiology of MCH through trend analysis.
2. Diagnose and investigate health problems and hazards affecting women, children, and youth.
   A. Conduct population surveys and publish reports on risk conditions and behaviors.
   B. Identify environmental hazards and prepare reports on risk conditions and behaviors.
   C. Provide leadership in maternal, fetal/infant, and child fatality reviews.
3. Inform and educate the public and families about maternal and child health issues.
   A. Provide MCH expertise and resources for informational activities such as hotlines, print materials, and media campaigns, to address MCH problems such as teen suicide, inadequate prenatal care, accidental poisoning, child abuse and domestic violence, HIV/AIDS, DUI, helmet use, etc.
   B. Provide MCH expertise and resources to support development of culturally appropriate health education materials/programs for use by health plans/networks, MCOs, local public health and community-based providers.
   C. Implement, and/or support, health plan/provider network health education services to address special MCH problems—such as injury/violence, vaccine-preventable illness, underutilization of primary/ preventive care, child abuse, domestic violence—delivered in community settings (e.g., schools, child care sites, worksites).
   D. Provide families, the general public, and benefit coordinators reports on health plan, provider network, and public health provider process and outcome data related to MCH populations based on independent assessments.
4. Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.
   A. Provide needs assessment and other information on MCH status and needs to policymakers, all health delivery systems, and the general public.
   B. Support/promote public advocacy for policies, legislation, and resources to assure universal access to age-, culture- and condition-appropriate health services.
5. Provide leadership for priority-setting, planning, and policy development to support community efforts to assure the health of women, children, youth and their families.
   A. Develop and promote the MCH agenda using the Year 2000 National Health objectives or other benchmarks.
   B. Provide infrastructure, communication structures and vehicles for collaborative partnerships in development of MCH needs assessments, policies, services, and programs.

Page 181 of 224

C. Provide MCH expertise to, and participate in the planning and service development efforts of, other private and public groups and create incentives to promote compatible, integrated service system initiatives.

6. Promote and enforce legal requirements that protect the health and safety of women, children and youth, and ensure public accountability for their well-being.
   A. Ensure coordinated legislative mandates, regulation, and policies across family and child-serving programs.
   B. Provide MCH expertise in the development of a legislative and regulatory base for universal coverage, medical care (benefits), and insurer/health plan and public health standards.
   C. Ensure legislative base for MCH-related governance, MCH practice and facility standards, uniform MCH data collection and analysis systems, public health reporting, environmental protections, outcomes and access monitoring, quality assurance/improvement, and professional education and provider recruitment.
   D. Provide MCH expertise/leadership in the development, promulgation, regular review and updating of standards, guidelines, regulations, and public program contract specifications.
   E. Participate in certification, monitoring and quality improvement efforts of health plans and public providers with respect to MCH standards and regulations.
   F. Provide MCH expertise in professional licensure and certification processes.
   G. Monitor MCO marketing and enrollment practices.
   H. Provide MCH expertise and resources to support ombudsman services.

7. Link women, children and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.
   A. Provide a range of universally available outreach interventions (including home visiting), with targeted efforts for hard-to-reach MCH populations.
   B. Provide for culturally and linguistically appropriate staff, materials, and communications for MCH populations/issues, and for scheduling, transportation, and other access-enabling services.
   C. Develop and disseminate information/materials on health services availability and financing resources.
   D. Monitor health plan, facility, and public provider enrollment practices with respect to simplified forms, orientation of new enrollees, enrollment screening for chronic conditions/special needs, etc.
   E. Assist health plans/provider networks and other child/family-serving systems (e.g., education, social services) in identifying at-risk or hard-to-reach individuals and in using effective methods to serve them.
   F. Provide/arrange/administer women's health, child health, adolescent health, Children with Special Health Care Needs (CSHCN) specialty services not otherwise available through health plans.
   G. Implement universal screening programs—such as for genetic disorders/metabolic deficiencies in newborns, sickle cell anemia, sensory impairments, breast and cervical cancer—and provide follow-up services.
   H. Direct and coordinate health services programming for women, children and adolescents in detention settings, mental health facilities and foster care, and for families participating in welfare waiver programs that intersect with health services.
   I. Provide MCH expertise for prior authorization for out-of-plan specialty services for special populations (e.g., CSHCN).

Page 182 of 224

J. Administer/implement review processes for pediatric admissions to long-term care facilities and CSHCN home- and community-based services.

K. Develop model contracts to provide managed care enrollees access to specialized women's health services, pediatric centers of excellence and office/clinic-based pediatric subspecialists and to community-site health services, (school-based health clinics, WIC, Head Start, etc).

L. Provide expertise in the development of pediatric risk adjustment methodology and payment mechanisms.

M. Identify alternative/additional resources to expand the fiscal capacity of the health and social services systems by providing MCH expertise to insurance commissions and public health care financing agencies, pooling categorical grant funding, and pursuing private sector resources.

8. Assure the capacity and competency of the public health and personal health workforce to effectively and efficiently address maternal and child health needs.

   A. Provide infrastructure and technical capacity and public health leadership skills to perform MCH systems access, integration, and assurance functions.

   B. Establish competencies, and provide resources for training MCH professionals, especially for public MCH program personnel, school health nurses and school-based health center providers, care coordinators/case managers, home visitors, home health aides, respite workers, and community outreach workers.

   C. Provide expertise, consultation, and resources to professional organizations in support of continuing education for health professionals, and especially regarding emerging MCH problems and interventions.

   D. Support health plans/networks in assuring appropriate access and care through providing review and update of benefit packages, information on public health areas of concern, standards, and interventions, plan/provider participation in public planning processes and population-based interventions, technical assistance, and financial incentives for meeting MCH-specific outcome objectives.

   E. Analyze labor force information with respect to health professionals specific to the care of women and children (e.g. primary care practitioners, pediatric specialists, nutritionists, dentists, social workers, CNMs, PNPs, FFNPs, CHNs/PHNs)

   F. Provide consultation/assistance in administration of laboratory capacity related to newborn screening, identification of rare genetic diseases, breast and cervical cancer, STDs, and blood lead levels.

9. Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal and child health services.

   A. Conduct comparative analyses of health care delivery systems to determine effectiveness of interventions and to formulate responsive policies, standards, and programs.

   B. Survey and develop profiles of knowledge, attitudes and practices of private and public MCH providers.

   C. Identify and report on access barriers in communities related to transportation, language, culture, education, and information available to the public.

   D. Collect and analyze information on community/constituents' perceptions of health problems and needs.

10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related problems.

Page 183 of 224

A. Conduct special studies (e.g., PATCH) to improve understanding of longstanding and emerging (e.g., violence, AIDS) health problems for MCH populations.

B. Provide MCH expertise and resources to promote "best practice" models, and to support demonstrations and research on integrated services for women, children, adolescents, and families.

California Maternal, Child and Adolescent Health (MCAH) Division: Criteria, Definitions, and Rating Scales for Prioritizing Among Identified MCH Issues

Maternal, Child and Adolescent Health Needs Assessment Stakeholder Meeting

Multipurpose Room, 1st Floor,
Secretary of State Building
1500 11th Street (Corner of 11th and O Streets), Sacramento

Wednesday, April 6, 2005

Agenda

8:15—8:30	**Coffee and Refreshments**	
8:30—8:45	**Overview of the day & Introduction**	**Gerry Oliva,** ***Family Health Outcomes Project (FHOP)***
8:45—9:00	**Welcome & Background**	**Catherine Camacho,** ***Deputy Director, Primary Care and Family Health Division***
9:00—9:45	**Overview of the Title V Needs Assessment process**	**Shabbir Ahmad,** ***Maternal, Child and Adolescent Health/Office of Family Planning (MCAH/OFP)***
	Description of MCAH Jurisdiction involvement in the Title V Needs Assessment Process	**Mike Curtis,** ***MCAH/OFP***
9:45—10:00	**Description of the methods to be used for selecting and applying criteria**	***FHOP***
10:00—12:30	**Criteria for selection of recommended 7 priority needs**	***Stakeholders/FHOP***
12:30	**Working lunch served**	
12:30—2:15	**Data on the potential MCAH priority needs**	***FHOP***
2:15—4:45	**Application of criteria to the potential needs**	***Stakeholders/FHOP***
4:45—5:00	**Wrap-up**	***MCAH/OFP Staff***

Page 187 of 224

MCAH Criteria (April 6, 2005)

1. **Criterion Name: Problem has serious health consequences**
   Weight:
   Definition/Concepts: This means that the problem identified could result in severe disability or death.
   Rating Scale: 3
   1= Problem is not life threatening or disabling to individuals or community
   2= Problem is not life threatening but is sometimes disabling
   3= Problem can be moderately life threatening or disabling
   4= Problem can be moderately life threatening but there is a strong likelihood of disability
   5= Problem has a high likelihood of death and disability

2. **Criterion Name: A large number of Individuals are affected by the problem**
   Weight: 2
   Definition/Concepts: This criterion considers the absolute number of people (the MCAH population) affected. It includes the concept that targeting a problem affecting a large number of individuals could have a greater impact on the health of the community than one affecting a relatively small number of people. This criterion is intended to provide a balance for a situation in which a few occurrences of a particular problem in a small group can result in a high rate but in reality the condition may only affect a few individuals in the community, e.g., a geographic area with a very small population and few births that has one teenage pregnancy will result in a high teen pregnancy rate for that geographic area.
   Rating Scale:
   1= Relatively few individuals affected
   2= Moderate number of individuals affected in particular subgroups
   3= Moderate number of individuals affected across the entire population
   4= Large number of individuals affected in particular subgroups
   5= Large number of individuals affected across the entire population

Page 188 of 224

3. **Criterion Name: Disproportionate effects among subgroups of the population**
   Weight: 2
   Definition/Concepts: This means that one or more population subgroups as defined by race, ethnicity, income, insurance status, gender or geography have *statistically* significantly worse indicator values of illness or condition when compared to another group
   1= No group is disproportionately affected by the problem
   2= It appears that one or more groups is disproportionately affected by the problem, but differences are not statistically significant
   3= Statistically significant differences exist in one group and the disadvantaged group is at least 1.25 to 1.75 times more likely to have a poor outcome
   4= Statistically significant differences exist in more than one group
   5= Statistically significant differences exist in one or more groups and at least one of the disadvantaged groups is greater than 1.75 times more likely to have a poor outcome

4. **Criterion Name: Problem results in significant economic/ social cost**
   Weight: 1
   Definition/Concepts: If problem is not addressed the result will be increased monetary costs, e.g., health care and/or social services costs to society and costs to employers, and or loss of productive individuals because of chronic illness, disability or premature death.
   Rating Scale:
   1= Economic/ societal cost is minimal
   2= There is some potential increased costs
   3= There is likely to be moderate increased costs
   4= There is likely to be substantial increased costs
   5= There will be great economic and societal cost

5. **Criterion Name: Problem is cross-cutting to multiple issues/ life span effect**
   Weight: 3
   Definition/Concepts: Problem at one life stage has long term impact in later life and/or problem is a proxy for a set of other related behavioral or social problems.
   Rating Scale:
   1= Problem limited to one life stage and is not associated with other problems
   2= Problem minimally impacts entire life course and is associated with multiple problems
   3= Problem moderately impacts entire life course and is associated with multiple problems
   4= Problem severely affects either entire life course or is associated with multiple problems
   5= Problem severely impacts entire life course and is associated with multiple problems

MCAH Priority Rating Tool

CRITERION #1 PROBLEM / ISSUE HAS SEVERE HEALTH CONSEQUENCES	CRITERION #5: PROBLEM IS CROSS-CUTTING TO MULTIPLE ISSUES/ LIFE SPAN EFFECT
CRITERION #2: LARGE # OF INDIVIDUALS ARE AFFECTED BY THE PROBLEM	
CRITERION #3: DISPROPORTIONATE EFFECTS AMONG SUBGROUPS OF THE POPULATION	
CRITERION #4: PROBLEM RESULTS IN SIGNIFICANT ECONOMIC/ SOCIAL COST	

Problem/Issue	In the line below each criterion number (e.g. C1), the assigned weight is Then, For each problem, score each criterion (1 through 5) and multiply the score by the assigned weight. Add weighted criterion scores to obtain Total Score for Problem.								Total Score For Problem
	C1	C2	C3	C4	C5	C6			
	3	2	2	1	3				
1. Overweight									
2. Substance Abuse									
3. Domestic Violence									
4. Prenatal Care									
5. Access to Care									
6. Birth Outcomes/Mortality									
7. Teen Births									
8. Breastfeeding									

Page 190 of 224

CALIFORNIA

CRITERION #1 PROBLEM / ISSUE HAS SEVERE HEALTH CONSEQUENCES	CRITERION #5: PROBLEM IS CROSS-CUTTING TO MULTIPLE ISSUES/ LIFE SPAN EFFECT
CRITERION #2: LARGE # OF INDIVIDUALS ARE AFFECTED BY THE PROBLEM	
CRITERION #3: DISPROPORTIONATE EFFECTS AMONG SUBGROUPS OF THE POPULATION	
CRITERION #4: PROBLEM RESULTS IN SIGNIFICANT ECONOMIC/ SOCIAL COST	

Problem/Issue	In the line below each criterion number (e.g. C1), the assigned weight is Then, For each problem, score each criterion (1 through 5) and multiply the score by the assigned weight. Add weighted criterion scores to obtain Total Score for Problem.							Total Score For Problem
	C1	C2	C3	C4	C5	C6		
	3	2	2	1	3			
9. Oral Health								
10. Injuries								
11. Asthma								
12. Mental Health								
13. Chlamydia Infections								
14.								
15.								
16.								
17.								
18.								

Page 191 of 224

Framework for Identifying and Prioritizing the Title V Health and Health Systems Access and Capacity Needs of CCS Eligible Children and their Families

Background:

Title V of the Social Security Act is a federal-state partnership that provides for programs to improve the health of all mothers and children, including children with special health care needs. California currently receives approximately $48 million in federal Title V funds that are jointly administered by Maternal and Child Health (MCH) Branch and the California Medical Services (CMS) Branch. Three population groups are served through Title V: pregnant women and infants less than 1 year of age; children ages 1 to 21 years; and children with special health care needs (CHSCN). The California Children's Services (CCS) program, California's CSHCN program, provides case management and payment of services for program-eligible CSHCN and promotes family-centered, community-based, coordinated care for these children.

CMS has established its CCS Needs Assessment Stakeholders Group, and contracted with Family Health Outcomes Project (FHOP) to assist in identifying needs related to CCS eligible children and their families and facilitating the process of problem identification and prioritization of those problems/needs. The process being used is an inclusive and systematic process of data presentation and analysis, identification of problems and setting priorities. This process has been used successfully for work with large planning groups with a diverse membership.[2]

Purposes of the Problem Identification and Prioritization Process

- Promote rational allocation of resources
- Create a systematic, fair and inclusive process
- Focus decision-making if there are many problems/issues identified
- Challenge participants to objectively and critically review data
- Document the process and results

The outcome of this process will be a 5 year needs assessment report and the selection of statewide performance measures to evaluate the results of our interventions. The report will be submitted in July 2005, as part of California's 2005-06 Title V Maternal and Child Health Block Grant application. CCS is committed to addressing the selected priorities, within our budgetary and legislative constraints.

Description of the Problem Identification and Prioritization Process

There will be two meetings of the CCS Needs Assessment Stakeholders Group for the purpose of setting priorities among identified needs. The first meeting is on January 27, 2005 and the second is planned for April or early May, 2005. In addition to the two meetings, the group members will review documents and participate in telephone or e-mail communications in the

[2] The process is adapted from a method included in the University of North Carolina, Program Planning and Monitoring Self-Instructional Manual, "Assessment of Health Status Problems" and described in the University of California at San Francisco Family Health Outcome Project (FHOP) "Developing an Effective MCH Planning Process: A Guide for Local MCH Programs".

Page 192 of 224

time period between the two large group meetings to review data, and provide input to assist in identifying significant problems. After reviewing and analyzing data on selected indicators, identified problems/issue will be submitted to the group for consideration in the overall prioritization process. During the April 2005 meeting, the full group will review the list of identified problems, review data about these problems/issues, agree on a final problem list, and receive orientation to and use a method of rating and ranking the identified problems. The results will be presented, discussed and confirmed by the group. The table below shows the steps of the process.

	Steps in the CCS Needs Assessment Stakeholder Group Process for Prioritizing Problems/Needs
I.	Meeting January 27, 2005
	Introductions/Share information
	CMS / FHOP present overall objectives of the Needs Assessment, scope, background and the recommended process for prioritization
	FHOP facilitates process of selecting up to 7 criteria that will be used by the Group members to assist in the ranking/prioritization of problems - Develop criteria - Develop criteria rating scales - Determine weights for each criterion (how important each criterion is relative to the other criterion)
	FHOP reviews criteria for selecting indicators with the group, receives input, and orients group to how data will be presented for their review.
	FHOP asks participants (key informants) to divide into groups. Groups will discuss how the core outcomes and issues identified through FHOP's indicator research, brief interviews with Stakeholders and e-mail survey can be assessed (e.g., suggests possible indicators, instruments, data sources). Their input is recorded and shared with the larger group, and this will be incorporated into the identification of the final list of indicators.
II.	Work is done by the Group in the months between meetings (can be accomplished by e-mail, phone or smaller group meetings):
	Review and input by Group Members of data collected and analyzed by FHOP/CMS Review and input by Group members of problem/issue list developed based on data
III	Meeting in April or early May, 2005:
	Group members agree on the final problem/issue list to be prioritized
	The Group sets priorities among the final problem list. These priorities will be the focus of the Title V, 5 Year Action Plan. • Group Participants use the agreed upon weighted criteria to score problems • Sum participants' scores / rank problems • Discuss and confirm results

CCS Stakeholder Criteria, Definitions and Rating Scales
for prioritizing among identified CSHCN issues/objectives
(April 28, 2005)

1. **Criterion Name: Problem has great impact on families (quality of life, functionality)**
   Weight: 3
   Definition/Concepts: This means that the child and the family's quality of life and functionality are affected by the problem. Examples are a parent cannot work; a child cannot go to school.
   Rating Scale: 3
   1= Problem is not affecting the quality of life or functionality of the family
   2= Problem is minimally or occasionally affecting the quality of life or functionality of the family
   3= Problem is moderately and/or frequently affecting the quality of life or functionality of the family
   4= Problem is negatively impacting the family's quality of life and functionality most of the time.
   5= Problem is severely negatively impacting the family's quality of life and functionality most or all of the time

2. **Criterion Name: Addressing the problem is important to consumers**
   Weight: 3
   Definition/Concepts: Addressing the problem is important to the recipients or potential recipients of services: child, siblings, parents, extended family
   Rating Scale:
   1= Addressing the problem is not important to consumers
   2= Addressing the problem is of some importance to consumers
   3= Addressing the problem is of moderate Importance to consumers
   4= Addressing the problem is important to consumers
   5= Addressing the problem is a very high priority for consumers

3. **Criterion Name: Problem results in great cost to program and/or society, there is a significant fiscal impact of not addressing it**
   Weight: 2
   Definition/Concepts: If problem is not addressed the result will be increased monetary costs, e.g., health care and/or social services costs to the CCS program or to society and loss of education and productivity of individuals because of chronic illness, disability or premature death.
   Rating Scale:
   1= Economic / societal cost is minimal
   2= There is some potential increased costs
   3= There is likely to be moderate increased costs
   4= There is likely to be substantial increased costs
   5= There will be great economic and societal cost

4. **Criterion Name: Addressing the problem maximizes opportunity to leverage resources and relationships for effective system change.**
   Weight: 2
   Definition/Concepts: There is opportunity for Agencies or Collaborative Partners to plan together or pool resources to address the problem and/or there is opportunity to build new relationships. Allows us to take advantage of opportunities to leverage resources and relationships to affect systems change
   Rating Scale:

Page 209 of 224

1= No known opportunity to collaborate
2= There may be opportunities to collaborate
3= There are opportunities to collaborate
4= There are opportunities to collaborate and some collaboration is already occurring
5= Major collaborative efforts are already underway

5. **Criterion Name: Addressing the problem would increase equity and fairness**
Weight: 2
Definition/Concepts: Definition/Concepts: This means that one or more population subgroups as defined by race/ethnicity, income, insurance status, gender or geography, diagnosis are more impacted than the general group. Addressing the problem or issues would promote equity and reduce disparities.
Rating Scale:
1= No group is disproportionately affected by the problem
2= It appears that one or more groups is disproportionately affected by the problem, but differences are not statistically significant
3= Statistically significant differences exist in one group
4= Statistically significant differences exist in more than one group
5= Very large statistically significant differences exist in one or more groups

6. **Criterion Name: There is likelihood of success. Problem is amenable to prevention or intervention, and/or there is political will to address it**
Weight: 1
Definition/Concepts: This means that there is a good chance that the strategies used to intervene in the identified problem will result in an improvement in outcomes. The intervention strategies are shown in research literature, by experts or by National, State or program experience to be effective or promising. The group also indicated this criterion would incorporate political will, e.g., the problem is a national or regional priority
1= No known intervention available
2= Promising intervention with limited impact (not effecting a wider array of problems), little political will
3= Proven intervention with limited impact, moderate political will
4= Promising or proven intervention with broad impact and moderate political will
5= Proven intervention with broad impact and strong political will

CONNECTICUT

Connecticut Title V Program

Matrix of Criteria for scoring Priorities for Maternal and Child Health in the State*

Sample Issues	Severe consequences	Extent of the problem (High incidence/ prevalence)	Trends	Consistent with Maternal and Child Health Bureau (MCHB) Objectives	Consistent with State Health Department Priorities	Acceptability to citizens	Total Score
Low birthweight							
Infant mortality							
Vision impairments							
Hearing impairments							
HIV							
Childhood communicable diseases							
Adolescent pregnancy							
Adolescent smoking							
Injuries - Intentional - Unintentional							

**Definitions for scoring on each of the six criteria*

Severity of consequence:

1 = not life threatening or debilitating to individuals or society
2 = slightly debilitating to individuals or society
3 = moderately debilitating to individuals or society
4 = life threatening or debilitating to individuals or society
5 = life threatening and debilitating to individuals or society

Extent of the problem:

1 = low incidence or prevalence
2 = moderate incidence or prevalence in some subgroups
3 = moderate incidence or prevalence in all groups
4 = high incidence or prevalence in some subgroups
5 = high incidence or prevalence in all subgroups

Trends:

1 = rapid decrease in past five years
2 = moderate/slow decrease in past five years
3 = no change in past five years
4 = moderate/slow increase in past five years
5 = rapid increase in past five years

MCHB Objective:

1 = not tracked by MCHB
2 = subset of an objective for the nation, tracked by MCHB
3 = main focus of objective for the Nation, tracked by MCHB

State priority:

1 = not consistent with state health priorities
2 = moderately consistent with state health priorities
3 = addresses one or more state health priorities

Acceptability to citizens:

1 = not perceived at a health problem; any effort to address it would be opposed
2 = not perceived at a health problem; efforts to address it would not be opposed
3 = recognized as a health problem; any effort to address it would be opposed
4 = recognized as a health problem; efforts to address it would not be opposed
5 = recognized as a health problem; efforts to address it would be welcome

State of Connecticut
Maternal and Child Health Needs Assessment

KEY INFORMANT INTERVIEW GUIDE

Date of Interview:

Purpose: To elicit data, information, opinions, and perspectives from key stakeholders and those who are well informed about 1) the needs of Connecticut's maternal and child health (MCH) populations, 2) the existing MCH service system/resources that exists in the state, and/or 3) the existing political context and other environmental factors that will affect the implementation of policy and programmatic changes. Information will be collected through in-person and telephone interviews, using a structured interview guide but open discussion will be encouraged. Interviews will take approximately 30 minutes. Issues to be addressed include: the priority needs of MCH populations in the state, identification of programs or aspects of the service system that work well and those that need improvement, identification of existing gaps in services and the most significant barriers that inhibit access to services, and identification of emerging or "hidden" populations that have high needs.

Introduction: I am calling on behalf of the State of Connecticut Maternal and Child Health Program. The Maternal and Child Health Program is conducting a comprehensive assessment to identify priorities for improving maternal and child health statewide. We are calling to ask you your opinions about what you believe is working and not working and solicit your input about how to improve maternal and child health.

Name of Interviewee:

Organization:

Individual's background and responsibilities with respect to MCH including professional affiliation (brief description/ open ended):

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1. The maternal and child health program is particularly concerned about specific target populations. For each of the following populations for which you have experience, what do you think are the major or emerging health concerns?

Population	Major Health Concerns
Women	
Pregnant women	
Children (2-12 years)	
Adolescents (13-19 years)	
Children with Special Health Care Needs	

2. Of these MCH populations, which do you believe are most at-risk and why? (women, pregnant women, children, adolescents and CSHCN)

3. For each of these populations for which you have experience, what are the most critical unmet needs or service gaps?

Population	Unmet Needs
Women	
Pregnant women	
Children (2-12 years)	
Adolescents (13-19 years)	
Children with Special Health Care Needs	

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4. Are there specific programs or aspects of the service system that stand out as working particularly well? Do you know of best practices that should be replicated or more fully supported?

5. Are there emerging or “hidden populations” in the state or in a specific region of the state upon which the system needs to focus or that needs additional support?

   If so, what types of services/supports are needed?

6. What recommendations do you have for strengthening/improving maternal and child health in the state? (For example, are there specific types of programs or aspects of the service system that you think are not working well, need to be reformed/ restructured, or need additional support?)

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Louisiana Child Health Needs Assessment Workbook

Table of Contents

Introduction…………………………………………………………………………3

OPH Regional Map ……………………………………………………………………4

Data ……………………………………………………………………………………5
Population Characteristics ……………………………………………………
Health Status …………………………………………………………………
Data Sources ……………………………………………………………………15

Child Mortality Deaths …………………………………………………………………7
Child Mortality Worksheet …………………………………………………………29

Identified Needs of Children and Adolescents in Louisiana …………………30
Child and Adolescent Health Identified Needs Worksheet ………………32
Maternal and Child Health Bureau (MCHB) Identified Needs Prioritization Method ……………………………………………………………………34
Scoring Method ……………………………………………………………………36
Possible Solutions to an Identified Child Health Need ………………………37
Possible Solutions to an Identified Adolescent Health Need ………………40
Finalized Needs Worksheet ………………………………………………………43

Appendix ……………………………………………………………………………… 46
Parish Poverty Level by OPH Region ……………………………………………46
Child Mortality Deaths – United States – 2002 ………………………………48

2

LOUISIANA

Maternal and Child Health Bureau (MCHB) Identified Needs Prioritization Method

This method of setting priority needs incorporates a framework that considers various criteria (the extent of the health problem, the severity of consequences, resource availability and acceptability). The Prioritization Method is used as a way of organizing a discussion to achieve consensus among different people and groups for ultimately setting priority child and adolescent health needs within the region.

Instructions:

1. Using the list of needs facing your region identified on the "Child and Adolescent Health Identified Needs Worksheet," enter these Needs into the column labeled "Child and Adolescent Needs/Problems Facing Region."

2. Fill out table using the scoring method provided.

3. Once the extent of the health problem, the severity of consequences, resource availability, and acceptability have been scored for each Child and Adolescent Need/Problem, calculate a total score for each Child and Adolescent Need/Problem.

4. Record the three highest scoring Child and Adolescent Needs/Problems (These are your Top 3 Child and Adolescent Needs).

5. Before making final decisions about the priority needs, the process and the results should be reviewed and agreed upon by all participants.

Example:

Scoring Method

Extent
1 = low incidence or prevalence
2 = moderate incidence or prevalence in some subgroups
3 = moderate incidence or prevalence in all groups
4 = high incidence or prevalence in some subgroups
5 = high incidence or prevalence in all subgroups

Severity of Consequences
1 = not life threatening
2 = slightly debilitating to individuals or society
3 = moderately debilitating to individuals or society
4 = life threatening or debilitating to individuals or society
5 = life threatening and debilitating to individuals and society

Acceptability
1 = not perceived as a health problem; any effort to address it would be opposed
2 = not perceived as a health problem; efforts to address it would not be opposed
3 = recognized as a health problem; any effort to address it would be opposed
4 = recognized as a health problem; efforts to address it would not be opposed
5 = recognized as a health problem; efforts to address it would be welcomed

Resources Available
1 = no resources available
2 = resources moderately available
3 = resources highly available

Child and Adolescent Issues/Problems Facing Region	Extent (High incidence/ prevalence)	Severe Consequences	Acceptability to citizens	Sub-Total	Resources Available	Total
Injuries	4	4	5	13	3	**16**
Without Healthcare Coverage	4	5	5	14	3	**18**
Obesity	2	3	4	9	1	**10**
Percent of Elevated Lead Blood Levels	4	4	4	12	2	**14**

34

Scoring Method

Extent
1 = low incidence or prevalence
2 = moderate incidence or prevalence in some subgroups
3 = moderate incidence or prevalence in all groups
4 = high incidence or prevalence in some subgroups
5 = high incidence or prevalence in all subgroups

Severity of Consequences
1 = not life threatening
2 = slightly debilitating to individuals or society
3 = moderately debilitating to individuals or society
4 = life threatening or debilitating to individuals or society
5 = life threatening and debilitating to individuals and society

Acceptability
1 = not perceived as a health problem; any effort to address it would be opposed
2 = not perceived as a health problem; efforts to address it would not be opposed
3 = recognized as a health problem; any effort to address it would be opposed
4 = recognized as a health problem; efforts to address it would not be opposed
5 = recognized as a health problem; efforts to address it would be welcomed

Resources Available
1 = no resources available
2 = resources moderately available
3 = resources highly available

Child and Adolescent Issues/Problems Facing Region	Extent (High incidence/ prevalence)	Severe Consequences	Acceptability to Citizens	Sub-Total	Resources Available	Total

35

Possible Solutions to an Identified Child Health Need

Child (Age 1-14) Health Need: ____________________________

Instructions: Identify specific activities and then rate its overall efficacy by scoring (low =1, medium=3, high=5) on effectiveness and whether resources are available. Then, from the scores, indicate the top three activities. Then, consider whether you would move this priority up or down on your list, given the level of the activities available to you to address the problem.

Activities/Strategies	**Short/Long Term**	**Effective**	**Resources**	**Total**
	☐ Short ☐ Long			
	☐ Short ☐ Long			
	☐ Short ☐ Long			
	☐ Short ☐ Long			
	☐ Short ☐ Long			
	☐ Short ☐ Long			

- Do you have a realistic choice of solutions for this need? **Yes / No**
- If you answered "no", what priority is this need now that you've considered solutions? (Higher, lower) ______________
- Do you need to reconsider this need being one of the top 3 needs? ______________

36

Finalized Needs Worksheet
Child and Adolescent Health Needs Assessment

Region: ___________________________________

Name: ____________________________________

Organization: ______________________________

Phone #: __________________________________

1. State your established vision/goals for the Child and Adolescent population in your region.

2. List the identified Child and Adolescent health needs based on the current existing health status data.

42

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3. For Resources and Services in the Region please "√" all that apply.

Resources/Services		Present within State	In State - Available to All	In State - Available to Limited* Populations	*Limited How?	Don't Know
Injury Prevention Education	Children					
	Adolescents					
Mental Health Services	Children					
	Adolescents					
Substance Use Assessment	Adolescents					
Substance Use Treatment/Intervention	Adolescents					
Early Head Start						
Early Steps						
Information on Health Care Coverage						
Training for Child Care Centers-Health and Safety						
Nutrition Education/ Counseling						
Immunization Services						
Parent Education Programs						
Emergency Medical Services for Children						
Lead Poisoning Assessment and Education						
Research and Referral Centers for Child Care						
Dental Sealant Programs						
Suicide Prevention Programs						
HIV Counseling & Testing						
School-based Health Centers						
Family Support Services						

*For example, limited by geographic location or financial criteria.

43

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4. List the Top 3 Child and Adolescent Health Needs that were identified by using the ranking method.

5. Propose short term (1 year) and long-term (5 year) activities that you have confirmed to be effective and that have resources available for addressing your Top 3 priority Child and Adolescent Health Needs.

44

6. In order for your needs assessment data to become a successful evaluation of the current health needs, outside input is required. Please list all of the outside input used (sources/partners/individuals/organizations).

When this workbook is completed, please return to the entire workbook to Tracy Hubbard, Office of Public Health, Maternal & Child Health, 325 Loyola Avenue, Room 612, New Orleans, LA 70112. (504) 568-5073 Phone 504-568-8162 Fax e-mail: thubbard@dhh.la.gov

45

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Child Health Needs Assessment
Healthcare Provider Survey

The Title V Maternal and Child Health (MCH) Block Grant is a federal government grant which provides approximately $15 million to fund MCH services throughout Louisiana through the Office of Public Health's (OPH) MCH Program.

Every five years, State Title V agencies are required to conduct a comprehensive needs assessment to:

- identify state MCH priority needs
- arrange programmatic and policy activities around these priorities needs
- develop measures to monitor the success of their efforts.

The OPH Child Health Program would like input from healthcare professionals on what are the needs of Louisiana's children that we can address through the State MCH Program during the next five years.

Priority needs for the Child Health Program that have been addressed in previous years include: 1) decreasing infant deaths due to SIDS, 2) decreasing unintentional injuries in children, and 3) decreasing child abuse and neglect. Based on these needs, program activities have been developed including a statewide SIDS Risk Reduction Public Awareness campaign, intensive nurse home visiting programs to low income first time mothers, training in infant mental health for public health staff, development of an assessment tool for early identification of families in need of additional support, and establishment of Regional Injury Prevention Coordinators.

The child health needs assessment will focus on ages 1 to 21 years, with overlap in the adolescent age group and the Children with Special Health Care Needs group. In separate processes, the needs of children under one year of age are being addressed through a Perinatal Needs Assessment and the needs of adolescents, ages 10-24 years, are being addressed through an Adolescent Needs Assessment. Your additional input for adolescents will be shared with the adolescent group.

We are asking your assistance in working with us in this process by taking this healthcare professional survey.

Click here to take survey

NEW HAMPSHIRE

New Hampshire CSHCN Program Initial Stakeholder Questionnaire

DEFINITION of Children with Special Health Care Needs

The federal Maternal and Child Health Bureau defines children with special health care needs (CSHCN) as those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.[27]

DIRECTIONS

SURVEY QUESTIONS

1. If programs could be developed to address some of the issues affecting CSHCN and their families, what do you think the **degree of impact** would be, for each issue?
2. What might be the **potential for collaboration** among interested stakeholders?

COMPLETING THE SURVEY

1. Please rank the **degree of impact** for each item listed in the survey, on a scale of 1-to-5.

   One (1) is the lowest degree of positive, significant impact and 5 is the highest degree of positive, significant impact.

2. Also rank the **potential for the development of community and/or interagency collaboration**, for each issue.

   Use the same scale, with 1 being the lowest potential and 5 being the highest potential.

PLEASE

DO NOT LEAVE ANY ITEM BLANK
AND SELECT ONLY ONE WHOLE NUMBER FOR EACH ITEM.

This is important for the automated data analysis process.

[27] McPherson M, Arango P, Fox H, et al. A new definition of children with special health care needs. *Pediatrics*. 1998;102:137-140.

191

NEW HAMPSHIRE

A. If programs could be developed to address any of the following **ACCESS TO CARE** issues, what degree of impact do you think each would have on the lives of children with special health care needs (CSHCN) and their families? What do you think the potential is for community and/or interagency collaboration to address these issues?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT	COLLABORATION POTENTIAL
A-1	Service and health status disparities based on geographic region (esp. rural NH)	1 2 3 4 5	1 2 3 4 5
A-2	Isolation of families leading to delay in treatment and increased self-treatment	1 2 3 4 5	1 2 3 4 5
A-3	Lack of access to adequate dental care	1 2 3 4 5	1 2 3 4 5
A-4	Lack of transportation options to access care; cost of transportation	1 2 3 4 5	1 2 3 4 5
A-5	Need for a directory of services	1 2 3 4 5	1 2 3 4 5
A-6	Limited access to technology and/or databases	1 2 3 4 5	1 2 3 4 5

B. Health services to CSHCN have been affected by the **LACK OF CAPACITY** in the current system, including a lack of professionals and a lack of education and expertise about special needs populations. Please rank the degree of impact upon CSHCN and their families if programs could be developed to address these issues. Also rank the potential for community and/or interagency collaboration to address these issues.

PROGRAMS TO ADDRESS		DEGREE OF IMPACT	COLLABORATION POTENTIAL
B-1	Need for more Certified Nursing Assistants (CNA)	1 2 3 4 5	1 2 3 4 5
B-2	Need for prepared/expert professionals	1 2 3 4 5	1 2 3 4 5
B-3	Continuing education/technical assistance for providers	1 2 3 4 5	1 2 3 4 5
B-4	Training for all staff in family-centered principles of care	1 2 3 4 5	1 2 3 4 5
B-5	Need for experts in endocrinology, gastroenterology, metabolic disorders	1 2 3 4 5	1 2 3 4 5
B-6	Mechanisms to influence pediatric residency training	1 2 3 4 5	1 2 3 4 5

192

NEW HAMPSHIRE

C. Changes in family demographics have created a new group of needs in NH. If initiatives could be developed to address the issues of **FAMILY DEMOGRAPHICS AND SUPPORT** listed below, what degree of impact do you think this would have on CSHCN and their families? What is the potential for community and/or interagency collaboration around each issue?

	PROGRAMS TO ADDRESS	DEGREE OF IMPACT	COLLABORATION POTENTIAL
C-1	Coordination of resources/capacity across geographic areas	1 2 3 4 5	1 2 3 4 5
C-2	Increasing number of children in poverty in NH	1 2 3 4 5	1 2 3 4 5
C-3	Lack of services for working poor	1 2 3 4 5	1 2 3 4 5
C-4	Need for outreach strategies to bring underserved into the system of care	1 2 3 4 5	1 2 3 4 5
C-5	Social support for families due to fewer nuclear and extended family constellations	1 2 3 4 5	1 2 3 4 5
C-6	Services for children being raised by grandparents	1 2 3 4 5	1 2 3 4 5
C-7	Services for homeless families	1 2 3 4 5	1 2 3 4 5
C-8	Increasing number of older parents in the caretaker role for CSHCN	1 2 3 4 5	1 2 3 4 5

D. Please rank the degree of impact programs to address the following **CHILD CARE and RESPITE** options would have on CSHCN and their families. What is the community and/or interagency collaboration potential to address these issues?

	PROGRAMS TO ADDRESS	DEGREE OF IMPACT	COLLABORATION POTENTIAL
D-1	Respite care for behaviorally and medically complex children	1 2 3 4 5	1 2 3 4 5
D-2	Home-based services for children with medical and behavioral needs	1 2 3 4 5	1 2 3 4 5
D-3	Need for group care/congregate care as long term living options	1 2 3 4 5	1 2 3 4 5
D-4	Increasing demand for child care options for families with young children with behavioral problems	1 2 3 4 5	1 2 3 4 5

193

E. If initiatives could be developed to address the following **NEW TREATMENT OPTIONS** what would be the degree of impact on CSHCN and their families? What is the potential for community and/or interagency collaborative programs for these issues?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT	COLLABORATION POTENTIAL
E-1	Increased use of pharmacology and the need for individualized evaluation and management	1 2 3 4 5	1 2 3 4 5
E-2	Information regarding allergies (e.g., food, latex) and associated treatments (e.g., dietary)	1 2 3 4 5	1 2 3 4 5
E-3	Increasing knowledge of brain function/chemistry with associated new treatments/interventions	1 2 3 4 5	1 2 3 4 5
E-4	Use of biomechanical engineering to provide treatment (e.g. robotics, specialized mobility devices)	1 2 3 4 5	1 2 3 4 5
E-5	Increasing knowledge of metabolism and nutrition leading to new treatments/service needs	1 2 3 4 5	1 2 3 4 5
E-6	Increased use of cochlear implants requiring both individual and family treatment/education	1 2 3 4 5	1 2 3 4 5

F. HOME-BASED SERVICES are required by some CSHCN. Please rank the degree of impact on CSHCN and their families if the following issues were addressed through new initiatives. What is the potential for community and/or interagency collaboration?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT	COLLABORATION POTENTIAL
F-1	Increasing number of children with significant medical problems who live at home	1 2 3 4 5	1 2 3 4 5
F-2	Educational services and care in the home setting	1 2 3 4 5	1 2 3 4 5
F-3	Specific training for professionals/paraprofessionals to provide care in home settings	1 2 3 4 5	1 2 3 4 5
F-4	Parents forced to leave employment to provide in-home care for CSHCN	1 2 3 4 5	1 2 3 4 5

194

G. What degree of impact would programs to address the **EDUCATIONAL NEEDS OF PARENTS** have on CSHCN and their families? What is the potential for community and/or interagency collaboration to develop such programs?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT	COLLABORATION POTENTIAL
G-1	Parent skill training in behavior and health	1 2 3 4 5	1 2 3 4 5
G-2	Preparation of parents for leadership roles	1 2 3 4 5	1 2 3 4 5
G-3	Assisting parents with technology used with CSHCN (e.g., hardware and software possibilities)	1 2 3 4 5	1 2 3 4 5
G-4	Parent-to-parent helping models that reimburse the "teacher"	1 2 3 4 5	1 2 3 4 5
G-5	Educational materials for parents that are clear and pragmatic	1 2 3 4 5	1 2 3 4 5

H. If initiatives could be developed for the following **HEALTH CARE COORDINATION** issues, what degree of impact would these have on CSHCN and their families? To what degree do you think there is a potential for interagency and/ or community collaboration in these areas?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT	COLLABORATION POTENTIAL
H-1	Support for care coordinators in the community	1 2 3 4 5	1 2 3 4 5
H-2	Care coordination in primary care offices	1 2 3 4 5	1 2 3 4 5
H-3	Case coordination for the most involved, medically complex children	1 2 3 4 5	1 2 3 4 5
H-4	Integration of care between primary and tertiary care settings	1 2 3 4 5	1 2 3 4 5
H-5	Coordination at all points of transition (e.g., preschool, middle to HS, youth to adult)	1 2 3 4 5	1 2 3 4 5
H-6	Need for intra-agency cooperation/collaboration	1 2 3 4 5	1 2 3 4 5

195

NEW HAMPSHIRE

I. Children born with conditions such as cystic fibrosis and spina bifida are surviving into adulthood due to improvements in treatment, and chronic conditions such as asthma, diabetes and mental illness are increasing. What would be the degree of impact on Youth with Special Health Care Needs (YSHCN) and their families if services were developed to help them with the following **TRANSITION** issues? What is the potential for collaboration on these issues?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT	COLLABORATION POTENTIAL
I-1	The health/medical needs of adolescents and CSHCN in transition (age 14-21)	1 2 3 4 5	1 2 3 4 5
I-2	Provision of adult health care for the special needs population	1 2 3 4 5	1 2 3 4 5
I- 3	Provider education regarding the developmental issues of youth and young adults with special health care needs	1 2 3 4 5	1 2 3 4 5
I- 4	Self-advocacy skills for youths with special health care needs	1 2 3 4 5	1 2 3 4 5
I- 5	Adequate funding for inclusion / self determination models of care	1 2 3 4 5	1 2 3 4 5
I- 6	Need for SSI and other funding after 18 years of age	1 2 3 4 5	1 2 3 4 5

J. What degree of impact would initiatives to address the following **MULTICULTURAL ISSUES** have on CSHCN and their families? What is the potential for collaboration within the community and/or interagency to develop programs?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT	COLLABORATION POTENTIAL
J-1	Need for cultural competence among providers and health care organizations	1 2 3 4 5	1 2 3 4 5
J-2	Lack of training focusing on multicultural issues	1 2 3 4 5	1 2 3 4 5
J-3	Increasing need to serve immigrant populations	1 2 3 4 5	1 2 3 4 5
J-4	Need for interpreters in health care settings	1 2 3 4 5	1 2 3 4 5
J-5	Differing beliefs and values re: self sufficiency and using public services	1 2 3 4 5	1 2 3 4 5

196

NEW HAMPSHIRE

K. Health and disease information is readily available from multiple resources, including the Internet. If initiatives were developed to address this **KNOWLEDGE EXPLOSION** what degree of impact might there be on CSHCN and their families? What is the potential for community and/or interagency collaboration on these issues?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT	COLLABORATION POTENTIAL
K-1	Increased need for parent - professional dialogue due to increasingly sophisticated consumers of care (educated via the Internet and other sources)	1 2 3 4 5	1 2 3 4 5
K-2	Need to assist families and professionals to evaluate and process new knowledge	1 2 3 4 5	1 2 3 4 5
K-3	Use of the Internet for diagnosis, counseling and consultation	1 2 3 4 5	1 2 3 4 5

L. SCHOOLS provide necessary treatment, care and related services to CSHCN. What degree of impact would initiatives to address the following issues have on CSHCN and their families? What is the potential for community and/or interagency collaboration?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT	COLLABORATION POTENTIAL
L-1	Demand for more complex nursing care in school settings	1 2 3 4 5	1 2 3 4 5
L-2	Support & education for school nurses	1 2 3 4 5	1 2 3 4 5
L-3	Funding of schools to meet the needs of CSHCN to avoid rationing of special education and related services	1 2 3 4 5	1 2 3 4 5
L-4	Need for after school and recreational activities for CSHCN	1 2 3 4 5	1 2 3 4 5
L-5	Need for interagency partnerships / collaboration between health and educational communities	1 2 3 4 5	1 2 3 4 5
L-6	Need for home – school collaboration and coordination	1 2 3 4 5	1 2 3 4 5

M. New knowledge has led to new **DIAGNOSTIC OPTIONS** for CSHCN. What would be the degree of impact on CSHCN and their families if services to address these issues were developed? What is the potential for community and/or interagency collaboration?

197

NEW HAMPSHIRE

PROGRAMS TO ADDRESS		DEGREE OF IMPACT	COLLABORATION POTENTIAL
M-1	Increased recognition of co-morbidity and dual diagnoses	1 2 3 4 5	1 2 3 4 5
M-2	Role of the environment in the etiology of health and developmental problems	1 2 3 4 5	1 2 3 4 5
M-3	Focus on prevention of chronic illness in children; (e.g., folic acid & spina bifida, asthma protocols)	1 2 3 4 5	1 2 3 4 5
M-4	Newborn hearing screening leading to earlier diagnosis and need for intervention (under 1 year)	1 2 3 4 5	1 2 3 4 5
M-5	Genetic counseling/treatment (new knowledge)	1 2 3 4 5	1 2 3 4 5

N. If initiatives could be developed to address the following needs of **VULNERABLE POPULATIONS**, what would be the degree of impact on CSHCN and their families? What is the potential for community and/or interagency collaboration?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT	COLLABORATION POTENTIAL
N-1	Increased number of CSHCN in foster care	1 2 3 4 5	1 2 3 4 5
N-2	Need for adoption/ permanency for CSHCN in out-of-home placement	1 2 3 4 5	1 2 3 4 5
N-3	Medical/health needs of emotionally disturbed children	1 2 3 4 5	1 2 3 4 5
N-4	Need for services for youth with special needs in the juvenile justice system (e.g., evaluation, medical services, mental health services)	1 2 3 4 5	1 2 3 4 5
N-5	Transitional support for teens leaving the foster care system or detention (e.g., mentors, housing, health care)	1 2 3 4 5	1 2 3 4 5

198

O. There is an increasing population of children with **SPECIAL NEEDS DIAGNOSES.** Please rank the degree of impact for CSHCN and their families if programs could be developed to address the following areas. What is the potential for community and/or interagency collaboration?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT	COLLABORATION POTENTIAL
O-1	The increasing survival of low birth weight babies with associated biological, cognitive, developmental and behavioral problems	1 2 3 4 5	1 2 3 4 5
O-2	Growing population of children with complex medical needs	1 2 3 4 5	1 2 3 4 5
O-3	Increasing longevity of CSHCN population associated with improved treatment (e.g., cancer, cardiac)	1 2 3 4 5	1 2 3 4 5

P. If initiatives could be developed to address the following **MENTAL HEALTH** issues, what degree of impact do you think each would have on the lives of CSHCN and their families? What is the potential for community and/or interagency collaboration?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT	COLLABORATION POTENTIAL
P-1	Early diagnosis and treatment of mental/emotional/ behavioral disorders in children	1 2 3 4 5	1 2 3 4 5
P-2	Need for family support and counseling	1 2 3 4 5	1 2 3 4 5
P-3	Lack of mental health services / professionals skilled in pediatric / family-based treatment	1 2 3 4 5	1 2 3 4 5
P-4	Need for early identification of infants and families at risk (e.g., addiction / domestic abuse)	1 2 3 4 5	1 2 3 4 5
P-5	Need for support groups for families	1 2 3 4 5	1 2 3 4 5
P-6	Need for information on how to access mental health services	1 2 3 4 5	1 2 3 4 5

Q. The delivery of quality services is the outcome of good **SYSTEMS PLANNING.** What degree of impact would such planning have on the following areas, if initiatives could be developed to address them? What is the potential for community and/or interagency collaboration for these areas?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT	COLLABORATION POTENTIAL
Q-1	Emphasis on evidence – based practice	1 2 3 4 5	1 2 3 4 5
Q-2	Adequate data systems to support care for CSHCN and families	1 2 3 4 5	1 2 3 4 5
Q-3	Demand for outcomes and accountability in healthcare and other service arenas	1 2 3 4 5	1 2 3 4 5
Q4	Inconsistency / differences in quality across programs, services	1 2 3 4 5	1 2 3 4 5
Q-5	Incorporation of a Continuous Quality Improvement process into state-funded agencies	1 2 3 4 5	1 2 3 4 5

R. If initiatives were developed to address the following **ETHICAL ISSUES**, what degree of impact would each have on the lives of CSHCN and their families? What is the potential for community and/or interagency collaboration?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT	COLLABORATION POTENTIAL
R-1	Complex ethical dilemmas associated with priorities, cost of care, available resources, expanding scientific info	1 2 3 4 5	1 2 3 4 5
R2	Possibility for genetic discrimination associated with familial syndromes	1 2 3 4 5	1 2 3 4 5
R3	Reimbursement for services based on the predicted natural history of a "diagnosis" rather than that of an individual child	1 2 3 4 5	1 2 3 4 5
R-4	Different expectations regarding care/treatment from consumers, medical professionals, managed care organizations	1 2 3 4 5	1 2 3 4 5

S. If initiatives could be developed to address issues of **PUBLIC FUNDING**, what do you think would be the degree of impact for CSHCN and their families? What is the potential for community and/or interagency collaboration?

PROGRAMS TO ADDRESS	DEGREE OF IMPACT	COLLABORATION POTENTIAL

200

S-1	Increase in the demand for Medicaid	1	2	3	4	5	1	2	3	4	5
S-2	Need for Medicaid restructuring	1	2	3	4	5	1	2	3	4	5
S-3	Potential for the rationing of services	1	2	3	4	5	1	2	3	4	5
S-4	Need for follow-up with families who are denied SSI or HC-CSD (Katie Beckett)	1	2	3	4	5	1	2	3	4	5
S-5	Adequate Medicaid reimbursement for providers	1	2	3	4	5	1	2	3	4	5
S6	Demand for blending / coordination of funding sources / funding flexibility	1	2	3	4	5	1	2	3	4	5
S-7	Increasing focus on set-aside, "carve-out" programs	1	2	3	4	5	1	2	3	4	5
S-8	Teaching families how to navigate/negotiate a complex and difficult service system	1	2	3	4	5	1	2	3	4	5
S-9	Need for new coding systems associated with new diagnosis, to insure payment	1	2	3	4	5	1	2	3	4	5

T. If initiatives could be developed to address the following issues related to **VALUES,** what degree of impact might this have on CSHCN and their families? What is the potential for community and/or interagency collaboration?

PROGRAMS TO ADDRESS		DEGREE OF IMPACT					COLLABORATION POTENTIAL				
T-1	Increasing tension between inclusion versus exclusion of the child with disabilities in community settings.	1	2	3	4	5	1	2	3	4	5
T-2	Responsibilities of the larger community for the needs of CSHCN	1	2	3	4	5	1	2	3	4	5
T-3	Educating politicians about the changing needs of constituents/families of CSHCN	1	2	3	4	5	1	2	3	4	5

U. HEALTH CARE COST remains a major barrier to access. Health insurance is not readily available to all segments of the NH population. If programs could be developed to address the following issues what degree of impact would there be for CSHCN and their families? What is the potential for community and/or interagency collaboration?

U-1	Increasing difficulty in obtaining adequate insurance coverage for CSHCN	1	2	3	4	5	1	2	3	4	5

201

U-2	Demand for coverage for durable medical equipment and non-pharmaceutical products	1	2	3	4	5	1	2	3	4	5
U-3	Frequent changes in insurance (e.g., with uncertain job market)	1	2	3	4	5	1	2	3	4	5
U-4	Limits imposed by the use of "health accounts" and the potential for medical needs of CSHCN not being covered	1	2	3	4	5	1	2	3	4	5
U-5	Co-pays, items not covered by insurance, out of pocket expenses	1	2	3	4	5	1	2	3	4	5
U-6	Increasing number of working poor not eligible for services	1	2	3	4	5	1	2	3	4	5
U-7	Difficulties/ demands associated with specialty referrals; "out of network" referrals	1	2	3	4	5	1	2	3	4	5
U-8	Payment for alternative / complementary treatment, (e.g., medications, nutritional, acupuncture)	1	2	3	4	5	1	2	3	4	5

End of Survey

Please review to be sure that the survey was completed by responding to all items in both columns.

202

NEW HAMPSHIRE

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs

Needs	Pyramid Level	Capacity	Strengths	Weaknesses/Gaps
Mental Health Improved quantity and quality of mental health services **Population:** - Children Special Health Care Needs (CSHCN) -Children -Adolescents	Direct Health Care Services	**Low**	-Community Mental Health Centers with children's services -SMS psychology services -SMS Child Development programs state network -Links to Early Learning Program –Early Childhood Comprehensive Systems (ECCS) grant - Anna Philbrook Ctr. (acute inpatient child psych)	-Discrepancy & lack of consistency in children's services -Critical staff shortages of qualified professionals
	Enabling Services		CARE NH supports and wrap around	-Private and public funding is insufficient -Lack of insurance parity for Mental Health services -Systematic care coordination services lacking
	Population-Based Services		N/A	N/A
	Infrastructure Building Services		-CARE NH Program -Potential new Substance Abuse and Mental Health Services Administration $	-Reimbursement barriers -Scarce resources

157

NEW HAMPSHIRE

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs

Needs	Pyramid Level	Capacity	Strengths	Weaknesses/Gaps
	Systems-Building/Collaboration		-DHMC child development psychiatry and psychology collaboration, including Comprehensive Office Rounds (COR) -Collaborative work with NAMI & Granite State Federation for Families -Pediatric Society initiatives (5/25 meeting, sponsoring Infant MH conference) -Title V support of 14 Regional Infant Mental Health Teams -Youth Suicide Prevention Assembly/Injury Prevention Committee (YSPA/IPC) -Child Fatality Review Committee	"Silo Effect" inhibits true collaboration
Respite Respite and child care for medically and behaviorally complex children **Population:** - Children Special Health Care Needs	Direct Health Care Services	**Low**	-VNA in-home services -Area Agencies have financial support -Cedarcrest and Crotched Mt. have center-based respite for medically complex	-Lack of trained staff (number of and skill level) to provide respite -Insufficient programs willing to provide childcare to CSHCN
	Enabling Services		-Area Agencies -Community-based funding -Medicaid waivers (HC-CSD)	-Limited and fragmented funding targeted to developmentally disabled adults and medically complex only
	Population-Based Services		-Healthy Child Care NH childcare health consultants providing training support for childcare providers to serve CSHCN	-Limited funding, serving limited regions of the State

158

NEW HAMPSHIRE

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs

Needs	Pyramid Level	Capacity	Strengths	Weaknesses/Gaps
	Infrastructure Building Services		-Cedarcrest provides model for training/education for C N A's - Preschool Technical Assistance Network (PTAN) provides consultants to preschools and child care centers	-No model for work force development -No financial support for health care consultants
	Systems Building/Collaboration		- Preschool Technical Assistance Network	-No unified system for respite for work force development or provision of care (like Oregon model) -Question of 'silo effect' as barrier to obtaining collaboration
Obesity Impact the growing overweight/obesity rate in NH children **Population:** -Children - Children Special Health Care Needs	Direct Health Care Services	**Low**	-WIC/Health Promotion unit -Selected SAU programs and DOE initiatives -NH Healthy Schools Coalition/Action for Healthy Kids (Tamara Martin) -Manchester program (DHMC and schools) -SMS regional pediatric nutritionists -School nurse initiatives	-Fragmented State-wide approaches -Lack of interdisciplinary team models for intervention
	Enabling Services		-Community based funding -Preventive Health and Health Services Block Grant - CDC	-Lack of family education and support -Lack of funding and reimbursement
	Population-Based Services		-Media attention to the issue -Walk and Bike to School Initiative with Health Promotion -Safe Sports Initiatives with Health Promotion and Oral Health	Lack of funding – no incentive for collaboration

159

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs

Needs	Pyramid Level	Capacity	Strengths	Weaknesses/Gaps
Obesity con't	Infrastructure Building Services		-Several school nurse initiatives -Media attention -Title V-funded community health centers required to use Body Mass Index (BMI) -State MCH office providing Community Health Centers (CHC) with Bright Futures physical activity resources -Governor's wife is pediatrician with high interest in the issue -Issue identified as a priority for funding from healthy NH Foundation for community projects	-Lack of buy in from professional organizations in community -Lack of consistent statewide data
	Systems-Building/Collaboration		N/A	-Lack of state support for regional initiatives
Oral Health Decrease the rates of dental disease among high risk children Population: -Children	Direct Health Care Services	High	-Community based & school based oral health programs -State Oral Health Program -State Oral Health plan -Increased Medicaid reimbursement rates -Established oral health surveillance system -Outreach to physicians to incorporate oral health into medical visits -Watch your Mouth campaign -Service delivery is community based through hospitals, CHC's schools, VNA's	-Severely limited funding -Rapidly declining workforce -Insufficient number of providers to treat special populations -Insufficient number of Medicaid providers -Limited functions allowed by auxiliary professionals -Geographic disparities -Lack of fluoridated public water systems -No state support -Endangered PHHS Block Grant
	Enabling Services		-Community and program based. Some dental clinics have "3 strikes – You're out" -Care coordination occurs at local programmatic level	-Parents do not value Oral Health and do not take kids to appointments -Care cordination is sependent on parental value of oral health. Children go untreated even when barriers are eliminated

160

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs

Needs	Pyramid Level	Capacity	Strengths	Weaknesses/Gaps
Oral Health Con't	Population-Based Services		-Fluoridation of Manchester seen as a model -Statewide Sealant Project – Year 1	-Anti-fluoridationists continue to be effective -Restrictive state regs require dentist's oversight of sealant application
	Infrastructure Building Services		-Free well-water (Fluoride) analysis for community health centers -Collaboration with Dept. of Environmental Services to facilitate water tests and record keeping in CHC's -describe (in grant) the high capacity currently – for another year only) when endowment redirects funding focus away from NH	-Water test results go to family rather than physician to prescribe fluoride supplements
	Systems-Building/Collaboration		-Participation in Watch Your Mouth public awareness campaign with endowment for Health, NH Dental Society, AAP, et al -Collaboration with Medicaid Dental Program -Collaboration with NH Dental Society as fiscal agent and Medicaid provider -Collaboration with hospitals on "community benefits"	-Severly limited state funds -Limited federal funds through endangered Preventive Health Block Grant (PHHS)
Safe Environments	Direct Health Care Services	**High**	Lead Program medical and environmental case management	N/A

161

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs

Needs	Pyramid Level	Capacity	Strengths	Weaknesses/Gaps
	Enabling Services		N/A	N/A
	Population-Based Services		-Lead Program -IP Program and contractors ICP and NHCADSV IP Plan -DV efforts -HCCNH -HVNH -CH Program -SIDS risk reduction -Adolescent health strategic plan -Child abuse prevention	-Limited staff resources -Lengthy contract approval process
	Infrastructure Building Services		Manchester Lead Hazard Control Program	Limited funding for lead hazard control activities outside of Manchester
	Systems-Building/Collaboration		Local Lead Action Committees	N/A
Healthy Pregnancies **Population:** -Women -Adolescents -CSHCN	Direct Health Care Services	**Low**	-Home Visiting New Hampshire programs in 18 program sites across the State. One site is primarily focused on minority women and LEP -Medicaid expanded eligibility for pregnant women -Funding for prenatal care at 13 community agencies	-No home visiting in Nashua as well as other communities
	Enabling Services		-Medicaid – reimburseable services for state funded prenatal programs for support/education services -Home Visiting Programs	N/A

162

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs

Needs	Pyramid Level	Capacity	Strengths	Weaknesses/Gaps
	Population-Based Services		-Ability to analyze data on disparities -Performance measures -Collaborative relationship with Dartmouth & UNH -New information on association of LBW and periodontal infection	-No PRAMS -No current partners addressing disparities -Lack ability to track and respond to emerging communities -Current data collection system inadequate -No access to dental treatment for high risk pregnant women
	Infrastructure Building Services		N/A	N/A
	Systems-Building/Collaboration		N/A	N/A
Adolescents Population: -Adolescents	Direct Health Care Services	High	-Teen specific reproductive health services offered at 10 clinics. Primary care services at site	-No dental services for high risk adolescent population
	Enabling Services		-Medicaid reimburseable support/education services for MCH Title V funded agencies only	N/A
	Population-Based Services		-Good relationships with internal & external stakeholders -Link to CHCs for promoting adol health -Adol plan released -Adol health coordinator -YRBS representative sample; addition of protective factors	-No dedicated funding -Limited staff resources -No statewide standards for adolescent medicine -Slow recognition (in medicine) of adol as special population -Lack of adol specialty providers
Adolescents con't	Infrastructure Building Services		N/A	N/A
	Systems-Building/Collaboration		N/A	N/A

163

NEW HAMPSHIRE

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs

Needs	Pyramid Level	Capacity	Strengths	Weaknesses/Gaps
Injury **Population:** -Children	Direct Health Care Services	**High**	N/A	N/A
	Enabling Services		N/A	N/A
	Population Based Services		-Opportunity to add violence module to BRFSS -YSPA -Statewide VAW plan -Statewide suicide prevention plan -Dartmouth IPC -UNH Center on Adolescence -MCH HVNH & CH support Programs -Frameworks project	-Lack of data -Weak relationship with DCYF & DOE -Weak in addressing middle childhood issues -Threat to PHSBG -Limited staff resources
	Infrastructure Building Services		N/A	N/A
	Systems-Building/Collaboration		N/A	N/A
Data **Population:** -All MCH populations	Direct Health Care Services	**Low**	N/A	N/A
	Enabling Services		N/A	N/A
	Population Based Services		N/A	N/A

164

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs

Needs	Pyramid Level	Capacity	Strengths	Weaknesses/Gaps
Data Con't	Infrastructure Building Services		-Data Team -HS staff -PCC staff -Analysis tools -Contract agency PMs used as Dept. model -Plan developed for data collection, use and linkages -FP data system is a model	-Data entry capacity -Access to data -Ability to analyze limited by lack of data linkages and agency capacity -Lack of child health data -Time intensive start up limits efficiency -Dissemination: DHHS approval process is slow
	Systems-Building/Collaboration		N/A	N/A
Safety Net Preserve safety net/infrastructure **Population:** -All MCH populations	Direct Health Care Services		-Increasing support for networking of primary health care centers	Many CHC's without dental facility
	Enabling Services	**High**	N/A	N/A
	Population Based Services		N/A	N/A
	Infrastructure Building Services		-Adapting contracts to shifting community needs -Collaborative relationship with contract agencies -PH Network emerging as local conduit -Improved ability to validate and communicate effectiveness of contract agencies -Strong children's advocacy network	-No funding methodology -Reimbursement rates may not be adequate -No mechanism for mobilization of advocacy efforts on MCH issues
	Systems-Building/Collaboration		N/A	N/A

165

NEW HAMPSHIRE

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs

Needs	Pyramid Level	Capacity	Strengths	Weaknesses/Gaps
Work Force Population: -All MCH populations	Direct Health Care Services	Low	N/A	-Declining number of dentists -Dental providers practice in Southern 1/3 of the State
	Enabling Services		N/A	N/A
	Population-Based Services		N/A	Declining number of dental providers will make it harder to recruit public health dentists
	Infrastructure Building Services		-Consistent staff -Training opportunities -Working to develop internal staff development -Ability to identify shortage areas	-Hiring freeze -Aging workforce -Limited funding to attract quality staff -Funding for HPSA provider recruitment center cut
	Systems-Building/Collaboration		N/A	N/A
Care Coordination Increased availability of care coordination for vulnerable populations (e.g. families of children receiving SSI for their own	Direct Health Care Services	Low	-Strong centralized care coordination through state Title V program - Upper Valley Parent to Parent	-Lack of qualified professionals -Lack of payment mechanisms for care coordination
	Enabling Services		N/A	-Lack of payment mechanisms for care coordination
	Population-Based Services		N/A	N/A

166

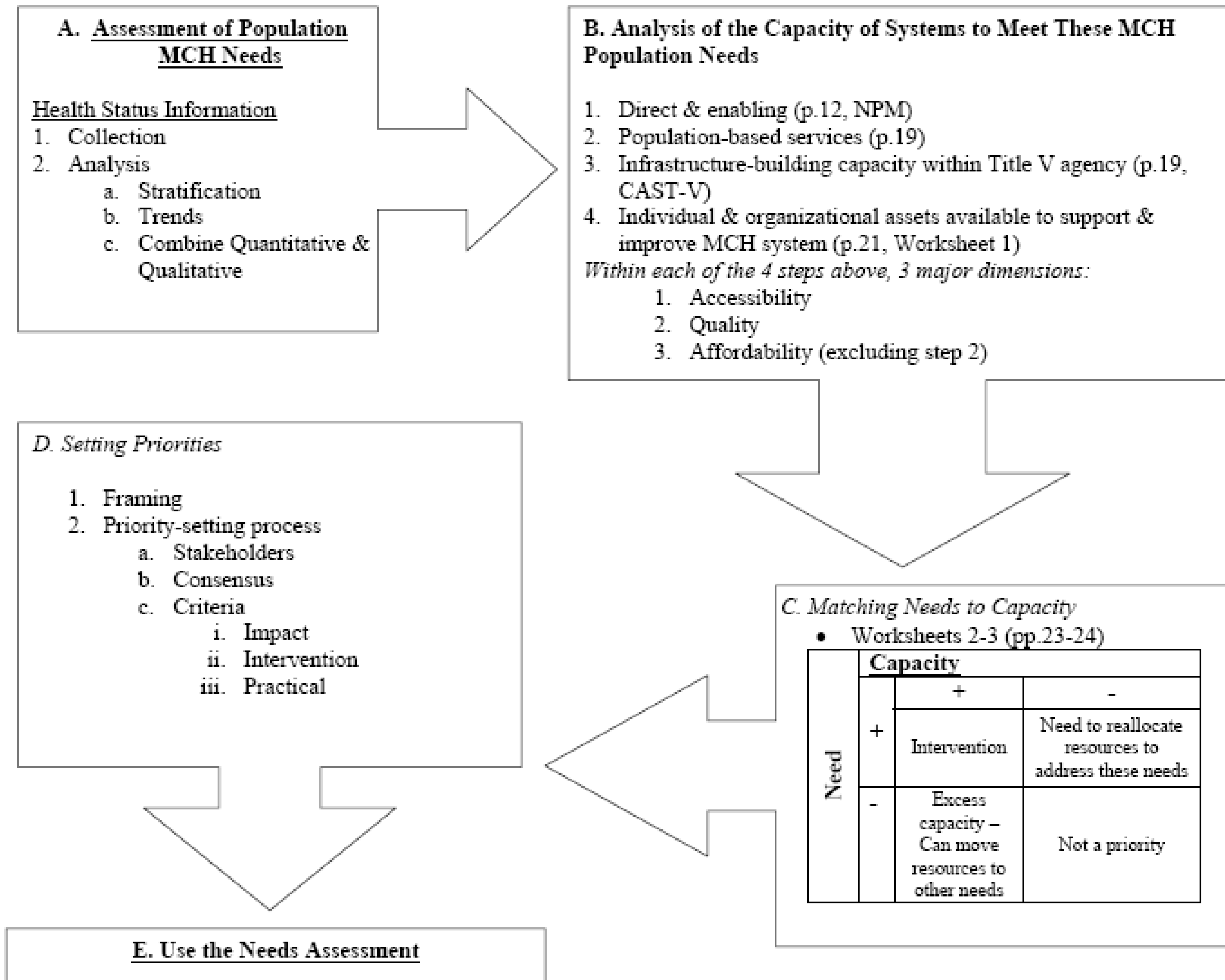
NEW HAMPSHIRE

Table CA-5: Worksheet 2: Analysis of MCH System Capacity to Address MCH Needs

Needs	Pyramid Level	Capacity	Strengths	Weaknesses/Gaps
	Infrastructure Building Services		-Strong centralized care coordination through state Title V program	-Lack of qualified professionals -No systematic training/education -Need to define skills, competencies
	Systems-Building/Collaboration		-Developing system of care coordination through Medical Homes -Developing models of care coordination for support through the NH ECCs Implementation Plan	-Multiple definitions of "care coordination" between and within early childhood systems

167

Conceptual Framework for the 2005 Title V Needs Assessment



VIRGINIA

Improving Health for Virginia's Families:

Priority Setting and Strategic Planning Workshop

June 15 and 16, 2005

Richmond, Virginia

Agenda

Wednesday June 15 (Priority Setting)

8:30 - 8:45	Introduction of Participants Overview of the Day
8:45 - 9:30	Review of the Needs Assessment Process in MCH MCH Data Sources for Decision-Making Needs as Values
9:30 - 10:15	Suggesting Areas of Importance Group Task #1
10:15 - 10:30	BREAK
10:30 - 11:15	Data Derived from the Virginia Five-Year Needs Assessment
11:15 - 12:00	Refining Areas of Importance Group Task #2
12:00 - 12:45	LUNCH
12:45 - 1:15	Report Back: Identifying Priorities

1:15 - 1:45	Suggesting Solutions
1:45 - 2:00	BREAK
2:15 - 3:45	Suggesting Solutions Group Task #3
3:45 - 4:30	Report Back Full Group Discussion Voting, if necessary Five-Year Priorities Recommended

163

WASHINGTON

Sample Logic Model Developed in Washington State to Address a Priority MCH Goal

Healthy Relationships for Pregnant & non pregnant women

Inputs or Resources	Activities	Outputs	Short-term Outcomes *(Focus: Knowledge /Awareness)*	Intermediate Outcomes *(Focus: Action/ Behavior Change)*	Long-Term Outcomes or Goals
TIME: MCH FTE .20 (?) Teens: Youth Development DV: MIH .6 FTE FUNDING: AB Ed Funding DASA $ MIH $ 144,000 SUPPORT: <u>Internal</u> CFH FTE: .10 Family Violence Work group MCH Mental Health Work group, 1 FTE <u>External</u> DSHS: MAA First Steps Providers Medical Providers PPADV Committee	**Current:** ASSESSMENT: 1. Gather data on healthy relationships through such surveys as BRFSS, PRAMS, HYS and analysis of other available data such as birth certificate data. 2. Participate on the PRAMS planning committee and administer PRAMS survey. 3. Monitor progress towards goals and objectives. 4. Healthy Relationships Key Informant Interviews and web search. Proposed: **-increase analysis of Maternal mortality data related to violence and mental health** ASSURANCE: 5. Educate/ train providers on domestic violence . [i] 6. Distribute DV and Pregnancy Fact Sheet and Booklet (exhibits, conferences and workshops) 7. Collaborate with WA State Coalition Against Domestic Violence (WSCADV) and Washington State Sexual Assault Centers to train medical providers on DV issues and promote DV and Pregnancy Guidelines Booklet/DV Fact Sheet and linkage between medical providers and	DV Fact Sheets DV Booklet PPADV Curriculum Report on Healthy Relationships Work plan for Healthy Relationships Four projects with Washington State Coalition Against Domestic Violence (Curriculum; training; Project Partnership, PPADV TA) Materials development with PPADV workgroup (12-14 external partners) FVPWG (Family	Activities 1-4: ▪ Improved recognition and surveillance of risk behaviors among women and women of CBA. ▪ Established a prevalence rate for the occurrence of all forms of domestic violence through use and monitoring of the PRAMS violence questions before, during and after delivery. Activities 5-9: ▪ Increased perinatal care provider *awareness and comfort* of domestic violence and screening: as measured by trainee "comfort" in screening questions from PPADV Curriculum ▪ Increased provider knowledge of domestic violence during pregnancy. ▪ Increased number of providers who support the idea of screening for domestic violence more than one time during prenatal care visits. ▪ Increased consumer	Activities 1-4: ▪ Improved identification of risk and protective factors to identify high-risk women and communities to better address their needs. ▪ Use of current and readily available data for program planning, implementation and evaluation Activities 5-15: ▪ Increased number of pregnant and non-preg women engage in safe relationships and leave unsafe ones **Decreased family violence.** • Increased the number of prenatal care patients who are screened (PRAMS data) by 4% per year. In 2002, 46% (43%, 50%) of postpartum women reported their provider had discussed physical abuse to women by their husbands or partners during their prenatal visits. Younger women, women on Medicaid and women of color were more likely to report this. Source: PRAMS, 2004. In 2002, 60% of postpartum women	Healthy Relationships <u>Indicators</u> **PREGNANT WOMEN:** ❑ **<u>Increased Access to Quality Prenatal Care</u>** ▪ Refer to the *<u>Access to Prenatal Care</u>* Logic Model ❑ **<u>Reduce Substance and Tobacco Use</u>** ▪ Refer to the *<u>Alcohol and Drug Free Women</u>* and the *<u>Tobacco Free Women</u>* Logic Model (I don't think I'd include tobacco as an indicator of social/emotional health) ❑ **<u>Improve Mental Health of pregnant and postpartum women</u>** ▪ Decrease proportion of postpartum women reporting they were moderately or very depressed in the months after delivery. In 2002, 7% () of women reported they were very depressed or had to get help postpartum. Source: PRAMS, 2004. ▪ Decrease the proportion of pregnant

47

Healthy Relationships External Group Mental Health External Group	DV Advocates (Project Partnership). 8. Link with the A/PI community DV agencies to promote DV issues. 9. Project Partnership Pilot: Developed with WA Coalition Against DV (WSCADV) Region X Funds and Verizon grant targeting providers to educate on DV issues. 10. Collaborate with stakeholders on the development of a Healthy relationships project which will work to increase positive relationships of youth (Healthy Relationships Project)[ii] 11. Participate in DOH Family Violence Workgroup and MCH Mental Health Workgroup 12. Monitor clinical practice for violence and mental health needs by: review of First Steps Monitoring reports, Interviews with DOH Community and Rural Health staff and Joint Commission reports on accreditation for screening activities. 13. Provide First Steps MSS services – screening, referral, and interventions- to promote healthy relationships for low-income pregnant women. 14. UW health education contract for training of providers (First Steps), pregnant women on safe and healthy environments, mental health, healthy relationships, and growth and development. 15. Develop and disseminate to all families of children ages 0-6 CHILD Profile messages and women's health flyer on health, growth, development, and safety. 16. Educate First Steps and WIC clients on basics of pregnancy and prenatal care, breastfeeding promotion, family planning, healthy lifestyle, and touches briefly on postpartum adjustment and newborn safety issues (signs of newborn illness, back sleeping, Shaken Baby	Planning, Injury Prevention, Health Promotion, HIV AIDS), Epi.. Number of perinatal care providers who have had current training on domestic violence screening at prenatal visits. UW contract (KB) Services Number of MSS visits CHILD Profile messages and women's health flyer Nine Months to Get Ready booklet Keys to Care Giving	awareness of domestic violence during pregnancy Activity 10: ▪ Increased number of youth who have received messages about healthy relationships. Activity 11: ▪ Increase in awareness and sharing of information on family violence and mental health for the MCH population. Activity 12: ▪ FS providers are trained in maternal mental health Activity 15: ▪ All women delivering in WA receive safety messages Activity 16: ▪ Pregnant women receive health messages about safety and hotline number Activity 17: MSS clients who are at risk for depression and poor maternal – infant bonding will have increased social support and healthy relationships	reported a health care worker asked them questions about whether someone was hurting them emotionally or physically during their prenatal visits. Source: PRAMS, 2004. • Low income preg women get screened for violence and assisted. • Women get educated about postpartum depression by their provider. In 2002, 77% (74%, 80%) of postpartum women reported their provider had discussed this with them during pregnancy. Family violence is associated with poor birth outcomes ad medical problems for women (DV fact sheet—studies show increased risk for LBW and miscarriage-Bullock 89, McFarlane 92, Fernandez 99; Murphy et al 2001; Kearney, 2003) **Improved promotion of Healthy Relationships for Youth** • Increased number of youths and adults who promote the messages on healthy relationships. • **See Adol Injury Logic Model** **Decreased Youth Violence:** • Reduced # of respondents on the HYS who report dating violence, feeling unsafe at school and weapon use. **Improved promotion of comprehensive prenatal care.** • HWS page 264, 270 • PRAMS provider reports of screening during pregnancy (Provider talked about:28% 1996; 40% 2000; 49% 2001; Provider asked about: 51% in	and postpartum women who commit suicide. From 1990-2002, the suicide rate among women who had been pregnant in the previous year was 2.0 per 100,000 livebirths. Source: MCH Assessment, 2004. ❑ Support and improve Maternal/Infant Bonding ▪ In 2002-03, 90% of postpartum women reported they had ever breastfed their baby or pumped and fed breastmilk to their baby. 68% of women reported they were still breastfeeding at 2 months postpartum. ❑ **<u>Decrease violence against pregnant and postpartum women</u>** ▪ Decrease the pregnancy-associated mortality rate due to homicide and undetermined injuries. From 1990-2002, the rate in Washington was 5.1 per 100,000 livebirths. (Source: MCH Assessment, 2004) ▪ Decrease the proportion of postpartum women who report their husband or partner pushed, hit, slapped, kicked, choke or physically hurt them in the 12 months prior to pregnancy or during pregnancy. In 2002-03, 4% reported domestic violence prior to pregnancy, 3% reported domestic violence during pregnancy, and 3% reported their husbands made them feel unsafe after the baby was born. Source: PRAMS, 2004. ▪ Decrease the proportion of births that are unintended. In 2002-03, the rate of births due to unintended pregnancies was % (54%) Source: PRAMS, 2004.

48

	Syndrome, etc). (Nine Months to get ready)[iii] 17. First Steps group setting pilots (3 pilots to promote group activities, social support and relationships for FS clients). 18. Support Safe Babies, Safe Moms program in DSHS to increase behavioral health services such as healthy relationships and parenting for chemically dependent pregnant and parenting women **POLICY:** 19. Monitor legislation and promote policies that work to promote healthy relationships of pregnant women and women of CBA. **Proposed:** 1. Explore (LHJ survey) access to mental health services for pregnant and postpartum women. 2. Explore (LHJ survey/First Steps Team stats) services needed by pregnant women. 3. Expand training and resources to FS and MCH providers **Related Logic Models:** • See Adol Injury Logic Model **Related DOH Programs:** • Injury Prevention Program	Proposed: Report on access and services needed.	**Proposed:** Increased community awareness of domestic violence during pregnancy and how to help.	2000 and 60% in 2001) • Increased number of calls to DV Advocate agencies from medical settings. (Data is limited but goal is to have better accounting from DV agencies) • Survey of Providers **Improved access to mental health services.** • PRAMS 2000: 60% said some to major depression Peri Indicators pg 17. • Prenatal depression may increase perinatal risk to birth outcomes, parenting and bonding.(cite data) • Increased referrals to mental health services **Eliminate/minimize health disparities, particularly for individuals with disabilities.** (Need PRAMS questions) Increase number of women who are engaged in safe, nurturing and positive relationships Activity 14: Lo income pregnant/parenting women on FS are better prepared psychologically for parenting Activity 15-17: ⇨ some women will use info and call the DV hotline ⇨ MSS clients who are at risk for depression and poor maternal – infant bonding will have increased social support and healthy relationships Activity 18: ⇨ Informed laws and policies related to the MCH population.	**WOMEN OF CHILD BEARING AGE:** ❑ Decrease the # of women who experience violence **<u>Intimate Partner Violence:</u>** ***--Decrease % of Women who state that their intimate partner has put them down or called them names during the past year from 6% of 2001 women*** **(BRFSS, 2001)** ***--Decrease % of women who say their intimate partner physically hurt them in the past year from 47% of 2001 women*** **(BRFSS, 2001)** **--See Also *Assault/Homicide* within this Logic Model** **<u>Decrease Unwanted Advances:</u>** ***--Decrease # of Women who received unwanted sexual touching before the age of 18 from17% of 2001 women*** **(BRFSS, 2001)** **<u>Decrease Assault/ Homicide of</u>**

49

					<u>Women:</u> *--Decrease the number of Hospitalizations of women who have been assaulted:* (VISTA) Rate of Hospitalizations that resulted from Assaults against women aged 15-44, for 1997-1999: 14.81 per 100,000 (Total # of Women Hospitalized as a result of Assault=552) DV results in 10%-20% of ER visits by women[iv] *--Decrease the number of assaults against women that end in homicide:* (VISTA) Rate of Homicides for 15-44 year old women: 1999-2001: 5.01 per 100, 000 (Total Count=396) 2000-2002: 4.98 per 100, 000 (Total Count= 395) DV results in 30% of homicides of women[v]

50

					--Decrease the # of Women who are raped: ▪ Of the more than 2.2 million adult women living in Washington, over 390,000 have been raped at least once during their lives[vi] ❑ **Reduce the amount of youth violence** ▪ See the *Healthy Youth* Logic Model ❑ **Reduce Substance Abuse and Tobacco Use** ▪ Refer to the *Alcohol and Drug Free Women* and the *Tobacco Free Women* Logic Model ❑ **Increased Access to Essential Health Services** ▪ Refer to the *Access to Services* and the *High Quality Health Care for Non-Pregnant Women* Logic Models ❑ **Improved Mental Health for Women of CBA** ▪ Refer to the *Access to Services* Logic Model

[i] Providing Perinatal Partnership Against DV (PPADV) Training for providers Distribution of PPADV Curriculum Develop and support PPADV trainers with materials as needed.

[ii] Healthy Relationships Project: The purpose of the Healthy Relationships proposal is to increase positive relationships for youth by using a prevention approach to promote healthy relationships and through collaboration with internal and external partners to understand youth violence issues.

51

[iii] Nine Months to Get Ready is a health education booklet of approximately 70 pages that is available to pregnant First Steps clients and WIC clients. MIH and WIC collaborated to revise the booklet. The new and much-improved edition is nearly ready to go to press now. The booklet covers the basics of pregnancy and prenatal care, breastfeeding promotion, family planning, healthy lifestyle, and touches briefly on postpartum adjustment and newborn safety issues (signs of newborn illness, back sleeping, Shaken Baby Syndrome, etc).

[iv] http://www.doh.wa.gov/HWS/doc/TV/TV_DV.doc

[v] http://www.doh.wa.gov/HWS/doc/TV/TV_DV.doc

[vi] http://www.doh.wa.gov/cfh/Injury/pubs/Rapes_in_Washington.pdf