MEETING STATE MCH NEEDS: A SUMMARY OF STATE PRIORITIES AND PERFORMANCE MEASURES

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

As part of their collaborative relationship with the Maternal and Child Health Bureau (MCHB), State and jurisdictional Maternal and Child Health (MCH) grantees (also referred to in this report as States or State block grantees) participate in extensive planning and evaluation processes. Beginning with a comprehensive needs assessment conducted every five years, States evaluate the needs of their MCH population, assess State resources, identify priority needs, and specify how they will measure success in meeting these needs. In addition to regularly reporting on a list of National Performance Measures (NPMs), States develop their own State Performance Measures (SPMs) that can assess performance that is not captured by National Performance Measures or that serve to enhance results obtained from National Performance Measures.

The Child Health Program of the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, under contract with the Federal Maternal and Child Health Bureau, reviewed changes in State and jurisdictional priority needs and how performance is measured in meeting those needs. Three aspects of the needs assessment and priority setting process required by each MCH grantee were examined:

- State Needs Assessments for the year 2005 were reviewed to examine priority needs identified by each State and compare them to priority needs identified in the 2000 Needs Assessment,

- Review of State documents to identify other needs described by States but not included in the State's required list of seven to ten priority needs, and

- Review of State Performance Measures to examine how they link to State priority needs and the sources of data that are being used by States in measuring achievement in meeting priority needs.

COMPARISON OF PRIORITY NEEDS

Each State is required to specify at least seven and no more than ten priority needs for their population, identified as part of their 5-year Needs Assessment. Assessment of how needs have changed from the previous Needs Assessment in 2000 to the most recent Needs Assessment in 2005 can provide insight into what is happening in the MCH population in the United States in general and provide information to the MCH Bureau and others for program planning.

The exact wording of each priority need listed by each State block grantee in 2005 and in 2000 was examined. Each need statement was categorized as follows:

1. What is the health issue or activity that has been identified as a priority need? Examples of health issues or activities include improving access to oral health care or reducing tobacco use.

2. Is the issue or activity targeted at specific populations or specific activities, for example, reducing the pregnancy rate among adolescents?

3. Who is the target population? Is it children, adolescents, pregnant women, Children with Special Health Care Needs, or others or all MCH populations?

4. Is there a subpopulation? For example, improving nutrition and exercise might be targeted at public school children.

This information was summarized to look at trends for the States in broad areas of focus across the five years. The findings are summarized here and displayed in Table 1 on page 19 of the complete report. Maps showing States with selected priority needs are also included beginning on page 23. For a detailed description of all priority needs, see the Appendix (page 43).

Key Findings

There was significant <u>increase</u> in State priorities to address specific health and health care issues.

More States are emphasizing the need to reduce obesity and overweight.

More than one-half of all States (34 of 59) identified reduction of obesity and overweight as a priority need in 2005 compared to just 10 States in 2000.

Closely related to efforts to reduce obesity and overweight were priority needs to promote healthy nutrition and exercise. The number of States targeting nutrition and physical activity increased from 9 in 2000 to 15 in 2005.

Overall, 43 of 59 States identified either reduction of obesity and overweight or promotion of nutrition and exercise as a priority need in 2005.

The mental health needs of MCH populations are an area of focus of twice as many States.

Improvement in mental health and access to mental health services was a priority need for half of the States (30) in 2005, more than double the number of States (14) that included mental health needs in 2000. This category includes States that named mental health or mental health care specifically and does not include States with priorities to reduce suicide, child abuse, or domestic violence, which were most often included in State priorities addressing injury reduction without mention of mental health care. Even though suicide and other injury needs were included in the injury category and not mental health, it is recognized that mental health issues are important considerations in the prevention of suicide and many other injuries and that activities to reduce these injuries may include a focus on mental health care.

More States have identified a priority need to assure a medical home and/or care coordination and want to expand these services to more than only Children with Special Health Care Needs.

The number of States with a priority need to assure a medical home and/or care coordination for their populations increased by almost two-thirds, from 17 States in 2000 to 28 States in 2005. Of note in 2005 was the addition of new populations to whom these important health care services would be expanded, including women and children.

Some priority needs have remained relatively <u>constant</u> over the years but continue to be priorities for many states.

Improving health and improving access to health care including oral health remain important priority needs for more than half of all States.

A primary focus of State MCH agencies is on improving the health of mothers, children and families including ensuring access to health care services of all types. The priority to improve health and access to care has been a consistent among State MCH agencies with about 60% of States specifying a need to improve health in general and improve oral health and access to care in 2000 and in 2005.

Access to prenatal care is a longstanding MCH priority. Now more States are working to improve preconceptional and interconceptional health.

Four times as many States (3 in 2000 and 13 in 2005) identified preconceptional and interconceptional health as a priority. The number identifying prenatal care decreased only slightly from 16 in 2000 to 14 in 2005.

Almost one-half of State grantees include pregnancy outcomes among their priority needs.

Improving pregnancy outcomes is a continuing need for State MCH agencies. Specific outcomes targeted by States include reducing low birth weight and preventing infant mortality.

Reducing disparities in health outcomes and access to health care is a priority for many States.

Populations targeted in activities to decrease disparities included racial and ethnic minorities, populations by geography, and disadvantaged populations among others. Health problems targeted ranged from general (health status) to specific (low birth weight).

The comprehensive needs assessment process sometimes leads to replacement of specific needs with new areas of emphasis or re-specification of goals and objectives.

There were needs that were less likely to be included by States in 2005. Replacement of a priority need can occur when States shift their program emphasis or re-specify needs in response to the MCHB application requirement that they list no more than 10 needs.

Injury prevention, reduction of legal and illegal substance use, and improving pregnancy, fertility and birth rates were all areas identified by more than 40% of States although the number of States with these priority needs decreased between 2000 and 2005.

The needs of all MCH populations were addressed. State MCH agency infrastructure needs to support program activities were also among listed priority needs.

For the **maternal and infant population**, birth rate was less often stated as a priority need as were pregnancy outcomes with the exception of infant mortality.

For **children**, there has been a shift in focus away from needs stated as access to care or addressing risk behaviors and injury toward healthy lifestyles, including reducing obesity and overweight.

Many States continued their focus on **adolescent** reproductive health in 2005. The need to address adolescent risk behaviors also remained a priority for many States and adolescents were included in the move toward promoting healthy lifestyles.

For **Children with Special Health Care Needs**, there has been consistent focus on assuring access to care and assuring that CSHCN have a medical home and care coordination. Transition and transition services increased as an area of focus.

For **women,** priority needs addressed many aspects of health and health care including access to care, injury prevention, and reduction of risk behaviors. Reduction of obesity and overweight and promoting healthy lifestyles was a new area of focus for women as well as for children.

State MCH Agency needs were included by two-thirds of States in both years. The need for data and surveillance decreased in 2005 while other agency needs such as the need for developing systems of care or interagency collaboration remained constant.

OTHER NEEDS IDENTIFIED BY STATES IN THE NEEDS ASSESSMENT PROCESS

The selection of priorities for MCH programs and activities requires that States carefully consider all the needs of the populations they serve, rank or otherwise prioritize these needs, and then choose up to ten to be included in their MCH grant application. Some States choose needs that are specific rather than broad, frequently choosing needs for which a system to measure success is already in place. Others discuss their needs in broader terms and select specific measures to represent success in meeting these needs.

Needs Assessment documents of three States chosen to represent each Department of Health and Human Service (DHHS) region were reviewed to determine which priority needs individual States identified but did not include on their final list of needs reported on Form 14. Needs Assessment documents were examined first to see if larger lists of priorities from which the final list was drawn were included and, if so, which needs presented by the stakeholder group were not included in the final State list of priority needs. The text of those documents without preliminary lists was also reviewed for information regarding issues considered but not included.

Key Findings

This focused review of Needs Assessment documents suggests that there are two main categories of needs that are not listed – those that are relatively new and those that are longstanding. "New" needs noted in this review included insurance, child care, basic needs and mental health. Longstanding needs included oral health, injury, substance abuse, healthy pregnancies, access to care, morbidity and mortality, and the needs of CSHCN. If the 2005 needs assessment process is any indication, one would expect to see many of these new needs on State priority lists in 2010. Although rationale for not including needs was not often stated, one can speculate that addressing many of the emerging needs means that MCH programs must move beyond their traditional

programs and activities and develop new partnerships to address the problems facing families.

REVIEW OF STATE PERFORMANCE MEASURES

Each State MCH agency must develop State Performance Measures (SPMs) to supplement the National Performance Measures (NPMs) required of all States. These SPMs allow states to measure progress in meeting state priorities that is not captured by the NPMs or may enhance data collected by national measures. State documents were reviewed to explore how closely State Performance Measures are linked to priority needs and the data sources used by States for these performance measures.

Key Findings

Linking Performance Measures to Priority Needs

- State Performance Measures, in the most general sense, reflect the priority needs identified by States. Many SPMs are specified to provide measures for broad areas of MCH activities such as primary and preventive care, access to all types of care, morbidity and mortality, reproductive health including birth outcomes, and health promotion. As was noted for the priority needs, some States develop performance measures that look at health problems with a focus on prevention while others develop measures that assess treatment activities. State Performance Measures that assess programs to improve nutrition and exercise versus those that seek to reduce obesity and overweight provide examples of the diverse ways that States approach the needs of their constituents.

- More specific areas of focus for grantee SPMs also reflect the shift in priority needs observed in review of the 2005 needs assessment process.

  - SPMs that address nutrition and physical activity are included by 47 grantees (80%). Of these, obesity is the focus of SPMs for 35 States and is another indicator of the importance that MCH grantees place on this health care problem.

    It is important to note that many SPMs classified in the TVIS as related to nutrition and physical activity are actually worded as measures of reduction of obesity and overweight. Thus, the number of States identified here as focusing on nutrition and physical exercise is much higher than the number of States with priority needs with that focus due to differences in classification schemes. Regardless of whether the SPM is written in terms of obesity and overweight or nutrition and physical exercise, 47 States have a State Performance Measure that addresses healthy weight for the MCH population.

- Mental health has been identified as an emerging area of focus in MCH priorities and 37 States (63%) included a State Performance Measure to measure progress in their efforts to address the mental health needs of MCH populations.

- Additionally, two-thirds of States have SPMs to measure progress in combating substance abuse with 57% targeting tobacco use specifically.

- One or more oral health SPMs are included by one-half of States.

- Not all States describe the links between their priority needs and performance measures but among those that did, States also linked specific National Performance Measures to priority needs.

- Twenty-one (21) States included multiple performance measures per priority need. The most common scenario was specifying multiple performance measures to form a composite measure of success for each priority need.

Identifying Data to Measure Performance

Data sources used by States to calculate their SPMs varied and included both national data and State-specific data. The use of national and other comparable data allows for consistent measurement over time and for comparison of performance from State to State if States have similar goals and state them in comparable ways.

- Vital records are the most commonly used source of data for State reporting and are used mainly for measures of prenatal care and natality and, to a lesser extent, for measures of mortality.
- Hospital data serve as another source of information that is collected by States in a manner that allows aggregate to the national level and comparison across States. States are using hospital data for SPMs in the area of hospitalizations for asthma or injury or to assess visits to the emergency department.

National survey data used by the States include:

- Pregnancy Risk Assessment Monitoring System (PRAMS), a source of data of particular importance for intendedness of pregnancy.

- Youth Risk Behavior Survey (YRBS), used by States to measure obesity and also tobacco and alcohol use in youth.

- Behavioral Risk Factor Surveillance System (BRFSS), important for some States in measures of smoking.

- The National Survey of Child Health (NSCH), the Pediatric Nutrition Surveillance System (PedsNSS) and the State and Local Area Integrated Telephone Survey (SLAITS). Examples of data from these sources include measures of physical activity (NSCH), breastfeeding (PedsNSS), and access to services for CSHCN (SLAITS).

National program data is another source of data for State Performance Measures:

- Medicaid data, used by States to report on receipt of dental care and EPSDT screening.

- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) data, used by States to report on overweight in children and breastfeeding among postpartum women.

States use State data systems or State surveys for more than one-third of their SPMs. These State data sources include special surveys, program data and data from other agencies. Among the more commonly cited sources are data from family planning programs, environmental lead screening programs, and CSHCN programs. One notable use of non-MCH data is the use of data from social services agencies or police departments to measure changes in reports of child abuse and neglect.

MEETING STATE MCH NEEDS: A SUMMARY OF STATE PRIORITIES AND PERFORMANCE MEASURES

PURPOSE OF THE REPORT

The Child Health Program of the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, under contract with the Federal Maternal and Child Health Bureau (MCHB), reviewed changes in State and jurisdictional priority needs and how they are measured. Three aspects of the needs assessment and priority setting process required by each State and jurisdictional MCH grantee (hereinafter referred to as States) were examined:

- State Needs Assessments for the year 2005 were reviewed to examine priority needs identified by each State and compare them to priority needs identified in the 2000 Needs Assessment,

- Review of State documents to identify other needs described by States but not included in the State's required list of priority needs which is limited to seven to ten needs, and

- Review of State Performance Measures to examine how they link to State priority needs and the sources of data that are being used by States in measuring achievement in meeting priority needs.

This report was prepared for MCHB to provide a broad overview of the areas identified by States as important for their constituents, to anticipate to some degree what priorities may arise in the next 5-year State planning cycle, and to determine what data States are using and what data they may need.

There are three sections in this report, corresponding to the areas of focus listed above:

BACKGROUND - STATE MATERNAL AND CHILD HEALTH PRIORITY SETTING AND PERFORMANCE REPORTING

The Maternal and Child Health Bureau operating within the Health Resources and Services Administration (HRSA) administers the Title V program and works as a partner with the States. This partnership acknowledges the unique abilities and concerns brought to MCH issues by each State. While many problems faced by mothers, children and families throughout the country are the same, States also face unique challenges and State MCH programs are in the best position to assess the needs of the population they serve, design programs to address these needs, and evaluate success. Thus, this partnership blends the needs of the nation's mothers, children and families as a group with the unique needs of those living in different States.

Title V support has evolved over time in terms of both how funds are provided to the States and how the States must account for how they use these funds to further the cause of women, children, and families they serve. A change from categorical programs to block grants recognizes the needs of individual States to address their own problems. With increased flexibility in use of Federal funds for program implementation came the obligation to account for how those dollars were spent and what impact they had on the lives of the target population. The evolution of accountability has occurred over the past 20 years. Needs assessment was the first accountability measure to be required and mandated performance measures were second, instituted in 1997.

Today, each State and jurisdictional MCH grantee is required to specify at least seven but no more than ten priority needs for their population, identified as part of their 5-year Needs Assessment. These priority needs are reported routinely on Form 14 of each year's Application/Annual Report. The needs assessment process is a lengthy and complex one and should inform the process by which States set their priorities. MCHB limits to ten the number of priority needs States can list on Form 14 of their Application but States may identify other areas of focus in their needs assessment process. An area of increasing public health concern may be identified as a new priority need and replace a need for which the State is making steady and long-term progress with a well-established program. These "old" needs and others that States are just beginning to explore or for which they may not yet have a cohesive plan may not make their Form 14 list of priority needs but still be a focus of State activity.

In order to measure progress in addressing their priority needs, States must report on both National and State Performance Measures. A set of National Performance Measures (NPMs) developed in the 1990's and revised periodically, provides uniform measurement of progress across States. These uniformly collected data allow assessment of progress nationwide on issues representative of the health of

America's mothers, children and families. In order to address their unique needs, States also specify State Performance Measures (SPMs) that may be related to performance in meeting State priorities that is not captured by the national measures or may enhance the data collected by National Performance Measures.

PART 1 - COMPARISON OF PRIORITY NEEDS

The first component of the work conducted under this contract was a review of priority needs, comparing needs identified in State or jurisdictional 2000 Needs Assessments with those identified as part of the 2005 Needs Assessment.

THE REVIEW PROCESS – FOUR STEPS

Step 1 - Review All Priority Needs for 2000 and 2005

Each State's priority needs for 2000 and for 2005 were reviewed in detail. The focus of the review was on trends across States in the areas identified to be the main needs of the MCH population and not on individual change in those needs within States.

Step 2 - Develop Decision Rules for Coding Priority Needs

The wording of priority needs across States varies considerably. Some priority needs are specific, e.g., "reduce infant mortality", and others are broad, e.g., "improve health among MCH populations". Some priority needs are broad in scope in order to address for the needs of multiple populations or report on multiple activities within the framework of the priority needs requirements of the application. Needs may be worded to specify the desired outcome, e.g., "improve birth outcomes" or the activity that will accomplish that outcome, e.g., "increase access to prenatal care". Some need statements incorporate both the activity and the outcome in a single statement.

The review of priority needs considered the following areas:

1. What is the health issue or activity that was identified as a priority need?
   Examples: Injury
   Access to care
   Pregnancy rate

2. Are there details that further describe the issue or activity?
   Examples: Injury: Motor vehicle crashes among 15-19 year olds
   Access to care: Access to oral health services
   Pregnancy rate: Unintended pregnancies

3. Who is the target population?
   Examples: Children
   Adolescents
   Children with Special Health Care Needs (CSHCN)

4. Is there a subpopulation within the target population?
   Examples: Children: Children on WIC
   Adolescents: Pregnant adolescents
   CSHCN: Youth with Special Health Care Needs

Variation in the wording of priority needs required basic decision rules to guide the classification of each need in order to create a dataset to examine trends. The distinction between health issue and activity is particularly important as many needs could be classified as one or the other with only a few changes in the wording, e.g., improve dental health or improve access to dental care.

Using the classification framework described above, each need was reviewed first to determine if it could be classified as a single need or as more than one need. Most priority needs were classified as one need but occasionally the priority need was complex and varied enough to merit two needs. An example of such a need follows:

> "Improve mental health and decrease substance abuse among children, adolescents, and pregnant and parenting women."

In the case of a need that was stated as an activity leading to a goal, e.g., improve access to preventive care to improve health, most were classified by their activity, particularly if the goal was to improve health by implementing that activity or assuring access to a service. It is assumed that the goal of all MCH activities is to improve health.

The target population was determined from the wording of the need. Some needs were stated simply, e.g., "improve access to health care" or "reduce injuries", and in those cases the target population was coded as all MCH populations.

Because the wording of priorities varies to such a degree, it is unlikely that all persons would interpret all needs in exactly the same way. Review of priority needs for this report was carried out by two project staff members with extensive MCH experience and agreement was reached on classification of each need. Others may disagree with the classification of some needs but for the purpose of comparison over time, this review made every attempt to be consistent across years.

Step 3 - Create a Database of Priority Needs

A table that listed the 2005 priorities next to the 2000 priorities was created for each State and each need was classified as in the examples below.

PRIORITY NEED	CLASSIFICATION
Reduce the rate of unintended pregnancy.	Issue: Pregnancy rate Issue Detail: Unintended pregnancy Target Population: Maternal/Infant Subpopulation: None
To provide physical examination to all children in grades 1 to 12 and provide appropriate intervention on an annual basis.	Issue: Access Issue Detail: Annual physical exams Target Population: Children Subpopulation: School-aged
Establish a medical home and increase care coordination for children with special health care needs.	Issue: Access Issue Detail: Medical home Issue Detail: Care coordination Target Population: CSHCN Subpopulation: None
To reduce the percentage of children who are overweight among WIC children 0-5 years of age.	Issue: Obesity and overweight Issue Detail: None Target Population: Children Subpopulation: WIC, age specific (0-5yr)
To strengthen the Health Information System to provide essential data to strengthen health care services focusing on preventive services.	Issue: Data and surveillance Issue Detail: Strengthen services/focus on prevention Target Population: MCH Agency Subpopulation: None

Step 4 - Summarize Needs

The classification categories for each priority need were entered into an Excel spreadsheet database to allow tabulation for specific issues and populations. The database of needs could be used to classify needs on several dimensions. For the purposes of this report, priority needs were examined in two ways. First, they were classified by the health or health care problem they addressed. Second, they were examined by the target MCH population group.

Improvement in health status was a frequently identified need and included health in general, oral health, mental health and behavioral health. Priority needs were frequently stated in terms of access to care and included different types of health care as well as the comprehensiveness of health care. In addition to health and health care, issues covered by priority needs were often specific to health issues such as birth outcomes, obesity and overweight, and health behaviors such as tobacco use.

The target population for each need, with the exception of the State MCH agency (see below), was assigned first to one of the three traditional core MCH populations and then to a subpopulation as appropriate. Core MCH populations included:

- Pregnant Women, Mothers, and Infants (Maternal/Infant or MI)
- Children and Adolescents
- Children (and Youth) with Special Health Care Needs (CSHCN or CYSHCN)

Specific subgroups of the core populations include women of childbearing age and other groups such as racial or ethnic minorities, low-income populations, or participants in public programs, to name a few.

As noted above, some needs were worded without reference to specific MCH populations and those needs were considered to be written for **all** MCH populations. Other populations mentioned specifically by some States included families, community, and citizens of the State.

Some priority needs as specified involved significant activity on the part of the State MCH agency and the agency was considered to be the target population. Typical needs in this category were the development of data collection and/or analysis capability and interagency collaboration to meet program goals.

Classifying a need as changed or unchanged was sometimes challenging. Only a few States worded needs exactly the same from needs assessment year to needs assessment year. In a few States, the wording and specificity of needs changed completely. The reviewers considered needs to be the same if their wording did not change at all or the intent and essential activities were the same. An example of the latter follows:

2000: "All three MCH populations should have access to quality oral/dental health."

2005: "Increase access to oral health services, providers, facilities, resources, and payer sources among the MCH populations."

RESULTS

Total Number of Priority Needs

There were 559 State priority needs in 2005. The average number per State (States can specify seven to ten) was 9.5 compared to 9.4 in 2000. On average, 4.2 needs per State were unchanged between 2000 and 2005.

A note of reminder: all references to States in the results presented in this section include all 59 MCH block grantees, both States and jurisdictions.

Changes in Priority Needs between 2000 and 2005

Aggregated categories of need (Table 1) were created to provide a "big picture" overview of the priority needs identified by State MCH agencies. The table looks at trends in two ways. The change in emphasis by States over time is captured in the second column, which starts with areas with the greatest increase in focus. The number of States identifying specific needs is seen in the third column. It should be noted that needs that have not changed appear in the middle of the table even though they have been identified as important by many States.

Table 1:

Health Problem or Issue	Change 2000 to 2005	Number of States 2000 vs 2005
Healthy lifestyles:		
Obesity and overweight	↑↑	10 vs 34
Nutrition and exercise	↑↑	9 vs 15
Mental health improvement & access to mental health care	↑↑	14 vs 30
Medical home / care coordination	↑↑	17 vs 28
Health improvement and access to health care	↑	36 vs 38
Oral health improvement and access to oral health care	↑	34 vs 35
Pre- or interconceptional care	↑↑	3 vs 13
Prenatal care	↓	16 vs 14
Pregnancy outcomes	↓	28 vs 26
Disparity reduction	↓	28 vs 26
Injury prevention, including suicide	↓↓	41 vs 33
Legal & illegal substance use	↓↓	34 vs 26
Pregnancy, fertility, birth rates	↓↓	35 vs 25

How to Read this Table

Health Problem or Issue

Broad categories of need are listed and are ordered by the amount of change in the number of States listing this need

Change 2000 to 2005

Amount of change from year to year is indicated by arrows:

↑↑ = substantial increase

↑ = some increase

↓ = some decrease

↓↓ = substantial decrease

Number of States 2000 vs 2005

Number of States with the problem/issue as a priority need in 2000 vs 2005.

Selected priority needs, chosen in collaboration with MCHB staff, are displayed graphically in US maps that are included at the end of the Key Findings section (page 23).

Key Findings

There was significant increase in State priorities to address specific health and health care issues.

More States are emphasizing the need to reduce obesity and overweight.

More than one-half of all States (34 of 59) identified reduction of obesity and overweight as a priority need in 2005 compared to just 10 States in 2000 (see Map 1 for States with this priority need in 2005). Most States target children and/or adolescents in their weight reduction efforts although some States include initiatives for women.

Closely related to efforts to reduce obesity and overweight were priority needs to promote healthy nutrition and exercise. The number of States targeting nutrition and physical activity increased by two-thirds, from 9 in 2000 to 15 in 2005 (Map 2). States with this health promotion focus were more likely to target all MCH populations.

Overall, 43 of 59 States identified either reduction of obesity and overweight or promotion of nutrition and exercise as a priority need in 2005.

The mental health needs of MCH populations are an area of focus in twice as many States in 2005.

Improvement in mental health and access to mental health services was a priority need for half of the States (30) in 2005 (Map 3), more than double the number of States that included mental health needs in 2000. This need crossed all MCH populations and ranged from specific needs, such as the need to improve counseling for pregnant women, to broad needs such as improving interagency collaboration to bring attention to mental health issues for MCH populations.

This category does not include State priorities to reduce suicide, child abuse, or domestic violence, which were included by some States in priority needs addressing injury reduction without mention of mental health care. Even though suicide and other injury needs were included in the injury category and not mental health, it is recognized that mental health issues are important considerations in the prevention of suicide and many other injuries and that activities to reduce these injuries may include a focus on mental health care.

More States have identified a priority need to assure a medical home and/or care coordination and want to expand these services to populations other than Children with Special Health Care Needs.

The number of States with a priority need to assure a medical home and/or care coordination for their populations increased by almost two-thirds, from 17 States in 2000 to 28 States in 2005 (Map 4). Of note in 2005 was the addition of new populations to whom these important health care services would be expanded. Previous medical home/care coordination needs focused primarily on CSHCN, but 2005 needs included women and children in general.

Some priority needs have remained relatively constant over the years but continue to be priorities for many states.

Improving health and improving access to health care including oral health remain important priority needs for more than half of all States.

A primary focus of State MCH agencies is on improving the health of mothers, children and families including ensuring access to health care services of all types. The priority to improve health and access to care has been a consistent among State MCH agencies with about 60% of States specifying a need to improve health in general and improve oral health and access to care in 2000 and in 2005.

Access to prenatal care is a longstanding MCH priority. Now more States are working to improve preconceptional and interconceptional health.

Four times as many States identified preconceptional and interconceptional health as a priority in 2005 compared to 2000 (Map 5). The number identifying prenatal care decreased only slightly (Map 6).

Almost one-half of grantees include pregnancy outcomes among their priority needs.

Improving pregnancy outcomes is a continuing need for State MCH agencies. Specific outcomes targeted by States include reducing low birth weight and preventing infant mortality.

Reducing disparities in health outcomes and access to health care is a priority for many States.

Populations targeted in activities to decrease disparities included racial and ethnic minorities, populations by geography, and disadvantaged populations among others. Health problems targeted ranged from general (health status) to specific (low birth weight).

The comprehensive needs assessment process sometimes leads to replacement of specific needs with new areas of emphasis or re-specification of goals and objectives.

There were needs that were less likely to be included by States in 2005. Replacement of a priority need can occur when States shift their program emphasis or re-specify needs in response to the MCHB application requirement that they list no more than 10 needs.

Injury prevention, reduction of legal and illegal substance use, and improving pregnancy, fertility and birth rates were all areas identified by more than 40% of States although the number of States with these priority needs decreased between 2000 and 2005.

The needs of all MCH populations were addressed. State MCH agency infrastructure needs to support program activities were also among listed priority needs.

For the **maternal and infant population**, birth rate was less often stated as a priority need as were pregnancy outcomes with the exception of infant mortality.

For **children**, there has been a shift in focus away from needs stated as access to care or addressing risk behaviors and injury toward healthy lifestyles, including reducing obesity and overweight.

Many States continued their focus on **adolescent** reproductive health in 2005. The need to address adolescent risk behaviors also remained a priority for many States and adolescents were included in the move toward promoting healthy lifestyles.

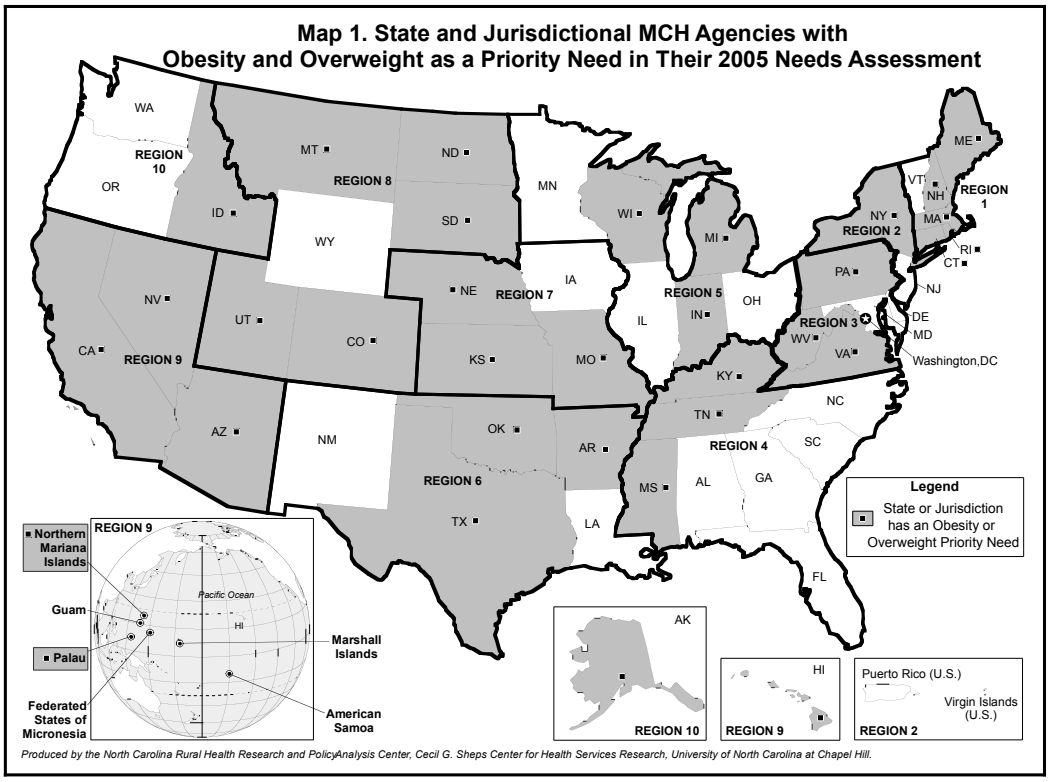
For **Children with Special Health Care Needs**, there has been consistent focus on assuring access to care and assuring that CSHCN have a medical home and care coordination. Transition and transition services increased as an area of focus.

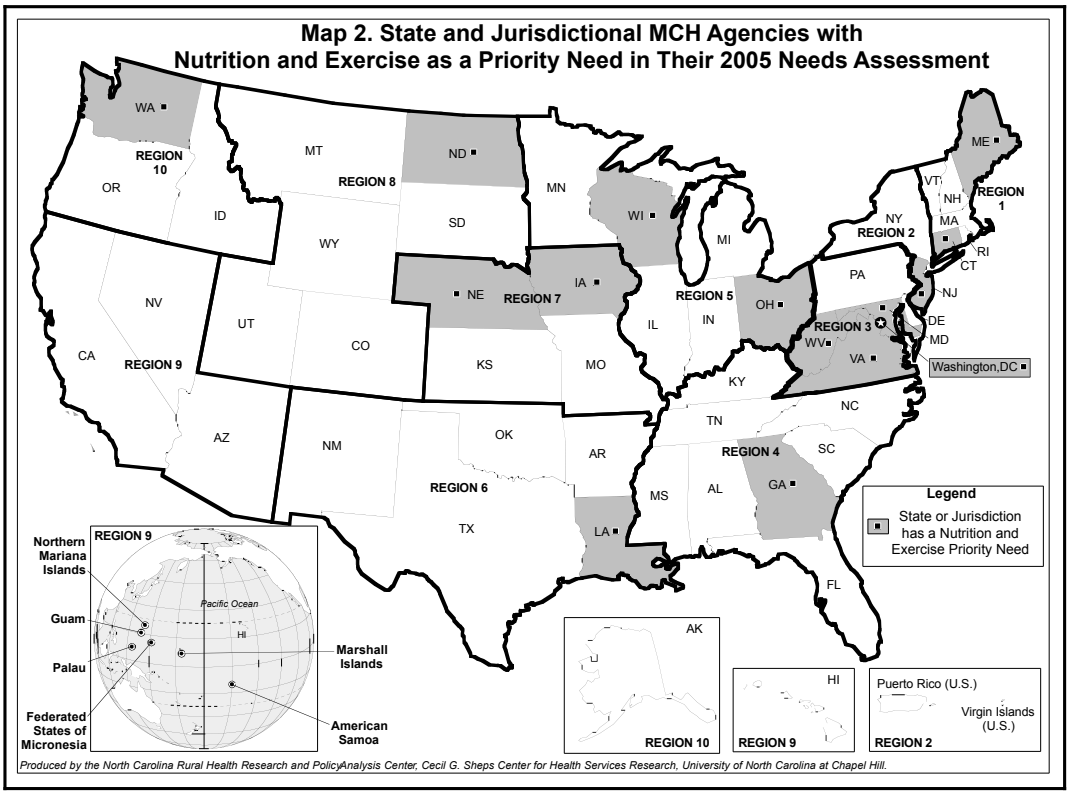
For **women,** priority needs addressed many aspects of health and health care including access to care, injury prevention, and reduction of risk behaviors. Reduction of obesity and overweight and promoting healthy lifestyles was a new area of focus for women as well as for children.

State MCH Agency needs were included by two-thirds of States in both years. The need for data and surveillance decreased in 2005 while other agency needs such as the need for developing systems of care or interagency collaboration remained constant.

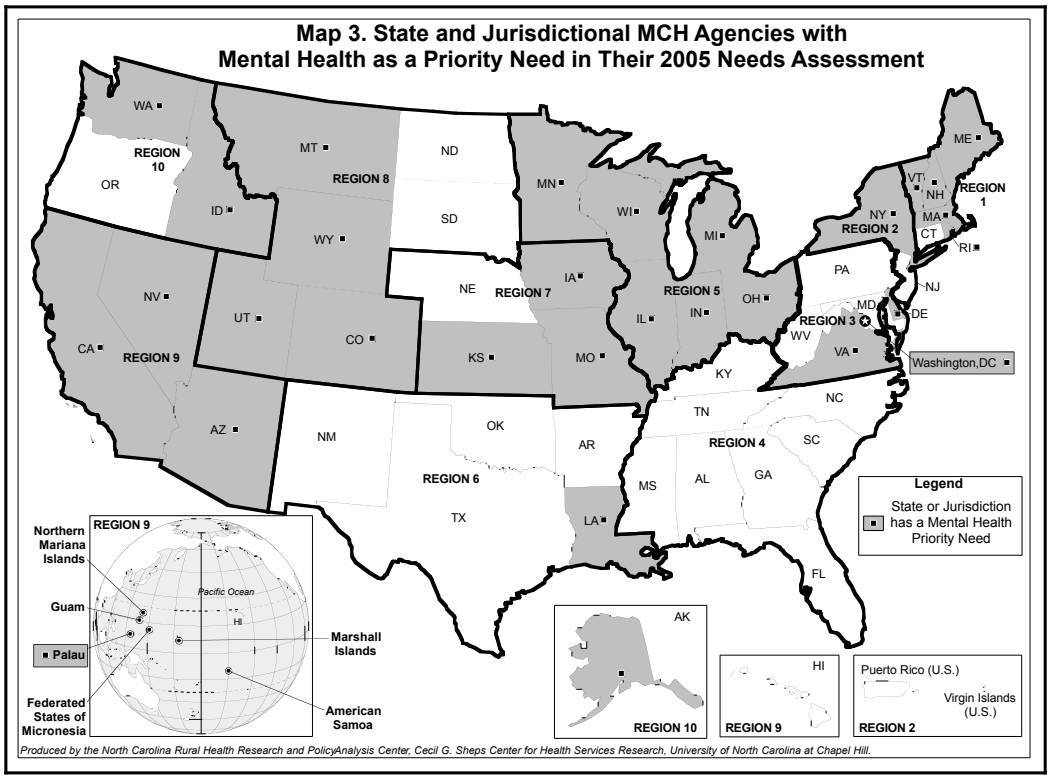
Detailed description of the priority needs described in this section is included in the Appendix.

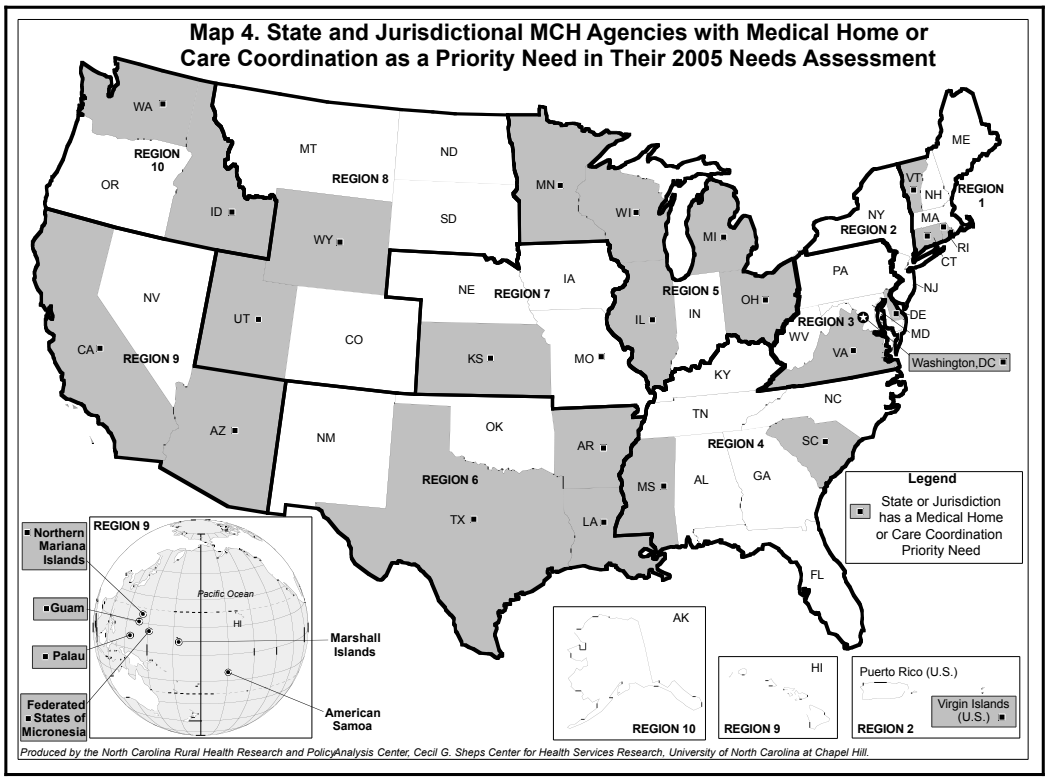
Maps 1 and 2 show States with obesity and overweight (Map 1) or nutrition and physical exercise (Map 2) as a priority need in 2005.



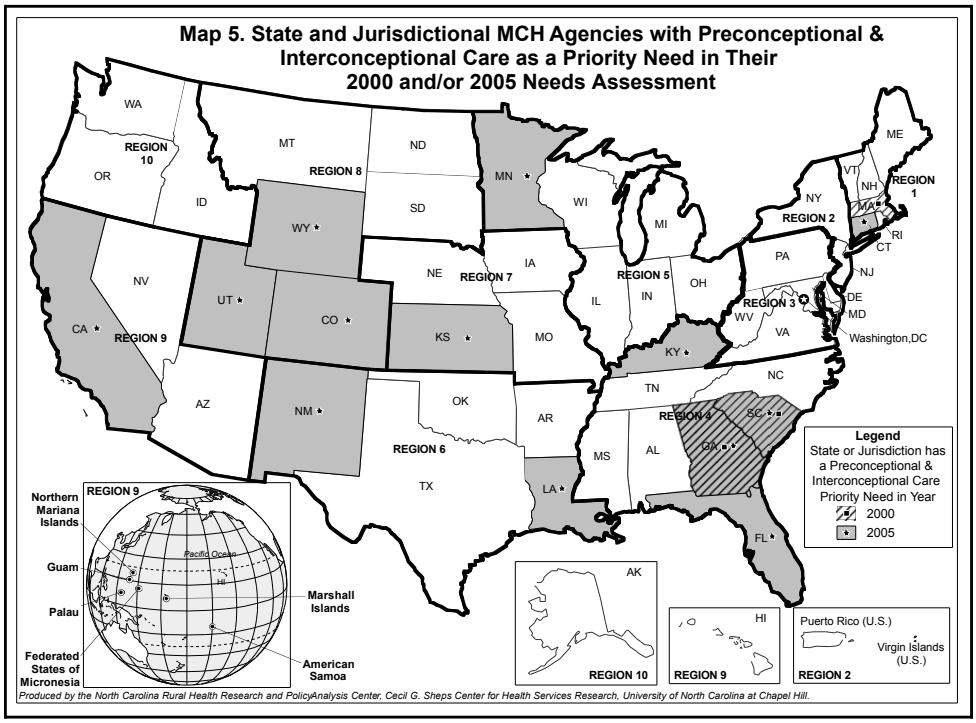


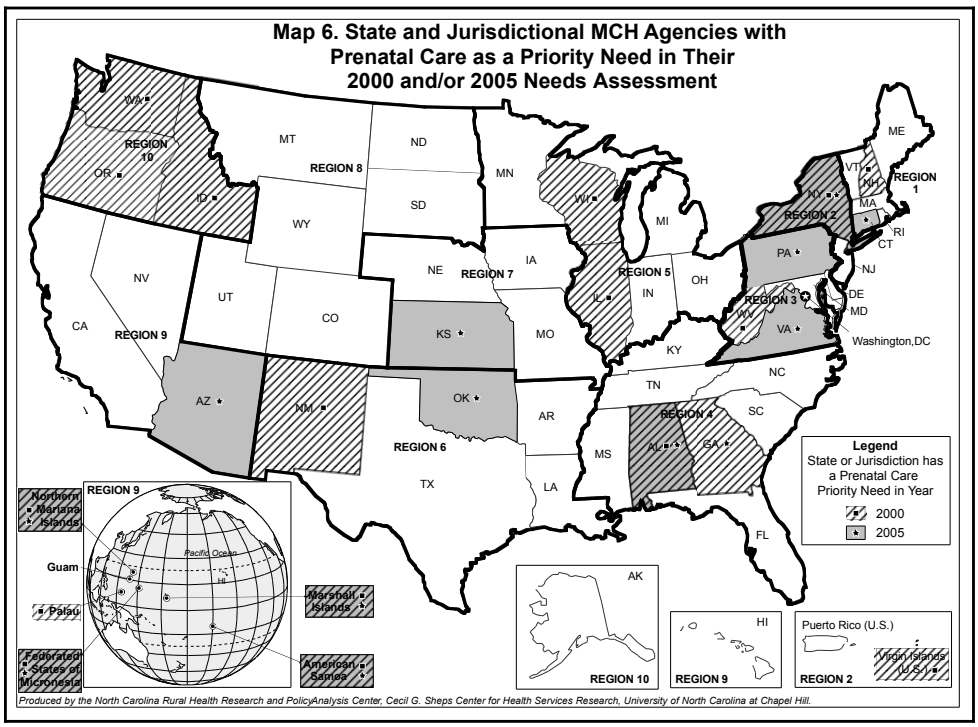
Maps 3 and 4 show States with mental health (Map 3) or medical home or care coordination (Map 4) as a priority need in 2005.





Maps 5 and 6 show States with priority needs for preconceptional and interconceptional care and for prenatal care in both 2000 and 2005. Comparison across years allows assessment of change in these closely related activities. It does not appear that States have replaced their priority need for prenatal care with one for preconceptional and interceptional care.





PART 2 - OTHER NEEDS IDENTIFIED BY STATES IN THE NEEDS ASSESSMENT PROCESS

The State needs assessment process is a comprehensive and complex process that engages public health officials and stakeholders and results in the identification of all issues of concern for mothers, children, and families. In this comprehensive activity, States are likely to identify other problems that are not included in their list of seven to ten priority needs. They may have plans to address those needs even though the needs do not make their list of priorities.

Needs considered to be a priority that do not make a State's priority list may be omitted for many reasons such as not ranking high enough in a consensus-based priority-setting process. Priority needs that were not included on a State's seven to ten priority needs may indicate areas where considerable need remains but progress is being made, or they may indicate areas of emerging concern.

Selected State Needs Assessments were reviewed in part 2 of this project to see what other needs State MCH agencies have identified. This information may be useful in anticipating changes in MCH focus in the future.

THE REVIEW PROCESS

Selection of States for Review

Needs Assessment documents were reviewed for three States from each DHHS region and included the following States and jurisdictions:

Region 1	Region 2	Region 3	Region 4	Region 5
Maine New Hampshire Massachusetts	New York Puerto Rico Virgin Islands	Virginia Maryland Pennsylvania	Mississippi North Carolina Kentucky	Indiana Ohio Minnesota
Region 6	**Region 7**	**Region 8**	**Region 9**	**Region 10**
Arkansas Texas New Mexico	Iowa Kansas Nebraska	South Dakota Utah Wyoming	California Hawaii Palau	Washington Idaho Alaska

Two States from each region were selected randomly and the third State was chosen for balance and to ensure jurisdictions were represented as well as diversity in population groups.

Document Review Process

Needs Assessment documents for selected States and jurisdictions were reviewed to determine which priority needs individual States identified but did not include on their final list of needs reported on Form 14.

In an effort to be as systematic as possible in this review and to avoid judgments on the part of the reviewers as to which problems were of most concern for a State, data for this review were obtained from the documents in a two-step process.

- Needs Assessments were examined first to see if larger lists of priorities from which the final list was drawn were included. For example, a State might hold stakeholder meetings and specific stakeholder groups, such as groups that focused on specific MCH populations, each recommended 5 priority needs for consideration for the final list of priority needs. Those preliminary lists were reviewed to see which needs presented by the stakeholder group were not included in the final State list of priority needs. Some States also sought input from local health departments and priority lists from those groups were also included in some Needs Assessments. Table 2 provides an example of how one State (California) included various stakeholder lists of priorities in its Needs Assessment.

- Needs Assessments that did not include preliminary lists from stakeholders or other groups with input into the process were reviewed to see if other needs were mentioned in another context such as part of a list of priorities for the entire State Health Department.

- In review of all documents, special attention was paid to the Needs Assessment summary which usually included a more detailed description of which needs remained from the previous Needs Assessment and which were changed.

- No assumptions were drawn from trend data for specific MCH health and health care delivery problems that were presented as part of a State's review of the health of their population. To be included in this review, a State had to indicate that the participants in the Needs Assessment process had reviewed the data or other input and selected these issues as critical.

Table 2: Selected Lists from California's 2005 Needs Assessment Document

Categorical-Level Problems as Ranked by Local Jurisdictions (p22)	Priorities as Ranked by Stakeholder Meeting Participants (p125)	Priorities as Ranked by Children with Special Health Care Needs Stakeholders (p148)	California's 10 Priority Needs (p151)
1 Health Conditions 2 Access to Care/Services 3 Substance Abuse 4 Prenatal Care 5 Special Populations 6 Oral Health 6 Birth Outcomes 6 Breastfeeding 7 Violence 8 Mental Health 9 Injuries 10 Other Topics 11 Mortality 12 Basic Needs 13 Education	1 Overweight 2 Access to Care 3 Birth Outcomes/ Mortality 4 Mental Health 5 Substance Abuse 6 Unintentional Injuries 7 Asthma 8 Domestic Violence 9 Teen Births 10 Prenatal Care 11 Chlamydia Infections 12 Oral Health 13 Breastfeeding	1 Expand the number of qualified providers participating in the CCS program, e.g., medical specialists, audiologists, occupational and physical therapists, and nutritionists. 2 Coordinate to develop and implement a system of timely referral between mental health, developmental services, social services, special education services and CCS. 3 Increase the number of family-centered medical homes for CSHCN and the number/% of CCS children who have a designated medical home. 4 Increase access of CCS children to preventive health care services (e.g., primary care providers, well child care, immunizations, screening) as recommended by the AAP. 4 Increase family access to educational information and information about accessing CCS services, including availability of and access to services offered by health plans. 4 Increase access to services for CCS youth, 17-21 years of age. 5 Decrease the time between referral to CCS and receipt of CCS services.	1 Enhance preconception care and work toward eliminating disparities in infant and maternal mortality. 2 Promote healthy lifestyle practices among MCAH populations and reduce the rate of overweight children and adolescents. 3 Promote responsible sexual behavior in order to decrease the rate of teenage pregnancy and sexually transmitted infections. 4 Improve mental health and decrease substance abuse among children, adolescents, and pregnant or parenting women. 5 Coordinate to develop and implement a system of timely referral between mental health, developmental services, social services, special education services and CCS. 6 Improve access to medical and dental services, including reduction of disparities. 7 Expand the number of qualified providers participating in the CCS program, e.g., medical specialists, audiologists, occupational and physical therapists, and nutritionists. 8 Increase the number of family-centered medical homes for CSHCN and the number/% of CCS children who have a designated medical home. 9 Decrease intentional and unintentional injuries and violence, including family and intimate partner violence. 10 Increase breastfeeding initiation and duration.

RESULTS

What information did States include in their Needs Assessment to describe other issues they considered?

Sixty percent (60%) or 18 of the 30 States reviewed included preliminary lists of priorities from which their final priority needs were selected. Most of the preliminary lists were the result of stakeholder meetings, local health department input, or lists from other groups participating in the process. Occasionally, lists of priorities developed as part of a larger statewide initiative to improve health were included. A small number of States included in their Needs Assessment summary issues that they considered but did not select to be listed on Form 14. Overall, 21 States had needs listed that did not make the final ten priority needs.

Why were identified needs not included on a State's list of priority needs?

Very little information was provided for why some needs made the list of ten priority needs and why some did not. Most States described a consensus process by which priorities were set and they may have provided the rationale for the needs they did select but rarely for those they did not. For those States that did discuss specific needs that were not chosen and why they were not, a few reasons emerged and are described below.

- Some States noted that they did not include a need because it was already being measured by a National or State Performance Measure. States sometimes talk about setting priorities and performance measures interchangeably. For example, a State identifying a need to reduce unintentional injury to children cited the National Performance Measure to reduce motor vehicle mortality as addressing that need.

- Needs were not included in the final list of ten because another organization has responsibility for this issue or a system has been put in place to address this need. An example is the institution of a Child Fatality Review panel that would review all child deaths and, thus, addressed the identified need to reduce child mortality.

- Some issues were deemed too broad to be addressed by MCH alone and needed a statewide effort; asthma is an example of such a need.

- Even though a need was not included, some States noted that it would still be a focus of activities as resources allowed.

What were the needs that were discussed in the Needs Assessment but not included on the final priority needs list?

General categories of needs rather than specific and detailed needs such as reducing low birth weight were considered. It is important to keep in mind that most of the needs listed below were extracted from lists of needs in the State Needs Assessment and were not taken from sections with extensive discussion of the issue. Therefore, there is not a detailed description for each need. Some of the unlisted needs are in areas that might be considered as emerging issues while others are needs included by other States in their priority needs and among those discussed in Part 1 as increasing in importance for MCH agencies. As demonstrated by California's list of needs, States frequently considered a large and comprehensive set of needs for their MCH populations.

- *Insurance* – Increased access to insurance was mentioned by several States. Insurance needs included access to health insurance and dental insurance. One State referenced a need for insurance for Children with Special Health Care Needs and another noted a need to increase enrollment in their State Child Health Insurance Program (SCHIP).

- *Child care and parenting support* – Several States identified child care as a need for families in their State. Child care needs ranged from quality of day care for children to the availability of day care and/or after school care, to the need for care for specific groups such as Children with Special Health Care Needs. A few States included a related area of concern, support for parents.

- *Basic needs* – The contribution of poverty to health problems was noted by several States and the need to address the basic needs of the population was included on several lists. These basic needs included the need for adequate housing, for transportation, for food, and the need for education.

- *Oral health* – Oral health and oral health care as a priority need was frequently included on Form 14 in 2000 and 2005 (34 States and 35 States, respectively). Of the 30 States whose Needs Assessments were reviewed for this report, some noted a need for improvement in oral health or oral health care but did not include this need on their final list of priority needs. Specific needs included access to oral health services for disadvantaged populations and specific oral health services such as sealants.

- *Mental health* – Mental health and mental health care was another area of increased focus by States in the comparison of 2000 and 2005 priority needs, with the number of States including this priority doubling since the 2000 assessment. Other States acknowledged mental health as a need for their population but did not include it on their final list. Some mentioned

mental health for specific populations such as children, adolescents, and pregnant women; others noted the need to treat specific mental health problems such as postpartum depression.

- *Injury* – Injury was a need that was noted by several States but was not always included on Form 14. While some States listed the need to reduce both intentional and unintentional injuries among MCH populations, most of the needs not included focused on intentional injuries in the family, injuries such as child abuse and neglect and domestic violence.

- *Pregnancy and maternal health* – Pregnancy-related needs were among those described by States but not listed in the final ten needs. These needs covered the spectrum of maternal and infant needs and ranged from preventing adolescent pregnancy to increasing breastfeeding. Other issues include services for high-risk mothers, improving pregnancy outcomes such as low birth weight, and reducing sexually transmitted diseases.

- *Access to health care* – Access to health care was listed as a need by stakeholder groups. This broad category of needs includes access to care in general as well as access to specific services such as health screening, primary care, and immunizations.

- *Substance abuse* – Substance abuse was a category of need mentioned by a few States but not included on their final list of ten priority needs.

- *Childhood morbidity and mortality* – Several States listed needs related to specific health conditions such as asthma (although there were too few asthma needs to consider as its own category) and reducing infant, child and adolescent mortality.

- *Needs of Children with Special Health Care Needs* – Needs of CSHCN are discussed separately because they represent a special case. Many States conducted their needs assessment by dividing into groups representing the different MCH populations. The group focusing on CSHCN often conducted their needs assessment by using a process that differed from other groups. In this review, CSHCN needs often coincided with the National Performance Measures addressing the needs of CSHCN and with needs identified through the State and Local Area Integrated Telephone Survey (SLAITS). Because States could list no more than ten needs on Form 14, some States appeared to restrict the number of needs addressing CSHCN to two or three which often left others on the CSHCN list unselected. For other population groups a priority need selected was often written broadly to cross various populations, such as a need to reduce substance use among children,

adolescents and pregnant women. Sometimes these broad needs included CSHCN and sometimes they did not.

Among the specific needs for CSHCN that were noted in the Needs Assessment but not on Form 14 were the need for increased access to services, the need for family support, and the need for insurance and financial support.

PART 3 - REVIEW OF STATE PERFORMANCE MEASURES (SPMs)

Each State MCH agency must develop State Performance Measures to supplement the National Performance Measures required of all States. SPMs may or may not be linked to priority needs and may reflect other areas of concern to the State or be associated with specific State initiatives.

In Part 3 of this project, States' 2007 Block Grant Application/2005 Annual Reports were reviewed to explore how States link State Performance Measures to priority needs and what data they use for these measures.

THE REVIEW PROCESS

A systematic approach was used to examine SPMs to answer several questions. First (phase 1), general categories were determined using the search engine of the Title V Information System (TVIS). This web-based tool presents SPMs already catalogued by the population served and area of focus. The categories used by TVIS were similar to those used in the review of priority needs (Part 1) and using TVIS to get a general sense of the categories of SPMs was an efficient way to summarize them.

In phase 2 of the State Performance Measure review, grantees' 2007 Block Grant Application/2005 Annual Reports were examined to determine which performance measures States indicate are linked to their priority needs and how closely they match those needs.

Finally (phase 3), data sources for all State Performance Measures were reviewed to explore which data sources were used to measure which activities or outcomes and to what extent States are using comparable data for similar outcomes and to what extent they are using unique data.

RESULTS

What are the general categories of State Performance Measures?

The Title V Information System (TVIS) takes data routinely reported by State MCH agencies and makes it available to the public on the TVIS website where it can be used to examine trends in many MCH activities. The TVIS database includes State Performance Measures, which were already categorized by health problem, e.g., oral health, or characterized by health care service or program activity, e.g., service coordination.

Because the categories used in the TVIS classification of SPMs was similar to that used by this project's staff in categorizing priority needs, data from TVIS can be used for a preliminary look at the types of issues addressed by State Performance Measures. These categories and the number of States with a State Performance Measure in this area are listed and discussed below.

Number of States	SPM addressing:
53	Primary/Preventive HC
51	Morbidity/Mortality
47	Nutrition/Physical Activity
43	Reproductive health
40	Substance use
37	Health screening
37	Mental health
35	Obesity
34	Access to Health Care
34	Health Promotion
34	Intentional/Unintentional Injury
34	Tobacco use
33	Birth outcomes
30	Oral health
27	Quality assurance
27	Service coordination
27	Specialized care
25	Prenatal care

Number of States	SPM addressing:
23	Family Support Service
22	Program Planning/Evaluation
19	Insurance
18	School health
17	Disparities
16	Child care
15	Case management
12	Other
11	Disease/injury surveillance and investigation
11	Hearing Screening
11	Outreach
9	Communicable disease
8	Asthma
8	Information Systems
5	Folic Acid
5	Immunization
4	Neural tube defects

<u>Broad Areas of Focus for State Performance Measures</u>

- Most State MCH agencies specified SPMs to assess progress in addressing primary and preventive health care, access to health care, and morbidity and mortality. Many of these categories are sufficiently broad to include the majority of MCH programs and activities.

- Reproductive health, a traditional focus of MCH programs, characterizes SPMs in 43 States or 73% of all grantees. Thirty-three (33) States specifically targeted birth outcomes in one or more SPMs.

- Health promotion is the focus of SPMs in 34 States.

Specific Areas of Focus for State Performance Measures for Many MCH Grantees

- *Nutrition and exercise* - SPMs that address nutrition and exercise are third on the overall list and are included by 47 States or 80% of all grantees.

  Obesity is the focus of SPMs by 60% of grantees (35 States) and is another indicator of the importance that State MCH agencies place on this health problem.

  It is important to note that many SPMs classified in the TVIS as related to nutrition and physical activity are actually worded as measures of reduction of obesity and overweight. Thus, the number of States identified in the review of SPMs as focusing on nutrition and physical exercise is much higher than the number of States with priority needs with that focus due to differences in classification schemes. Regardless of whether the SPM is written in terms of obesity and overweight or nutrition and physical exercise, 47 States have a State Performance Measure that addresses healthy weight for the MCH population.

- *Mental health* has been identified as an emerging area of focus in MCH priorities and 37 States (63%) included a State Performance Measure to assess progress in their efforts to address the mental health needs of MCH populations.

- *Oral health* - One or more oral health SPMs are included by 30 States. Inclusion of SPMs for oral health was also consistent with the increase in focus on this area described in Part 1.

- *Substance abuse* - Two-thirds of grantees (40 States) have SPMs to measure progress in combating substance abuse and 57% of grantees (34 States) specifically target *tobacco* use.

- *Service coordination* – Twenty-seven (27) grantees have a State Performance Measure regarding service coordination, which is consistent with the increased focus on service coordination in State priority needs.

- *Child care* is a State Performance Measure for 16 States and was noted in Part 2 to be a need that was not on the priority needs list for some States but was identified and discussed in their needs assessment process.

- *Insurance* also is included as a State Performance Measure (19 States) and included in identified but unlisted needs by some States.

Do States link their State Performance Measures to their priority needs and how closely do they match?

Each grantee's 2007 Block Grant Application/2005 Progress Report was reviewed to examine which SPMs are linked by grantees to which priority needs. Section IV of the Block Grant Application/Progress Report, where progress on SPMs is discussed, includes sections on background and overview, State priorities, National Performance Measures with results and State Performance Measures with results. The detail provided in their review of State priorities in this section of their report varies. Some States clearly list SPMs, NPMs or other measures that they consider to be linked to their priority needs and which will serve as a measure of success for each need. Other States do not provide this detail.

Twenty-six (26) States specifically linked some or all of their SPMs to priority needs in this section of their Block Grant Application/Annual Report. Of the 26 States with detailed description of which measures they were using to gauge success in addressing their priority needs, 23 States also linked specific NPMs to priority needs. Twenty-one (21) States included multiple performance measures per priority need.

In general, assignment of any performance measures to priority needs fell into three categories: multiple performance measures determine success in meeting a need, a single measure serves as a proxy for measuring success, or a performance measure is the same as the priority need, i.e., the wording is the same. Examples of these three categories of linking measures to needs is described below.

- *Multiple National and State Performance Measures* are used to measure progress on a single priority need. Alabama provides an example:

Priority Need	Performance Measures
Assure appropriate primary care, including prenatal care, for all Title V populations – including low income, immigrant, and minority groups.	NPM #1, 3, 5, 6, 7, 9, 12, 13, 18 SPM #1 – Of 0-9 year old children enrolled in AL Medicaid's EPSDT Program, % who received care coordination in the reporting year. SPM #2 – Of children and youth enrolled in AL Medicaid's EPSDT Program, % who received any dental services in the reporting year. SPM #5 – The degree to which the state CSHCN program assures that all CYSHCN have adequate access to primary and specialty care and allied health and other related services.

- *One State or National Performance Measure is used as a proxy measure* for a broad priority need. Indiana provides examples:

Priority Need	Performance Measures
To decrease tobacco use in Indiana.	SPM #3 – The percent of live births to mothers who smoke.
To reduce obesity in Indiana.	SPM # 8 – The percentage of high school students who are overweight or at risk.

- One State or National *Performance Measure is an exact (or almost exact) measure of the priority need*. Pennsylvania provides an example:

Priority Need	Performance Measures
Decrease alcohol-related driving morbidity and mortality among teens.	SPM #2 – Rate of motor vehicle crashes due to drinking for 17-19 year olds.

What data are used for State Performance Measures? Are States using unique data sources or data sources in common?

The sources of data used by States to calculate State Performance Measures were examined in detail. National surveys, national program data, vital records, and hospital data collected in a comparable manner by individual States provide the data for more than half of all State Performance Measures and are used by virtually all States. The use of national and other comparable data allows for consistent measurement over time and for comparison of performance from State to State if they have similar goals and specify them in comparable ways, e.g., using Pregnancy Risk Assessment Monitoring System (PRAMS) data to measure percent of pregnancies that are intended.

A review of these national data sources with examination of the types of performance measures associated with them provides information about what components of each data collection system are being used to measure and how they relate to the categories of State Performance Measures and priority needs described above.

National Surveys or Nationally Comparable Data to Measure Performance

Vital Records

Forty-one (41) States have State Performance Measures that use vital records data. Measures vary and include both birth and death statistics. Specific topics are listed below if more than one State included a State Performance Measure in that area. Within the description of performance measures using vital records and all other data sources, States may be represented in more than one category.

Reproductive health measures using vital records

Smoking in pregnancy	15 States
Prematurity or low birth weight Some States focus on particular populations such as adolescents or minorities	14 States
Prenatal care States may measure early or late care	9 States
Alcohol use in pregnancy	4 States
Other measures: Interpregnancy interval, birth defects	2 States for each measure

Mortality measures using vital records

Infant mortality Cause of infant mortality varied with six States looking specifically at SIDS deaths. Other areas of focus included infant mortality among minority infants and infants born to adolescent mothers and mortality due to prematurity and birth defects.	11 States
Injury mortality Motor vehicle crash mortality for adolescents 15-19 years of age is the most common injury mortality measure.	6 States

Pregnancy Risk Assessment Monitoring System (PRAMS)

Almost half of all States (N=25) have a State Performance Measure that uses PRAMS data. Specific topics are listed below for States if more than one State included a State Performance Measure in that area.

Intendedness of pregnancy	17 States
Smoking related to pregnancy	7 States
Maternal mental health	5 States
Alcohol use in pregnancy	4 States
Breastfeeding	3 States
Other measures: pregnancy weight gain, having a controlling partner	2 States for each measure

Youth Risk Behavior Survey (YRBS)

Almost half of all States (N=27) have a State Performance Measure that uses YRBS data. Specific topics are listed below if more than one State included a State Performance Measure in that area.

Overweight or at risk for overweight Two more States use YRBS data to measure youth participation in physical activity.	12 States
Smoking or other tobacco use	12 States
Alcohol use	9 States
Mental health	5 States
Sexual intercourse	3 States
Fighting	2 States

Behavioral Risk Factor Surveillance System (BRFSS)

Twelve States have a State Performance Measure that uses BRFSS data. Specific topics are listed below if more than one State included a State Performance Measure in that area.

Smoking	9 States
Healthy weight	4 States
Mental health	3 States
Other measures: use of folic acid, access to preventive care	2 States for each measure

Medicaid Program Data

Over one-third of States (N=25) have a State Performance Measure that uses Medicaid program data. Specific topics are listed below if more than one State included a State Performance Measure in that area.

Dental care	17 States
EPSDT screening	9 States
Care Coordination	2 States

Hospital Discharge Data

Eleven States have a State Performance Measure that uses hospital discharge data. Specific topics are listed below if more than one State included a State Performance Measure in that area.

Hospitalization One-half of States are using hospital data to measure hospitalization for asthma. The other half use these data to measure injury hospitalization.	10 States
Emergency department visits	3 States

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

Eight States have a State Performance Measure that uses WIC data. Specific topics are listed below if more than one State included a State Performance Measure in that area.

Overweight	6 States
Breastfeeding	2 States

Other National Surveys or National Reporting Systems

- The National Survey of Child Health (NSCH) is used by 4 States for various SPMs.

- The Pediatric Nutrition Surveillance System (PedsNSS) is used by 6 States to measure breastfeeding or overweight.

- The Fatality Analysis Reporting System (FARS) is used by one State to measure performance in reducing motor vehicle crash mortality.

- The State and Local Area Integrated Telephone Survey (SLAITS) is used by four States for various measures of service to CSHCN.

- The Family Planning Annual Report (FPAR) is used by three States for measures of access to family planning services.

State Data to Measure Performance:

Thirty-eight percent (38%) of all State Performance Measures rely on data collected by State agencies for calculating success. Only two States rely on national data for all of their State Performance Measures. The most commonly used State data include special surveys such as school-based surveys for dental disease, State programs such as lead reduction, data collected by collaborating agencies such as social service departments, and process data collected as part of an ongoing initiative or capacity-building endeavor. Selected categories of SPMs that are measured using these types of data are listed below. In many cases, specific SPMs within each category vary considerably.

State-specific surveys for various topics, e.g. overweight, dental caries, primary care, CSHCN services, health insurance	18 States
Lead screening	12 States
CSHCN program data	13 States
Social services, police or other agency data for child abuse and neglect	9 States
Other family planning data for various measures	3 States
School-based data for various measures	9 States

APPENDIX

PRIORITY NEEDS IN DETAIL

PRIORITY NEEDS IN DETAIL

I. PRIORITY NEEDS BY HEALTH OR HEALTH CARE PROBLEM

A. HEALTH BEHAVIORS

Twice as many States specified a need addressing healthy lifestyles in 2005 than had in 2000 and they identified this need in both general and specific terms.

1. Healthy Lifestyles including promoting exercise and nutrition or reducing weight	2000 20 States 2005 45 States

Frequently this need was expressed in terms of promoting/encouraging nutrition and/or exercise. Similarly, more than three times as many States specified a need to reduce obesity and overweight in 2005 as had in 2000.

1a. Nutrition and/or exercise	2000 9 States 2005 15 States
1b. Obesity and overweight	2000 10 States 2005 34 States

Examples of priority needs addressing healthy lifestyles include:

- "Promote healthy nutrition and physical activity across the lifespan" (MD 05)
- "Reduce Obesity among Children, Adolescents and Women" (MO 05)
- "Promote healthy behaviors and reduce risk-taking behaviors among adolescents" (GA 05)
- "All children and adolescents should be physically active for at least 30 minutes, limit screen time to no more than two hours, and eat five or more servings of fruits and vegetables each day" (IA 05)
- "Increase capacity to promote healthy weight" (MA 05)

2. Injury prevention – all categories	2000 41 States 2005 33 States

Reducing injuries was one of the most commonly listed needs in 2000 but was included as a priority need by fewer States in 2005. Reducing intentional injury was more frequently mentioned in both years compared to reducing unintentional injury. The number of States identifying unintentional injury as a

priority need increased over the five years while State focus on intentional injury decreased by a comparable amount.

Those States specifying specific types of injuries on which they would focus, often mentioned domestic or family violence, child abuse and neglect, and suicide. Specific unintentional injuries were rarely noted.

2a. Intentional injury	2000 31 States 2005 25 States
Suicide	2000 8 States 2005 6 States
Domestic violence	2000 10 States 2005 8 States
Abuse and neglect	2000 12 States 2005 8 States

Examples of priority needs addressing intentional injury prevention include:

- "Reduce the rate of child abuse and neglect" (AK 00 and 05)
- "Decrease intentional and unintentional injury death rates among children and adolescents" (CA 00)
- "Decrease violence toward children and youth" (DC 05)
- "Reduce the incidence to teen suicide" (MI 05)
- "Decrease the incidence of domestic violence among women of childbearing age" (NV 05)

2b. Unintentional injury	2000 14 States 2005 19 States
Motor vehicle crashes	2000 3 States 2005 3 States

Examples of priority needs addressing unintentional injury prevention include:

- "Decrease intentional and unintentional injury death rates among children and adolescents" (CA 00)
- "Reduce rates of child and adolescent motor vehicle injury and death" (CO 05)

3. Legal and illegal substance use — 2000 34 States; 2005 26 States

Other health behaviors such as substance abuse or health problems frequently caused by health behaviors such as intentional injury were included as priority needs by many States. Fewer States included priority needs in these areas in 2005 than had in 2000.

Of the personal behaviors targeted by States in their priority needs, many included the use of legal and illegal substances. Reduction in the use of legal and illegal substances was included by more than half of the States in 2000 but was mentioned by fewer States in 2005.

3a. Alcohol — 2000 12 States; 2005 9 States

3b. Tobacco — 2000 28 States; 2005 21 States

States were more likely to target efforts at tobacco use in both years but alcohol use was an area of focus for some States. Examples of priority needs addressing use of legal or illegal substances include:

- "Prevent substance use in MCH populations" (MT 05)
- "Reduce the number of women smoking during pregnancy" (AR 05)
- "Reduce the percentage of young people who smoke" (KY 00)
- "Reduce alcohol use by adolescents" (TN 05)

B. IMPROVING HEALTH OR ACCESS TO HEALTH CARE

Improving health is a primary goal for MCH agencies but the way States express this need varies by their approach to the problem. States may express their need as improvement in health status but plan to achieve that goal by changes in program activities. Other States may have the same goal for improvement in health but state their need in terms of improvement in services. Each approach essentially represents different sides of the same coin but the different wording may reflect a difference in philosophy or approach of the MCH agency. Some States could have priority needs to both improve health and improve health care.

1. Mental health improvement and/or access to mental health care — 2000 14 States; 2005 30 States

Needs addressing mental health were classified in a manner similar to general health and oral health, i.e., improving mental health or improving access to mental health services. The number of States identifying these needs doubled from 2000 to 2005. Again, States might have a need to improve mental health, to improve mental health services or both.

1a. Mental health	2000 4 States 2005 15 States

The number of States that stated a need to improve mental health tripled from 2000 to 2005. Examples of priority needs to improve mental health include:

- "Improve the mental health of MCH populations" (CO 05)
- "Improving mental health status" (WA 00)
- "To reduce depression and mental health issues for women, especially before, during and after pregnancy, and in children and youth" (UT 05)

1b. Access to mental health care:	2000 10 States 2005 17 States

States could also frame their mental health needs in terms of access to care and the number of States with this as a priority need increased slightly from 2000 to 2005. Examples of priority needs to improve access to mental health care include:

- "To improve access to mental health services for children, including those with special health care needs, and their families" (NH 05)
- "Assure pregnant and parenting women are screened and referred to appropriate mental health services" (IA 05)
- "Increase access to mental health services, providers, facilities, resources, and payer sources among the MCH populations" (NV 05)

2. Medical home and/or care coordination	2000 17 States 2005 28 States

The number of States with a priority need to assure a medical home and/or care coordination for their populations increased by two-thirds, from 17 States in 2000 to 28 States in 2005. Of note in 2005 was the addition of new populations to whom these important health care services would be expanded, including women and children. Examples of priority needs to ensure a medical home or care coordination include:

- "Ensure a medical home and coordinated services to children with special health care needs" (DE 05)
- "Assure appropriate screening, identification, intervention, care coordination and quality medical homes" (OH 05)
- "Expand availability, quality and utilization of medical homes for children" (VA 05)

3. General health improvement and/or access to health care	2000	36 States
	2005	38 States

Almost two-thirds of States in each year included a priority need to improve health or improve health care.

Some States expressed their need to improve health as just that, i.e., improving health, while others expressed a need to improve access to care as a means to improve health. Priority needs to reduce morbidity and/or mortality (without specific cause) were included in the first category.

3a. General health and well-being or reducing morbidity & mortality	2000	19 States
	2005	20 States

The number of States that included improving health or reducing morbidity and/or mortality in general (infant mortality excluded) as a priority need changed little from 2000 to 2005. Examples of priority needs to improve health and well-being or reduce morbidity and mortality include:

- "More children should be in good health, be safe and be protected" (AZ 00)
- "Improve adolescent health status" (CT 05)
- "Decrease mortality and morbidity among adolescents" (GU 05)

3b. Access to health care including primary care and preventive care	2000	29 States
	2005	28 States

More States specified a need to improve health in terms of access to health care than had specified a need to simply improve health but the number of States with an emphasis on improving access to care changed little from 2000 to 2005. Examples of priority needs to improve access to health care include:

- "Improve access to health care" (HI 00)
- "Assure access to health care for MCH populations, including children with special health care needs" (MT 05)

- "To increase the availability and access to preventive and primary health care services for the MCH population, including children with special health care needs" (PR 00)

4. Oral health improvement and/or access to oral health care	2000 34 States 2005 35 States

Needs addressing oral health were classified as those with the goal of improving oral health status or those that sought to improve access to oral health services. The number of States identifying these needs changed little 2000 to 2005. States included needs addressing oral health or oral health care or both.

4a. Oral health improvement	2000 12 States 2005 13 States

The number of States that included improving oral health as a priority need increased slightly from 2000 to 2005 but represented less than 25% of States. Examples of priority needs to improve oral health include:

- "Assure dental health for all children" (WI 05)
- "Decreasing dental caries in children" (AS 00)
- "Improve oral health" (GA 05)

4b. Access to oral health care	2000 25 States 2005 22 States

Oral health needs of the MCH population were more likely to be framed in terms of improving access to oral health care although the number of States that specified this need decreased slightly from 2000 to 2005. Examples of priority needs to improve access to oral health care include:

- "Increase the awareness of the need for dental health care during pregnancy and increase the number of women who seek dental care during pregnancy" (ID 05)
- "Assure access to oral health care for children in Iowa" (IA 05)
- "Increase the use of the oral health care system for all MCH populations" (UT 05)

5. Healthy Pregnancies

Provision of services to ensure healthy pregnancies and healthy infants is a long-standing MCH function. Priority needs were reviewed to look at the activities and outcomes associated with these goals.

5a. Prenatal, preconception or interconception care	2000 19 States 2005 23 States

The number of States identifying a need related to care of childbearing women either during pregnancy or before or between pregnancies changed little from 2000 to 2005.

Prenatal care	2000 16 States 2005 14 States
Preconceptional/ Interconceptional care	2000 3 States 2005 13 States

The number of States identifying prenatal care as a need changed little from 2000 to 2005. The number of States identifying preconceptional or interconceptional care as a need increased markedly from 2000 to 2005. Examples of priority needs to improve access to and use of prenatal, preconceptional or interconceptional care include:

- "Assure access to prenatal care, especially for low income, minority, and immigrant populations" (AL 00)
- "Increase the percent of women with a live birth who have received adequate prenatal care as determined by the Kotelchuck Index" (AS 05)
- "Increase access to preconceptional and interconceptional care" (SC 00)

5b. LBW, VLBW, Prematurity	2000 17 States 2005 14 States

Reducing low birth weight has been an MCH priority for many years but decreased as a priority from 2000 to 2005. Improving birth weight was more commonly stated than reducing prematurity. Examples of priority needs to reduce low birth weight include:

- "Decrease the low birth weight rate" (FL 05)
- "Addressing disparities in the rates of low birth weight and premature birth" (PA 05)

5c. Infant mortality — 2000 22 States; 2005 19 States

The number of States targeting infant mortality as a priority need also decreased slightly from 2000 to 2005. Infant mortality could include neonatal or perinatal mortality but most often was simply referred to as infant mortality. Examples of priority needs to reduce infant mortality:

- "Decrease infant mortality rates" (FM 05)
- "To reduce the rates of neonatal mortality and morbidity" (MH 05)

5d. Pregnancy, fertility or birth rates — 2000 35 States; 2005 25 States

Pregnancy, fertility and birth rates were more commonly identified needs for the maternal/infant population among the 59 States and jurisdictions but decreased in frequency from 2000 to 2005.

Unintended birth rates — 2000 22 States; 2005 16 States

Repeat pregnancy rates — 2000 3 States; 2005 2 States

Many States specifically targeting unintended or repeat pregnancies and many priority needs regarding pregnancy rates specifically identified adolescents as the target population. Examples of priority needs to improve pregnancy rates include:

- "Reduce unintended pregnancies" (SD 05)
- "Reduce teen pregnancy and unintended pregnancy in women of all ages" (CO 05)
- "Reduce the fertility rate among girls age 15 through 17" (IL 00)

5e. Breastfeeding — 2000 6 States; 2005 11 States

Breastfeeding as a priority need increased from 2000 to 2005. Some priority needs were stated in terms of breastfeeding initiation and/or breastfeeding duration.

Examples of priority needs to increase breastfeeding include:

- "Increase breastfeeding" (KS 05)
- "To increase the initiation and duration of breastfeeding" (ND 05)

6. Disparity reduction 2000 28 States
2005 26 States

The number of States identifying reduction in disparities as a need changed little from 2000 to 2005. Populations targeted in efforts to reduce disparities included racial and ethnic minorities, populations by geography, and disadvantaged populations among others. The disparities targeted ranged from general (health status) to specific (low birth weight). Examples of priority needs to reduce disparities include:

- "To eliminate racial and ethnic health disparities impacting mothers and infants" (MN 05)
- "To increase prenatal care utilization focusing on population disparities" (ID 05)
- "Reduce the racial disparity between black and white infant mortality rate and between Native American and white infant mortality rate" (MI 05)

II. PRIORITY NEEDS BY POPULATION GROUPS

Looking at trends in priority needs by the population targeted was carried out in order to ascertain that the needs of all MCH populations were addressed (as is required in the Needs Assessment) and to look at how needs for specific populations have changed over time.

Priority needs addressing services to the maternal and infant population included pregnancy-related needs for adolescents. Children's needs also included other adolescent needs unless stated otherwise. Needs for CSHCN may have been targeted at children or at youth with special health care needs or both. Needs with MCH as the target group included those needs that specifically stated MCH and those that did not state the population, e.g., "improve access to dental health services". The State MCH agency as the target population was used for those needs where the activity focused primarily on MCH agency functioning or structure.

	Year 2000 Number of States (of 59)	Year 2005 Number of States (of 59)
Core MCH Populations		
Maternal and infant	53	55
Children	55	55
Children with Special Health Care Needs	39	44

	Year 2000 Number of States (of 59)	Year 2005 Number of States (of 59)
Subsets of Core MCH Populations		
Adolescents	49	50
Parents/Families	20	19
Women/Women of childbearing age	17	22
Other populations		
MCH – unspecified populations	37	37
State MCH Agency	38	38
Community/Citizens	6	7

Most States had at least one priority need that focused on the needs of the maternal and infant population and at least one that focused on children. Children with special health care needs were the target population for priority needs in more than two-thirds of States. The needs of adolescents were addressed by most States. Overall, the distribution of priorities changed little from 2000 to 2005 with all traditional MCH groups represented in most States. It may be surprising that some States did not include needs specifically targeted at the maternal/infant or child population. However, those States not specifically naming children or pregnant women and infants might have needs that were worded to address the needs of MCH populations.

A. Priority Needs Addressing the Needs of Mothers and Infants

Priority needs that address the health or health care of mothers and infants are described under Healthy Pregnancies in the preceding section.

B. Priority Needs Addressing the Needs of Children

Priority needs that address the health or health care of children are described below. Needs included in this category were those that specifically targeted children and not those that targeted adolescents only (see next section for discussion of adolescents needs).

Healthy lifestyles, obesity and overweight, nutrition and exercise	2000 18 States 2005 31 States
Access to care – health, dental, mental health	2000 27 States 2005 21 States
Health and well-being including reducing morbidity and mortality	2000 21 States 2005 20 States
Risk behavior or injury	2000 30 States 2005 20 States
Other needs	2000 25 States 2005 21 States

In 2000, improving access to care and reducing injury and risk behavior were the two areas most commonly targeted by States in priority needs for children. In 2005, both areas were included less frequently but were still part of the priority needs of one-third of States. In 2005, one-half of States included a priority need focused on healthy lifestyles for children including nutrition and exercise and obesity and overweight. Healthy lifestyles were the area of greatest increase for children. Other needs included immunizations and early screening/identification, among others.

Examples of priority needs for children include:

- "To improve access to oral health care for children, including instituting preventive environmental measures" (MD 00)
- "To reduce the rates of domestic violence to women and children, child abuse, and childhood injury in Indiana" (IN 05)
- "To increase the number of children and adolescents who thrive" (TX 00)
- "Prevent overweight and obesity in children" (HI 05)
- "Increase percent of children whose disability is identified early" (MN 00)

C. Priority Needs Addressing the Needs of Adolescents

Priority needs that address the health of adolescents were examined further.

Risk behavior or injury	2000 34 States 2005 36 States
Reproductive health	2000 24 States 2005 21 States
Healthy lifestyles, obesity and overweight, nutrition and exercise	2000 6 States 2005 25 States
Other needs	2000 20 States 2005 28 States

Many priority needs focusing on adolescents addressed the reproductive health needs of that population or on their risk behaviors and the need to address these health and behavior issues among adolescents remained constant among the States over the five-year period. An increased focus on healthy lifestyles was also noted for the adolescent population with the number of States identifying healthy lifestyles as a need increasing dramatically over the five years. Other needs for adolescents included general health and well being and mental health.

Examples of priority needs addressing the health and health care of adolescents include:

- "Reducing Teen Pregnancy (NJ 05)
- "To reduce the rate of self-inflicted injuries and suicides in young adults 15-19 years of age" (NY 00)
- "Youth choose healthy behaviors and will thrive" (VT 05)

D. Priority Needs Addressing the Needs of Children with Special Health Care Needs

Priority needs that address the health and well being of Children with Special Health Care Needs were examined further.

Access to care	2000 25 States 2005 25 States
Medical home/care coordination	2000 15 States 2005 18 States
Transition	2000 8 States 2005 13 States
Other needs	2000 21 States 2005 15 States

Access to care was the most common priority need for CSHCN and was included by almost one-half of States. Access to care could include access to primary care as well as specialty care, oral health care and mental health services. One-quarter of States specifically mentioned a medical home and/or care coordination for CSHCN as a priority need. Needs expressed as successful transition or access to transition care was more frequently mentioned in 2005 than they had been in 2000. Other CSHCN needs included parental involvement in care and nutrition.

Examples of priority needs addressing the health and health care of Children with Special Health Care Needs include:

- "All children with special health care needs should be in a system of specialty care" (AZ 05)
- "Ensure a medical home and coordinated services to children with special health care needs" (DE 05)
- "Improve transition to adult life for youth with special health care needs" (HI 05)

III. STATE MCH AGENCY NEEDS

Certain priority needs were considered to be needs of the State MCH agency because the goals or activities of the need involved considerable activity on the part of the agency and, in some cases, activity of the agency that would have an indirect impact on a specific MCH population.

Priority needs that were characterized as having the State MCH Agency as the target population were included by 65% of States (n=38 States) in both 2005 and 2000. Needs ascribed to the State MCH agency as the target population were quite varied and did not lend themselves to classification as readily as other needs. The first two broad categories represent many of the State MCH Agency needs and the number of States with needs in these categories is listed. Of note is the fact that only half as many States identified data needs in 2005 as had in 2000.

Data systems for program planning or other purposes	2000 32 States 2005 17 States
Develop systems of care, integrate services, promote collaboration	2000 14 States 2005 15 States
Other State MCH Agency	2000 20 States 2005 25 States

Examples of priority needs that address the needs of the MCH agency include:

Data system needs:

- "Obtain & utilize reliable evidence to: a) identify preventable causes of maternal, child and adolescent mortality and morbidity; b) develop preventive public health campaigns targeting high risk populations; and c) perform process and outcome evaluation" (LA 05)
- "Improving and integrating information systems" (NJ 05)
- "Create a unified data system and surveillance system to monitor services delivered to the MCH populations" (NV 05)

Systems of care, service integration, collaboration needs:

- "Improve interagency coordination among PA's agencies to facilitate delivery of services to PA's families, eliminate barriers and duplication of services, reduce fragmentation to more effectively utilize resources" (PA 00)

- "Improve coordination among health care plans, primary physicians, and the Pediatric Centers" (PR 05)
- "Establish collaborative relations at state/local level" (CT 05)
- "Integrate existing services and supports for adolescents and young adults into a comprehensive system that draws upon their own strengths and needs" (ME 05)

Other needs:

- "To implement a neonatal genetic screening, diagnostic and treatment" (PW 05)
- "Assess and develop strategies to address underinsurance for vulnerable populations to improve access to affordable, acceptable health care" (VA 05)
- "Exercise leadership in nurturing partnerships that promote systematic communication, coordination, shared resource allocation and education around health improvement efforts" (VA 05)
- "Strengthening public health infrastructure at the state and local levels" (NC 00)
- Improve cultural competency across all programs that work with the Maternal and Child Health population (ID 05)