Promising Approaches to the Title V Needs Assessment: Preliminary Findings

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I. Introduction and Overview

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

Despite this long-standing requirement, States have varied widely in the rigor, comprehensiveness, and usefulness of their needs assessments. To gain a better understanding of this variation and to identify best practices among the States, the Maternal and Child Health Bureau (MCHB) has contracted with Health Systems Research, Inc. (HSR) to conduct an analysis and evaluation of the States' Title V needs assessment processes. This analysis includes several components:

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

This report presents the first component's preliminary findings, identifying five basic elements of the needs assessment and discussing the criteria that define success in each area. It is based on examples from a review of 15 State needs assessments from 2000, with the goal of identifying methods, practices, and activities that States may find useful as they prepare to conduct the 2005 needs assessment. The methods used to produce this report are discussed in more detail below.

A. Methods

The abstraction tool, included in the Appendix, was developed by HSR and is based on a review of the literature and the 2000 Block Grant guidance, describing the structure of the needs assessment. It includes information about the process used to conduct the needs assessment; the quantitative and qualitative indicators of need; the assessment of system capacity; and the priorities selected based on the needs assessment.

The 15 study states were selected based on HRSA Field Officer interviews to determine which States in the ten DHHS regions had needs assessments that provided the most useful lesson or example for other States. The goal was not necessarily to identify the "best" needs assessments or to rate the assessments' overall quality. The States selected for this review were: Alaska, California, Colorado, Florida, Iowa, Kansas, Minnesota, New Jersey, New Mexico, Oklahoma, Puerto Rico, Rhode Island, Virginia, Washington, and Wisconsin.

Based on HSR's review, the analysis of State needs assessments was divided into the following five areas:

- The use of qualitative and quantitative health indicators;
- Data sources and data analysis;
- Capacity assessment;
- Setting priorities and putting it all together; and
- The needs assessment process.

In each of these areas, HSR identified criteria for a successful assessment and analyzed the abstracts of the 15 study States' assessments in accordance with these criteria. In the following sections of this report, these five areas are discussed in turn, highlighting the

methods and approaches of particular States when they may be useful or applicable to other States. It should be noted, however, that this analysis only reflects the methods and activities that were described in the 2000 needs assessment documents. Other activities may have been conducted that were not mentioned (or were discussed elsewhere in the Block Grant application). Lastly, while our goal was to identify worthwhile practices and interesting models, a State's absence from these examples does not imply a judgement of inferiority.

II. Indicators of Need

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

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

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

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

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

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

Seven states included qualitative measures, although most included data for only one or two indicators. **Florida** included five qualitative health indicators, most of which were measured through consumer feedback. Two Florida indicators were measured through consumer focus groups (the factors affecting poorer pregnancy outcomes for black women and possible

medical reasons for racial disparities in infant mortality), and two were measured through a consumer survey (stability of CSHCN health, and overall rating of the health status of CSHCN). The **Wisconsin** needs assessment included key informant interviews of county health department directors, tribal health center directors, and the director of the Milwaukee City Health Department. These interviews enabled state officials to obtain qualitative data on health care access, child care availability, dental access for children, and the increasing number of special needs children in the state.

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

Overall, the **Rhode Island** needs assessment addressed all of the criteria mentioned above. It included half of the national performance measures, as well as a qualitative measure of the knowledge, attitudes, and practices of adults with regard to their relationships with their teenagers, obtained through a statewide telephone survey of parents. Other interesting Rhode Island indicators were: the prevalence of open neural tube defects, the type of contraception used by women at family planning clinics, the percent of children who did not visit a dentist in the past year, reasons for childhood hospitalizations, and children's use of safety seats,

safety belts, and bicycle helmets. A number of indicators for CSHCN included: the rate of babies born with birth defects, the ten most frequent congenital anomalies among newborns, and the number of children hospitalized for brain-related injury (and of those, the proportion requiring institutional or professional at-home care).

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

III. Data Collection and Analysis Process

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

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

- **Use of both quantitative and qualitative studies (focus groups and key informant surveys) as data sources**. Different types of needs are best explored and described using different types of data. For example, incidence and prevalence can best be described using quantitative data. Programmatic impact can best be captured using qualitative studies. Because both of these types of information are necessary for a thorough needs assessment, it is important that both types be used.

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

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

Most of the study States were able to use a combination of State level and more geographically targeted data. Several States (e.g., **Colorado, California, Florida, Iowa, Minnesota,** and **Oklahoma**) were able to use State-level data from national data collection

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

Oklahoma uses a lot of quantitative data sources to conduct their needs assessment. Some data sources are national but Oklahoma has developed many of them because of a locally determined need for surveillance data. The sources cited in the needs assessment are:

National:

- Oklahoma Pregnancy Risk Assessment Monitoring System
- Oklahoma Youth Risk Behavior Survey
- Behavior Risk Factor Surveillance Survey
- Consumer Assessment of Health Plan Survey (both adult and children's section)
- Oklahoma Youth Tobacco Survey
- Oklahoma Uniform Crime Report
- Reportable OSDH Injury Surveillance System (contains information on burns; traumatic brain injuries; traumatic spinal cord injuries; and submersions (drowning and near drowning))
- Children with Special Health Care Needs Survey (Community Assessment Tool for Children with Special Health Care Needs (CATCH)
- National Immunization Survey

Oklahoma:

- Oklahoma Toddler Survey (surveys a sample of State resident mothers with children two years of age). Designed as a longitudinal follow-up to PRAMS and is unique in the nation.
- First and Fifth Grade Health Surveys – population-based surveys developed and operated by the Assessment and Epidemiology Division within MCH
- Health Provider Survey (in collaboration with the OK Health Care Authority (OHCA) the OSDH surveyed all licensed health care providers in selected counties. The purpose of the survey was to identify barriers that may affect the use of health care services by SoonerCare (Medicaid managed care system) participants.
- Drug Use Needs Assessment Survey (focused on questions pertaining to domestic violence and injury)
- Lead (CLPPP competed for and was awarded a three-year grant from CDC to initiate lead prevention in 39 high-risk Oklahoma zip codes.) After identifying children at risk, intervention will be initiated to lower blood lead. Another component of the grant will include informing public health practitioners in the state about the effects of lead on children and what forms of intervention are available.
- Maternal Serum Alpha-fetoprotein screening (MSAFP) Screening provided to all public maternity clients in OK. The screening test combines maternal risk factors, MSAFP and the human chorionic gonadotropin free beta to screen for downs syndrome, trisomy 18 and other chromosomal abnormalities.
- OK Birth Defects Registry – covers Oklahoma County (OK City), Cleveland County and Tulsa County until 1993 but since 1994 statewide case ascertainment.

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

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

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

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

Other surveys included:
Medical Home Practice Standards mail survey—addressed to physicians, this survey included questions on the practice of accessible, family-centered, comprehensive, continuous, coordinated, compassionate and culturally competent care for CSHCN. It was used to identify practice strengths and weaknesses in these areas. A majority of respondents indicated that they would be interested in training about the Medical Home concept.

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

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

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

Kansas's data were also obtained from the Kansas Hospital Association and the physician licensure database. **Minnesota**, in addition to using Public Safety data, worked with the State planning agency as well. They also obtained data from Abbott Labs and the Urban Institute. **Oklahoma** worked with the Health Care Authority as well as the Department of Public Safety, while **Virginia** used reports obtained from the Department of Social Services as well as the State Police.

IV. Capacity Assessment

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

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

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

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

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

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

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

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

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

A. RESOURCES AND SERVICES AVAILABLE

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

1. Individual Providers

Nine states analyzed the availability of primary care providers (physicians and/or allied health professionals) and mapped or listed the federally designated health professionals' shortage areas (HPSAs) within their State.

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

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

The availability of dentists to serve low-income children was a significant capacity indicator in six State needs assessments. These states measured dental provider availability using one or more of the following measures: the proportion of dentists and clinics providing some Medicaid dental services for children, the number of dentists serving children at outpatient dental clinics, and federally designated Dental HPSAs.

2. Institutional Providers

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

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

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

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

3. Enabling Services

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

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

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

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

support. **Minnesota** included an assessment of the size of the unmet need for crisis respite care services, based on the average number of families on the waiting list for respite care services.

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

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

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

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

4. Population-Based Services

Documenting capacity and unmet needs for population-based services is a more difficult task compared to that for direct or enabling services because there are less data available on the size of the population reached and the "in-need" population. In fact, the needs assessments reviewed provide little analysis of the existing capacity in

population-based services. Instead, most include a listing of many population-based services they provide or contract out for, such as lead screening, newborn biochemical screening, newborn hearing screening, injury prevention programs, oral health education and screening programs, SIDS public education, and folic acid education campaigns. Only in a few cases are data provided on the numbers reached or unmet need for population-based services, for example in the area of childhood immunizations.

While not analyzing the capabilities or reach of existing population-based services, many States have identified priority health needs that could be addressed through enhanced population-based services. For example, based on extensive survey data showing limited use of dental services by low-income children, **Florida** identified the need for expanded publicly funded dental screening programs for children. Similarly, using key informant and parent survey data, **Minnesota** and **Rhode Island** identified the need for enhanced early identification and tracking systems for infants and toddlers, special education services for school-age children with disabilities, and transitional services for adolescent CSHCN. In light of alarming indicators regarding substance abuse among pregnant women and domestic violence in **Puerto Rico**, the Commonwealth's needs assessment identified a need for new population-based screening services for substance abuse among pregnant women and other public awareness, screening and intervention programs to address the issue of domestic violence. **Minnesota's** needs assessment highlighted data on poverty, hunger and homelessness as risk factors associated with poor health and mental health problems for the MCH population. Minnesota identified a need for new population-based health education approaches that focus on promotion of healthy community conditions and family support to address the underlying causes of poor health outcomes, and raise awareness of mental health problems and resources.

5. Infrastructure Building Services

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

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

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

B. FACTORS AFFECTING THE ACCESSIBILITY AND QUALITY OF AVAILABLE SERVICES

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

C. ASSESSMENT OF COMMUNITY LEVEL MCH CAPACITY

While many States talked about the incorporation of needs assessments from local health agencies or community/regional MCH planning councils, very few State needs assessments clearly articulated the local level capacity. The exception was **Rhode Island**, which provided much of its health indicator data at the local township level. Community-level capacity assessments were also a significant data source for the State needs assessments of **Florida** and **Minnesota. Florida** requires each local Healthy Start coalition to conduct a capacity assessment as part of its strategic planning process, and **Minnesota** requires local health agencies to conduct needs assessments, including performing an inventory of local services and other resources and assets every two years.

D. STRUCTURAL AND ENVIRONMENTAL FACTORS LEADING TO CHANGE IN TITLE V CAPACITY NEEDS

1. Expansions of Public Insurance and Shift to Managed Care

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

2. Growing and Changing Nature of Immigrant Populations

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

E. ASSESSMENT OF INTERNAL ORGANIZATIONAL CAPACITY

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

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

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

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

Retardation and Substance Abuse Services as well as the need for improved coordination and integration of various public and private systems of care for CSHCN.

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

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

V. Setting Priorities and Putting It All Together

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

- **Local participation**. The needs assessment should utilize input from local constituencies, including local health agencies and consumers, in identifying priorities. Consumer, advocacy, or local provider organizations may offer insight into regional or local issues that affect the populations they know best.
- **Defined methodology**. The needs assessment should include a specific protocol and set of criteria for ranking and prioritizing the needs identified by the assessment.
- **Integration.** The capacity assessment analysis should be integrated with the assessment of needs. Analyzing the needs in the context of the system capacity, and vice versa, will reveal the gaps in the system that contribute to needs going unmet, and will highlight the areas of need that can be addressed most successfully through systems changes.
- **List of priorities**. A comprehensive list of priorities should be included in the needs assessment document. Health status and outcome goals, quantitative and qualitative capacity assessment goals, and internal capacity assessment goals should also be included.

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

frequency the priority was mentioned. The resulting priority needs were arranged in a table, marked according to the type of service, and the MCH population affected. For example, the first priority, dental access for children, is recorded as an enabling service involving children and CSHCN.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VI. Process

The final element of a successful needs assessment underlies and supports all of the issues discussed above, is the process used to conduct the assessment. Critical components of this process include:

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

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

- **Inclusion.** The needs assessment should also include a deliberate process for including and reflecting diverse perspectives, including those of local or regional health agencies; consumers and families; individual and institutional providers that serve pregnant women, infants, and children; advocates; and representatives of multicultural groups.

- **Application.** Finally, the needs assessment process should include a direct link to the identification of priorities and allocation of resources.

> **Wisconsin** had a distinct and well-defined needs assessment process. A Needs Assessment Coordinator oversaw the planning and coordination of the process, and a Needs Assessment Planning Team was established, comprising 12 Bureau of Family and Community Health (BFCH) and DPH Regional Office staff and managers. The team refined the needs assessment design, reviewed and reworked the interview outline, and field-tested the outline with DPH staff not involved in the process. Through a series of the key informant interviews they incorporated a variety of perspectives in the definition of needs and priorities, including county health department directors, the Milwaukee city health director, nine Milwaukee municipal directors, and Tribal Health Center directors. The areas of concern raised in these interviews shaped the organizational structure of the needs assessment.

Unfortunately, few of these aspects of the process were described in detail in the state needs assessments reviewed. The locus of responsibility for the needs assessment was rarely specifically discussed, although several states described the use of a leadership or management team to oversee the process. For example, **Oklahoma's** needs assessment was overseen by an MCH/CSHCN Leadership Team, and **Virginia** relied upon the Management Team from the Office of Family Health Services.

Similarly, the state needs assessments rarely described the technical resources they relied upon to conduct data analyses, although a few mentioned the use of both internal and external sources of support. **Colorado's** needs assessment referred to the use of an MCH Information Specialist to assist in the analysis and interpretation of data; **New Jersey** described the use of the state's Center for Health Statistics and the MCH Consortium's Data Work Group.

More detail was generally presented on the various perspectives included in the needs assessment and the role of consumers and families in the process. These roles varied in the extent of the involvement of outside stakeholders. The major avenues for stakeholder involvement in state needs assessments included the following:

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

- **Advisory Groups.** Several states established Advisory Councils to guide the conduct of the needs assessment, often including family or consumer representatives. **Colorado** relied upon an Advisory Council on Health Programs for Women and Children, which includes two parent representatives, for advice in selecting measures and determining priorities based on needs assessment findings. **Alaska** formed an 18-member Maternal, Child, and Family Health Advisory Committee, including both professionals and parents, to oversee the needs assessment. **Virginia** used an Advisory Committee on Children and Families, made up of consumers and representatives of community organizations, to review needs assessment data. Depending on how these groups are used, this route allows outside stakeholders to give input at various points in the needs assessment process and to offer interpretations of early needs assessment findings.

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

assessment, and they identified gaps in available data. They also collected, analyzed and displayed data that might be included in the final document.

Many states also described the conduct of local-level needs assessments and the incorporation of their findings into the state needs assessment process. Although several states appear to require local health jurisdictions to conduct needs assessments in their communities, they vary in the extent to which this information is used to inform the state-level needs assessments. **California** requires its 61 local health jurisdictions to conduct a community health assessment and develop an MCH plan; these are then used in the identification of state-level priorities, but do not appear to be reflected in the assessment of statewide needs. In contrast, **Minnesota's** Community Health Service agencies are required to conduct needs assessments as part of their biannual planning process; needs identified through this process were added to the MCH Indicators Menu for the statewide needs assessment. A third example is that of the state of **Washington,** where both local needs assessments and a survey of nursing directors in local health districts were conducted. In addition, **Washington** conducted five regional meetings with facilitated discussions of service system assets, gaps, and impacts of policy on the MCH population. The information from these meetings was incorporated into issue papers used in the final selection of statewide priorities.

The previous section described the processes used by states to identify priorities based on the needs assessment. This is the final step in the needs assessment process, and it is critical that it be both inclusive and based on the findings of the needs assessment. This is most easily effected when the needs assessment process is directed toward the identification of priorities from the outset.

The **Kansas** MCH Needs Assessment is one part of the state's larger, more broadly defined Joint State Needs Assessment (JSNA). The JSNA is a joint effort of three HRSA-funded programs: Primary Care (Office of Local and Rural Health), HIV/AIDS (Bureau of Epidemiology and Disease Prevention [BEDP]), and Maternal and Child Health (Bureau for Children, Youth, and Families). This state needs assessment uses the CDC surveillance cycle as its conceptual framework and also uses the Title V Block Grant Performance Measurement System in a circular model describing the entire process of assessing needs and setting priorities.

This process involved grouping indicators into indexes, including (1) Primary care index, (2) Pregnant Women, Mothers, and Infants Family Planning Index, (3) Pregnant Women, Mothers, and Infants Perinatal Index, (4) Children and Adolescents Child Health Index, (5) Children and Adolescents Adolescent Health Index, (6) CSHCN Index. In each index, the indicators were further subdivided into county indexes, population density groups according to race/ ethnicity, and population density peer groups. These were then further divided into categories including demographic, socioeconomic, health status/health risk, and access/resources.

A contractor was hired to assist with the MCH data collection and analysis portion of the assessment. An extensive list of local and state level organizations, advocacy groups, and multicultural groups provided input into the needs and priorities of the population (including the Adolescent Health Program, Adult & Medical Services, AIDS Program, the Behavioral Risk Factor Surveillance System, Breast and Cervical Cancer Program, Bureau for Children, Youth, and Families, Bureau of Epidemiology & Disease Prevention, and the Bureau of Health Promotion). Consumers were included as members of a Steering Committee that identified preliminary state priorities.

VII. Challenges and Lessons Learned

As this review shows, the 15 study States varied widely in their approaches to and execution of the Title V needs assessment, and the documents they produced varied in the depth, level of detail, and thoroughness with which they addressed each of the elements of needs and capacity assessment, and in the areas of focus of the assessment. Despite this variation, the States appear to have faced several common challenges as they approached the needs assessment, including the following:

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

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

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

- Assessing capacity, especially at the system level. Most of the study States presented a wide range of indicators of need, but focused their capacity assessments narrowly. Rather than examining the capacity of the overall system serving children and families—including Medicaid, SCHIP, Early Intervention, and special education, as well as public- and private-sector MCH services—many States simply reported the number of children served through Title V-funded programs. This does not describe capacity (as it is not clear whether these programs could serve more clients), nor does it address the capacity of the full range of resources available to MCH populations.

- Marrying needs and capacity assessment. The integration of the needs and capacity assesements can provide a powerful analytical tool. This analysis can reveal areas of significant unmet need (those with high need and low capacity), areas of greatest opportunity to intervene (high need and high capacity), and areas of excess

capacity (low need and high capacity). Perhaps due to the structure described in the Block Grant guidance, most States' needs and capacity assessments were distinct, and the findings of the two were not integrated.

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

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

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

In addition, it is critical that State-level assessment efforts be coordinated with ongoing health planning efforts at the local and community levels. State officials can benefit from the work of local communities in assessing their needs and resources, both in the information they can provide and the resources they can save in preventing duplication of effort.

Finally, as has been discussed earlier, the findings of the needs assessment must be linked to the identification of priorities and allocation of resources. This is the final, critical step in the

planning process and should involve consistent criteria and be based on the empirical findings of the assessment efforts.

This analysis represents the first step in a larger assessment of the Title V programs' conduct and use of the five-year needs assessment. It is hoped that these preliminary findings will provide useful guidance and ideas as the States approach the 2005 needs assessment process.

Appendix: Needs Assessment Abstraction Tool

Maternal Child Health Needs Assessment and Block Grant Abstraction Forms and Interview Template
State:
I. Overall Description of Needs Assessment: • Purpose of NA. • How will it be used? • Who (what agencies and at what level) will use the assessment information?
Definitions: • How does State define "need"? • How does the State define "capacity"?
Organization of the Assessment – State Level: • Identify the agency, person, title of person(s) responsible for the development and conduct of the NA. • What data analysis and epidemiological capacity was available to the process? • Were outside consultants used? If so, describe purpose and type of consultation. • Was an intra-departmental or inter-agency group formed to oversee the assessment? • What conceptual framework or organizing principles were used to organize the NA?

Organization of the Assessment – Local Level:

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

II. Data Collection and Analysis Processes

A. Major sources of quantitative data:

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

B. Major sources of qualitative data:

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

C. Analysis

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

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

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

Survey Follow-up Questions
V. Priority Setting

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

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

LIST OF PRIORITY NEEDS