Health Systems Research, Inc.
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Review of the Title V 5-Year Needs Assessment Process in the States and Jurisdictions

FINAL REPORT

Prepared for
HRSA/MCHB

Prepared by
Vivian Gabor
Gretchen Noonan
Jodi Anthony
Evan Gordon

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Table of Contents

Chapter I. Introduction

A. Background

The mission of the Maternal and Child Health Bureau (MCHB) and its State, community, and family partners is to improve the physical and mental health, safety, and well-being of the Nation's women, infants, children – including children with special health care needs (CSHCN) – and adolescents and their families. Under the legislative authority of Title V of the Social Security Act, each of the 50 States and eight jurisdictions are granted Maternal and Child Health (MCH) Services Block Grant funds on an annual basis. These funds are used to build and support State- and Territory-level systems to achieve the MCHB mission, based on the particular needs of their MCH populations. Title V agencies are encouraged by MCHB to engage in an ongoing strategic planning process, which includes a Needs Assessment process, and to use this information to plan and implement programs and policies that address those needs.

Each Title V agency is required to conduct and submit a formal assessment of their State or Territory's MCH needs every 5 years. This assessment is based on a comprehensive examination of the needs of the State or Territory's MCH populations and the capacity (defined as accessibility, affordability, and quality) of available public and private resources and systems to serve those needs. The goal of the required 5-year Needs Assessment is to help Title V agencies reexamine their program planning priorities so that they can align their programs, policies, and resources to address the most important maternal and child health issues in their jurisdictions. Once the priorities are identified, the Title V agencies are also asked to identify the performance measures (including national and State-specific MCH measures) that they will use to monitor progress toward each of these priorities.

MCHB gives Title V agencies wide latitude to shape the framework and process of their Title V Needs Assessment. As a result, though all States submit a 5-year Needs Assessment that presents data on needs for each MCH population group, discusses their assessment of capacity at each

MCH pyramid level, and identifies priorities for the next 5 years, the processes the States and jurisdictions use to conduct their Needs Assessment can vary widely.

In 2004, Health Systems Research, Inc. (HSR), under a contract with MCHB, developed a manual on how to conduct a Needs Assessment, tailored to the needs of MCHB's grantees. The manual laid out the essential elements of every step of the Needs Assessment and how they can all fit together to be an effective program planning tool. The manual also specified the characteristics of a process that could transform what otherwise might be solely a data-driven effort into one that results in a more comprehensive assessment of priority issues that are applicable and acceptable to the families and communities the Title V program efforts ultimately should affect. These characteristics included:

- **A clear leadership structure,** which has the ability to assemble data from both public and private sources
- **Engagement of stakeholders,** to the extent feasible and applicable to each State or Territory's political and geographic circumstances, to solicit meaningful input from a range of stakeholders on the current issues affecting the health and well-being of women, infants, children, and families at the State, community, and subgroup levels
- **A structured and inclusive priority-setting process** that includes convening a body of stakeholders, choosing priorities through consensus methods, and establishing specific criteria to rank and select priorities
- **Collaborative program planning.** Ideally, the outcome of establishing a leadership team and engaging stakeholders in the needs identification and priority-setting process is to build collaborative relationships that, over the long term, can work together to build and strengthen the system of care, as well as to ensure the quality and accessibility of that care, for women, infants, children, and families.

B. Study Purpose and Design

In spring 2006, MCHB engaged in discussions with HSR about how to further the efforts begun in 2004 around the 5-year Needs Assessment. As a result of these discussions, HSR conducted a comprehensive review of the recently completed 2005 Title V 5-year Needs Assessment process in the States and jurisdictions. The specific goals of this study are to:

- Gain a better understanding of the characteristics of the maternal and child health Needs Assessment process as it is implemented in the States and jurisdictions
- Examine how the priorities developed from the Needs Assessment are applied in State or local program planning
- Learn about promising approaches that were used in the most recent 5-year Title V Needs Assessment.

In short, this study aims to (1) provide a comprehensive assessment of how States implemented their Title V Needs Assessments in 2005 and (2) identify promising approaches among the States and jurisdictions that other Title V agencies can learn from and adapt in their own ongoing Needs Assessment and program planning efforts and for the 2010 Needs Assessment for Title V.

HSR used a two-phase approach to conduct this study. In the first phase of the study, researchers examined the 2005 Title V Needs Assessment documents of 58 States and jurisdictions.[1] The text of these documents was reviewed and abstracted to describe the variation in approaches used in the assessment process and identify most common and creative strategies Title V agencies used. Specifically, HSR abstracted information pertaining to the following elements of the process:

- The conceptual framework that drove the process
- The leadership structure established for the process
- The extent and nature of stakeholder involvement
- How MCH priorities were selected
- How the Needs Assessment results are being used in ongoing program planning, as well as Title V agencies' ongoing MCH Needs Assessment activities.

The second phase of the study involved a more indepth examination of the process in selected States. Based on information drawn from the document review, HSR identified promising aspects of the Needs Assessment process at work in the 12 States listed on the next page.

1 The Virgin Islands was not included in this review.

12 States Selected for In-Depth, Tailored Telephone Discussions		
California	Colorado	Connecticut
Georgia	Hawaii	Indiana
Louisiana	New Hampshire	New Mexico
Virginia	Washington	Wisconsin

Through open-ended discussions with Title V staff from each of these States, with topics and issues for discussion tailored to each State's Needs Assessment document, HSR obtained more indepth information about the processes these States used, the types of stakeholders they involved and how, and the specific methods they employed as part of their Needs Assessment processes. Examples from these States' experiences are incorporated into this analysis to provide Title V planners with options, ideas, and specific tools that they can adapt for various aspects of the Needs Assessment process in their States and jurisdictions. Both the document review and followup telephone discussions were guided by seven research questions:

Figure 1. Seven Research Questions

- **Framework and Goals.** What were the conceptual framework and the overarching goals that guided the Needs Assessments? Was there a single process, or were there two separate processes for the general MCH population and for children with special health care needs?
- **Leadership.** What leadership structure was established within the MCH agency for the Needs Assessment process, and what types of individuals and organizations were included?
- **Stakeholder Engagement.** What types of stakeholders were engaged in the process, and what methods were used to obtain their input on identifying and/or prioritizing MCH needs and capacity issues?
- **Selecting Priorities.** What processes and criteria did the States and jurisdictions use to rank and select its top MCH priorities, and what types of individuals and organizations did they involve in this stage of the process?
- **Application of Assessment Findings.** Did the Needs Assessments document clearly that the priorities selected were subsequently used for ongoing program planning purposes? How was the Needs Assessment integrated or coordinated with their program planning?
- **Ongoing Assessment.** To what extent do Title V officials discuss specific plans for ongoing Needs Assessments? When they do, what types of MCH information are analyzed on a more frequent basis?

- **Lessons Learned.** What factors in the process have an impact on the results of the Needs Assessments, and what are the key successes, challenges, and recommendations?

C. Organization of the Report

The findings from both phases of the study are discussed in the next chapter of this report. The findings are organized by the seven research areas detailed above. Within each research area the findings are presented in two sections. The first section summarizes the findings from the document review. The second section highlights promising methods or approaches that were identified primarily from the individualized telephone discussions with 12 selected States. The final chapter presents recommendations for ways in which MCHB might provide technical assistance (TA) and further guidance to States in planning for their next 5-year Title V Needs Assessment. It also examines ways in which the States could continue to learn from each other's experiences and promising practices.

Chapter II. Findings

A. Framework and Goals of the Needs Assessments

State Title V agencies had significant latitude in the development of a conceptual framework for their assessment. HSR was particularly interested in the extent to which this framework was fully articulated and the degree to which it guided the assessment. Presumably, those agencies with a well-defined framework or specific health goals, which could be used to measure health status, would be better equipped to collect, interpret, and use both capacity and needs data to make priority decisions than agencies without such an overarching framework and health goals.

> Washington State Title V officials framed their needs assessment process by asking, "What defines a healthy MCH population, and what do we need to do to create a healthy MCH population?"

This study also assessed the extent to which capacity and needs were linked and whether the assessments for the CSHCN population were different from the general MCH populations. HSR's review of the 2000 Needs Assessments indicated that most States simply reported health information and capacity information separately. The results of the data collected did not link these two types of information directly to tell a more complete story. HSR's review of the 2005 Needs Assessments, therefore, focused on whether States were able to address the formidable challenge of linking the two types of data. HSR was also interested in whether the assessment processes for the CSHCN and general MCH populations were different and, if so, how.

1. Document Review Findings

From the document review, it appears that at least eight States (Alabama, California, Hawaii, Louisiana, Nevada, New Hampshire, North Carolina, and Oregon) used a separate process for the needs assessment of the general MCH and CSHCN populations. In these States, the separate

processes were led by the division or agency administering the programs for the specific population.[2]

Reviewing the documents to determine whether needs and capacity were clearly linked indicated that nearly three-fifths (59 percent) of the Needs Assessments did not relate health issues for each population group clearly to the strengths and needs or capacity of their MCH systems. States that did link their assessment of needs to their assessment of capacity also linked the data to their priority needs.

2. Promising Practices

For the most part, the officials in the selected States shared a common view of the 5-year process of intensive data collection, analysis, and prioritization of needs as an opportunity to step outside their ongoing program management responsibilities to reassess their program priorities. Title V agencies use and report on the standard set of MCH performance measures for the MCH Block Grant annual report and application process. The 5-year assessment, however, allows them to commit resources to the collection and analysis of additional data and different kinds of information. This information, which focuses on needs and capacity, is used to engage new and current partners in identifying priority MCH needs for the State and to support Title V programming and planning efforts. The information is also used to garner critical stakeholder collaboration to build and support systems of care at the community level necessary to address the identified priority needs.

> "We wanted to be able to use the findings from the local needs assessments to prioritize MCH needs, understand local system capacity strengths and weaknesses, build or strengthen collaborative relationships at the community level, and then take all of this information to help us shape the direction of statewide MCH planning for the next 5 years."
>
> *– California*

2 While it is interesting to note that these eight States maintain separate Needs Assessment processes for their MCH and CSHCN populations, the number of States that fall into this category is small enough to render any stratification by this factor unreliable. Thus, such States will not be broken out in the discussion that follows about varying processes across States.

Common goals of 5-year Needs Assessment for these Title V officials are as follows:

- **Obtain qualitative information from a variety of MCH stakeholders, including providers and consumers, on needs and system capacity.** Virginia and Louisiana officials, for example, noted that the qualitative information they were collecting put their quantitative indicators in perspective, identified emerging MCH needs for which data are not yet available, and helped them to understand better the factors affecting the accessibility and quality of services and systems of care.
- **Identify gaps in system data capacity, particularly on emerging issues such as behavioral health and women's preconception health.** California officials, for example, learned that they had limited data on women and children's mental health, perinatal substance use, and other preconception health issues. They used the Needs Assessment process to partner with other State agencies working on these issues in order to add questions to their surveys and share information from existing mental health program data files.
- **Promote coordinated planning and optimal use of limited resources across various State programs and with the local MCH agencies.** Title V officials in Hawaii, for instance, pointed out that the purpose of the Needs Assessment was not only to identify and prioritize needs, but also to understand their internal capacity to synthesize the information and select priority areas in which they and their partners could have a potential impact. Colorado Title V officials, whose process was largely framed around regional Needs Assessments conducted with county agencies, noted that the inclusive processes they used for their 5-year Needs Assessment helped garner local support for the priorities now in place at both the State and local levels. These priorities are shaping program planning, which includes engaging local agencies to present best-practice strategies specific to the priority need areas.
- **Improve coordination and collaboration with stakeholders in assessing MCH priority needs, implementing plans, and allocating resources to address those needs.** Title V officials in Connecticut noted that the 5-year Needs Assessment was an opportunity to involve other agencies and community partners meaningfully. One of their key goals for the assessment process was to educate stakeholders about Title V; raise awareness about MCH needs; and obtain input from a range of stakeholders, including consumers. They also saw this as an opportunity to foster collaboration with partners to build capacity in priority program areas where their capacity assessment identified large gaps or unmet needs.
- **Provide an education and advocacy tool for increased investments in maternal and child health.** Several States, including New Hampshire, Connecticut, New Mexico, and California, reported that data from their 2005 Needs Assessments was useful in applying

for public and private grants with stakeholders and for educating public officials about the MCH needs in their State.

Most States were satisfied with the perceived purposes of the Needs Assessment and the conceptual framework that they used to organize the process. They reported that the 2005 process worked much better than in 2000 and that only minor adjustments to the framework likely would be made for the next assessment.

During the telephone discussions and analysis of the Needs Assessment documents, HSR discovered variations in the overarching approaches that Title V agencies used to frame the structure of the data collection and related strategic planning processes. These approaches are highlighted in the text boxes that follow. While the approaches may appear to be unique to the focus, size, and structure of each of these four specific Title V programs, in essence they offer models that could be used by other States and jurisdictions.

New Hampshire: Investing in a Long-term Process

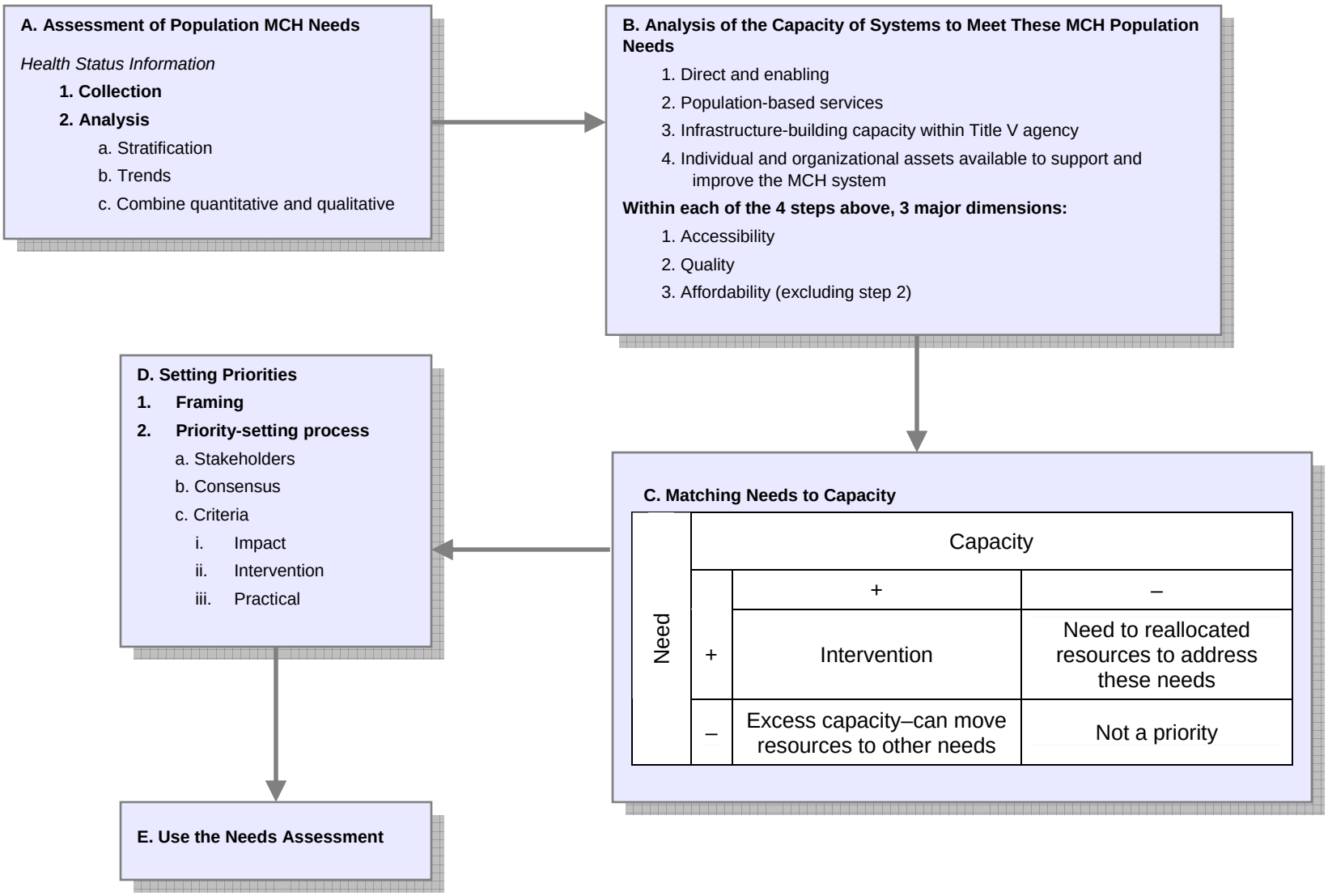
In New Hampshire's Needs Assessment, the assessment processes for the general MCH population and CSHCN were carried out in two separate but parallel tracks. Capacity assessment was an important emphasis for both groups, as was a blending of capacity information with needs data to select the most important and feasible areas in which to focus program planning efforts. New Hampshire officials noted that the process was well-planned internally by a senior leadership team who met on a monthly basis throughout the process. The team based the framework for their linking of the needs and capacity assessment data on recommendations detailed in the MCHB guide entitled *Promising Practices in MCH Needs Assessment: A Guide Based on a National Study.* A diagrammatic representation of this framework, as it was adopted in New Hampshire, is shown in Figure 2.

New Mexico: Using Priority Areas to Guide the Process

New Mexico's Title V agency decided early in the process that the Needs Assessment should focus on agreed-upon priority topic areas. The agency decided to define the limits of the assessment rather than conduct "a wide-ranging assessment of all dimensions of health and well being of this population," as was the case in many States. They developed 10 priority topic areas based on input from the State's department of health, other agencies, communities, advisory groups, and other stakeholders. For each of these topics or issues, they compiled data not only on current health status, trends, gaps, and disparities but also on risk factors, positive influence factors (assets) and State capacity to address each issue. Additionally, the State staff researched the literature and interviewed stakeholders to identify evidence-based policies and programs and other strategies that have been shown to be effective in addressing each of the priority issues.

The Title V agency realized that the added value of the 5-year process was that it offered a way to bring a broader group of stakeholders into the process of developing a consensus on, and building political support for, the allocation of resources to priority MCH needs. An ancillary and important goal of the process was to strengthen partnerships that could advocate at the State and local levels for more resources targeted to the needs of the MCH population.

Figure 2. New Hampshire's Framework for Needs Assessment Process



California: Building from the Ground Up

California's 5-year Needs Assessment for the State's general MCH population used a locally oriented approach. The State Maternal, Child and Adolescent Health (MCAH) Office of Family Planning Branch required each of the 61 MCAH local jurisdictions to conduct a local Needs Assessment as they had done 5 years earlier. For the 2005 assessment, however, the State provided more hands-on assistance to the local jurisdictions to reduce the burden of the Needs Assessment requirement and make it more useful to them in local program planning. The State also sought to standardize the data collection and reporting processes to facilitate the synopsis at the State level of needs and priorities identified through these 61 separate processes.

In addition to the local-level data gathering and analysis and local-level stakeholder involvement, the State structured its 2005 Title V Needs Assessment to obtain more input from stakeholders at the State level. The leadership team held meetings with their branch staff and other State agency staffs (including the State mental health, social services, and education agencies) and held facilitated meetings with other external stakeholders to identify emerging issues and prioritize needs.

Washington: Using a Health Promotion Approach

Washington State views the Needs Assessment process as an ongoing strategic planning process whose purpose is to engage management and staff members in order to identify priority outcomes and have those outcomes guide funding decisions. The State envisioned a new conceptual framework for its 2005 5-year Needs Assessment soon after completion of their 2000 Needs Assessment. State officials say that in 2000, their Needs Assessment process involved tabulating indicators and identifying priorities in three separate retreats (one for each population group). In retrospect, the State felt that this was not an effective process for several reasons: it was labor intensive; there was no integration of efforts across population groups; and it was too focused on the block grant indicators, which resulted in a morbidity-focused, or what they called a "deficit-oriented," approach. The new approach for this State sought to move MCH program planning toward a health promotion approach focusing on positive outcomes. (Copies of Washington State Needs Assessment materials are in the Appendix.)

Also notable is the fact that Washington State's Needs Assessment process was guided differently from the way most States and jurisdictions conceptualize their Needs Assessments. The State started with the desired outcomes and worked backwards. They asked what attributes were necessary for "health" within different population groups and then worked on what would be needed to achieve those results. (An example of a completed logic model table and summary issue brief developed for one of Washington State's priority goals can be found in the Appendix.)

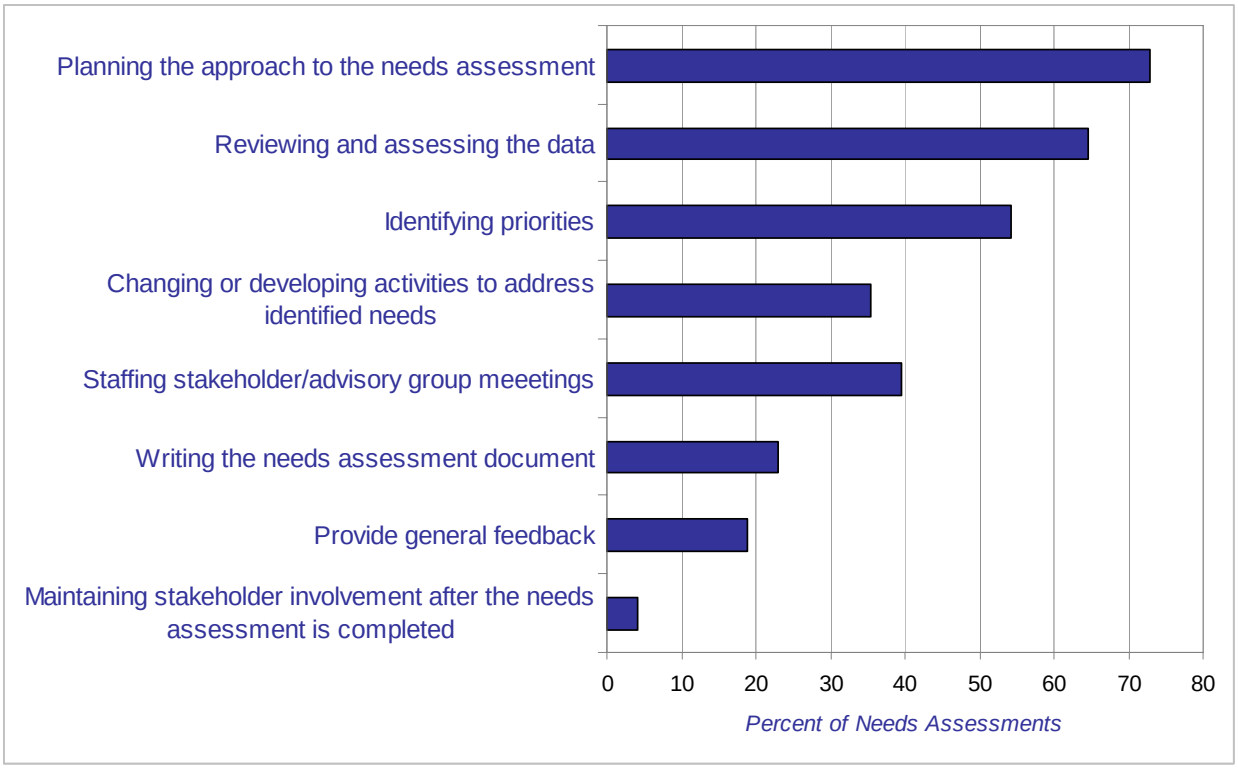
B. Leadership of the Assessment

HSR reviewed the Needs Assessment documents in an effort to understand the extent to which Title V agencies used a team approach to guide the assessment process and whether this took the form of a leadership team, committee, or central workgroup. In order to appreciate more clearly the nature of these groups and their role in the process, HSR also examined the composition of the leadership group, the number of times they met throughout the process, and the specific activities in which they were involved. The information obtained from the telephone discussions with Title V officials provided important background context to facilitate a deeper understanding of the types and range of agencies and organizations involved in the Needs Assessment leadership teams and the intensity of their involvement.

1. Document Review Findings

Three-quarters of the Needs Assessments documents described the leadership structure they used in the process. Most of this group (86 percent) indicated that the process was led by a leadership team or central workgroup. Of those who mentioned having a leadership team, 20 percent said that the team met three or more times and 10 percent said that the team met two or three times. The remaining documents did not provide information on the frequency of the leadership team meetings. As shown in Figure 3, the most commonly cited roles of these teams were planning the approach to the Needs Assessment, reviewing and assessing the data that were collected on needs and capacity, assisting in the identification of priorities, and assisting in the staffing of meetings to obtain input from MCH stakeholders (see Figure 3).

Figure 3. Leadership Group Roles (n=48*)



**Note: 5 of the 43 grantees with specified leadership groups had separate structures for MCH and for CSHCN activities; these separate structures were counted twice.*

State- or Territory-level MCH program officials were overwhelmingly the most common members of the Needs Assessment leadership teams. Seventy-nine percent of the leadership teams included these officials. There was little commonality across the Title V agencies, however, regarding the other members of their leadership teams. The most common groups represented on these teams are other State agencies, families or other consumers, local providers, and local government. Nine included representatives from other State health agencies. Seven teams included families or other consumers as members of the Needs Assessment leadership team (though they may have been included in more States as members of an advisory group). Representatives from the Office on Women's Health were included in four teams. Finally, three leadership teams included representatives from one or more of the following: local-level community service providers, local-level government, the State Medicaid agency, the State Department of Social Services, the State Department of Education, and/or the State office on oral health.

Title V agencies often relied on additional experts during the Needs Assessment process. These experts included an information specialist or an epidemiologist in nearly half of the States and jurisdictions (48 percent) and outside consultants in nearly one-third of the States (31 percent). It was less common for the Needs Assessments to use MCH consortium data workgroups (used by 9 percent) or State centers for health statistics (used by 7 percent) for their data needs.

Consultants played a variety of roles in the process across States, ranging from having the responsibility for the entire assessment, to serving as a member of the management team. The most common role for consultants was to help in collecting and interpreting existing data and/or conducting primary data collection through focus groups, key-informant interviews and surveys. Several Title V agencies also used a consultant to develop and facilitate retreats and meetings where the Needs Assessment information was summarized and participants came together to select the State's priorities.

2. Promising Practices

During the indepth telephone discussions, Title V officials described a variety of leadership structures, with varying levels of engagement in the Needs Assessment process. While the leadership structure in each of these 12 States was somewhat different, the keys to success and lessons learned were similar. Some of the key components of the process that States found to be important and/or worked very well include the following:

- The leadership team agreed on the approach and clarification of roles and responsibilities from the beginning of the process.
- There was frequent communication, information sharing, and organization in all aspects of the process, from making decisions on participants for a meeting to writing a summary of the Needs Assessment findings.
- Inclusion of an MCH epidemiologist in the core workgroup (and population-specific subgroups where this structure was used) was critical to the design of the data collection analysis plan and processes for priority setting and aided the collection, interpretation, and analysis of the data.

- Involvement of the core workgroups at priority setting meetings was key to enabling the staff and stakeholders to make the connection between what they had learned about the breadth of MCH population needs and the system capacity issues.
- The identification of a very strong Needs Assessment Coordinator who was passionate about MCH issues, had good people and analytical skills, and was outgoing and very organized enhanced communication within the team and across subgroups.

Table 1 highlights several models of the leadership structure and the roles of leadership teams in place in selected States, and more detailed information is presented later in this section.

Table 1. Leadership Structure Models in Selected States

State	Leadership Structure	Role
California	Core teams for MCH and CSHCN. The Family Health Outcomes Project (outside agency) was involved in every level of the assessment.	The MCH team coordinated the tasks of the local jurisdictions; the CSHCN team led an internal capacity assessment.
Georgia	An advisory committee, a management team, a core team, and an internal steering committee. A consultant was included on the management team.	Each group had its own tasks to be completed in the process.
Hawaii	A core team and population-specific workgroups. Private consultants were used.	The core team maintained responsibility for the entire process. Consultants developed the framework and facilitated some of the CSHCN meetings.
Louisiana	A steering committee and population-specific workgroups. A consultant was used for group facilitation.	The steering committee was responsible for the workplan, writing, and identification of stakeholders. The population-specific workgroups were responsible for data collection and analysis.
New Hampshire	A core team.	The group met monthly and provided overall leadership.
Virginia	A leadership team and a working team with divisional representation and intradivision meetings.	Divisions were responsible for specific tasks, the working team brought everything together, and the leadership team maintained oversight.
Wisconsin	A core team.	The team divided responsibilities by specialty; participation was part of employee performance reviews.

One change to the leadership structures that States would make for the future is to add several subject matter experts and representatives from other agencies to the leadership team. These

experts would be part of the decisionmaking process from the beginning and would be able to plan for the future realistically.

One State noted that engaging a large number of Title V agency staff members in the process, divided into working subgroups, made the data collection and analysis work more efficient and higher in quality. This very participatory Needs Assessment process helped the agency to set realistic priorities and affect direct programming toward their priorities within each section of the agency. All subgroup members and the leaders of each group had to come to consensus on the data needs, how to involve stakeholders relevant to their particular population group, how to manage the process, and how they would analyze the combination of quantitative and qualitative data they collected. The Title V Director in this State said that the many of the staff members who were involved worked together as partners, learning from one another and sharing resources, and she noted that this process of "friendly competition" created the best Needs Assessment for their population group. The State Director said that this process not only improved the quality of the information they gathered but had the secondary effect of developing important leadership skills among managers and other staff members at the agency.

A few of the States had various levels of leadership teams and said that this was a time-consuming arrangement that required many meetings. They most likely will consolidate these teams in the future or think about other ways to share information and get input from all those involved.

States also reflected on the use of consultants. At times, it was beneficial to use consultants with specific expertise in strategic planning and meeting facilitation or to call on consultants who had expertise and long-term relationships with other stakeholders to engage them in the process. Consultants also had the added value of being more objective than a health department staff member in terms of their particular population or cause. Moreover, State officials reported that stakeholders felt more at ease discussing the problems and issues with the current programs with outside facilitators than with State staff members. Several States pointed out that having the

additional resources of the consultant to develop tools for discussion, summarize meetings, distribute notes, and move the process along proved very useful. One State noted that it would be advantageous to hire a contractor to schedule, perform, and summarize all interviews and focus groups as well as to summarize and analyze all data findings.

Several States cited disadvantages to relying too heavily on consultants for data analysis or for obtaining input from stakeholders. Title V Officials from New Hampshire, who had hired a consultant in 2000 to collect and analyze most of the secondary data and to collect information from stakeholders, said that when the 2000 process was complete, there was less "buy-in" to the process and less ownership of the priorities from their staff members. They said that the position of the MCH epidemiologist is an "inside job" and requires someone who is involved in the ongoing MCH work of the agency. Similarly, one State that used consultants to facilitate community meetings said that the next time, they would have their staff more involved in the focus groups so that the people who manage the programs could hear firsthand the opinions and experiences of providers and consumers.

Louisiana: Focused Expertise by Population Group

Louisiana's Title V Program used workgroups for their Needs Assessment. Each of these subgroups was comprised of external stakeholders and internal program staff members specific to population groups and brought both knowledge of capacity and expertise of the subject matter to guide the prioritization process.

Each of the State's five population-focused workgroups made decisions about primary and secondary data needs, managed data collection and analysis, and carried out an initial prioritization of needs. The subgroups included not only steering committee members but other representatives from various State agencies and organizations. Each subgroup worked with an MCH epidemiologist to review existing databases, State and national reports, and other data sources systematically for data and information to describe the health status of their population. They each had their own processes for collecting stakeholder input and for performing their subgroup's assessment based on the quantitative and qualitative data collected.

Georgia: A Role for Everyone

Georgia's Title V agency used four different levels of leadership, each of which has a clear mandate to maximize the input of both internal and external stakeholders:

- The Needs Assessment **advisory committee** included as many outside partners as possible. This committee stayed in constant e-mail contact and had two meetings (attended by approximately 50 people each). Background information was presented at these meetings, and the attendees were asked for their opinions of the State's needs, barriers to care, what is working well, and what issues are emerging.

- An **internal steering committee** with "high-level" leaders met once at the beginning of the process to contact various people involved in epidemiology and

others responsible for contracts, with the goal of informing them that they would be called upon to help later in the process.

- The **management team,** an ongoing group responsible for the yearly block grant submission, includes the Needs Assessment Coordinator, a consultant, and the Director of Policy Planning and Evaluation. The team provided oversight to the Needs Assessment process and met on a monthly basis.

- The **core team** provided day-to-day management of the Needs Assessment process. They planned and coordinated activities and were responsible for the "lion's share" of the work. The team consisted of the Needs Assessment Coordinator, a policy planning group, a data evaluation team, and several interns.

Virginia and Wisconsin: Internal Staff Members as Decisionmakers

The States of Virginia and Wisconsin both prioritized dividing the responsibilities for the Needs Assessment and building ownership of the process within their program staffs, but they did so in somewhat different ways.

The State of **Virginia's** Needs Assessment process was guided by a leadership team and coordinated by a working team with representatives from maternal and child health program divisions within each of the State agencies. The leadership team included the Title V Director, an epidemiologist, and the preexisting management team and met on a weekly basis throughout most of the process. The working team worked with each division to ensure that they collected and analyzed that would apply to their specific population group. The data analysis support activity was coordinated at the leadership team level, and the workgroup helped bring together information from each division.

Wisconsin's Title V Needs Assessment process was carried out by a team of staff members led by the State Systems Development Initiative Coordinator. The team included the directors of both the general maternal and child health and CHSCN components of the program and several individuals with data expertise, including an injury prevention research scientist, two epidemiologists, and a master's degree student who performed all the data analysis. State officials said that participation in assessment activities was required as part of employees' performance goals, thus encouraging more people to contribute to the assessment process than might have otherwise.

C. Stakeholder Engagement in the Process

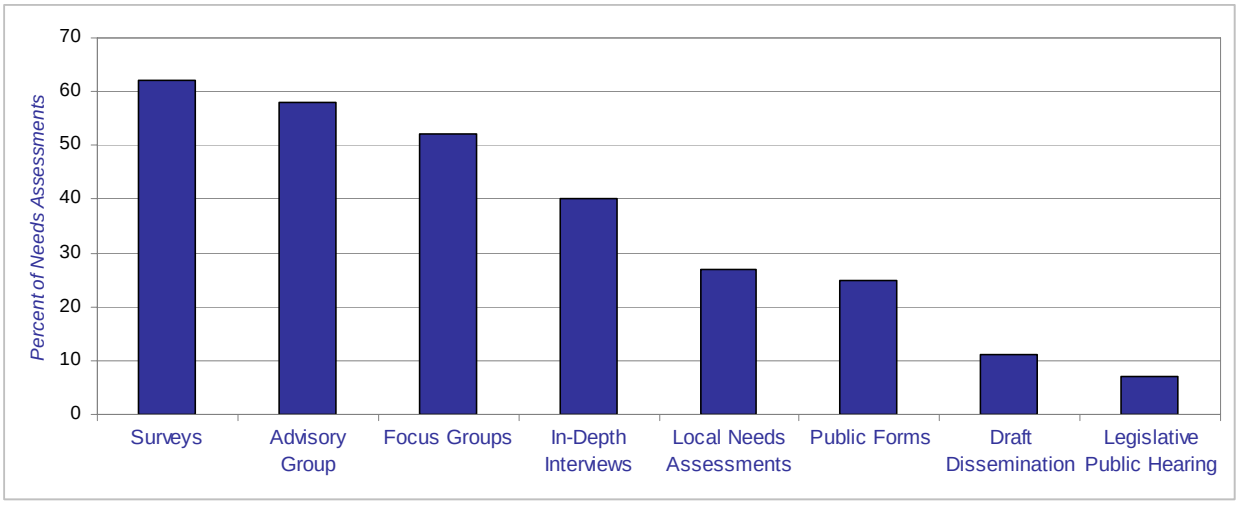
The MCHB guidance for the 5-year Title V Needs Assessment requires States to include in their documentation a discussion of "citizen and family members' involvement in the Needs Assessment process." Technical assistance trainings provided by MCHB to Title V agencies prior to the 2005 Needs Assessment highlighted the importance of stakeholder involvement throughout the Needs Assessment process and various ways that stakeholders input could be obtained. These trainings and HSR's 2004 MCHB needs assessment report emphasized that engagement of stakeholders is a critical component of the process, both to ensure broad-based input on the determination of needs and to gain insights from the perspective of a range of partners including researchers, providers, advocacy organizations, and families who may benefit from Title V services and systems. States can use stakeholders in one or more stages of the

Needs Assessment process, including determination of needs, identification of system capacity and resources, priority setting, and ongoing program planning.

1. Document Review Findings

The document review process revealed that more than one-half of the States and jurisdictions involved stakeholders in their Needs Assessment processes. Of those that involved stakeholders, the majority used more than one method to obtain their input. The proportion of Title V agencies whose Needs Assessment reports documented the use of each of these methods are displayed in Figure 4. The most common methods, used by more than 50 percent of the Title V agencies were collecting information from stakeholders through surveys or focus groups, involving stakeholders in formal advisory groups, or by a combination of these methods. Indepth interviews, local Needs Assessments, and public facilitated meetings or forums were the next most common methods. Though less common, some Title V agencies solicited stakeholder input on drafts of their Needs Assessment documents and only a few held public hearings.

Figure 4. Methods of Obtaining Stakeholder Information (n=58)



a. Use of Surveys

Surveys were the most common method of obtaining stakeholder input, with almost two-thirds of Title V agencies (62 percent) using this method. These surveys most frequently targeted local-level providers (56 percent) and families (44 percent). The various methods for administering the surveys included telephone, mail, e-mail, videoconferencing, in-person meetings, and Web site. The goals of these primary data collection efforts varied, with the following being the most common goals:

- Identify and rank priority needs or issues.
- Gauge system capacity.
- Learn about specific needs that the State has not been tracking, which will allow the State to seek out sources of information or data in their quantitative assessment of MCH needs.
- Determine needs and solutions for addressing them.
- Reach key stakeholders who were unable to attend the interviews and focus groups.

Surveys as a Method for Obtaining Stakeholder Input

Target Populations

- Local-level providers
- Internal stakeholders
- Families

Methods

- In-person
- Telephone
- Mail
- E-mail
- Web site

Intent

- Identify and rank priorities
- Gauge system capacity
- Assess needs (both ongoing and emerging)
- Determine solutions for addressing needs
- Engage stakeholders who were unable to attend interviews/focus groups

States with medium and large child populations and those with a majority of their total population living in metropolitan areas were more likely to obtain stakeholder input for the Needs Assessment through special surveys than the States and jurisdictions with smaller child populations and those whose population resides primarily outside of metropolitan areas.

b. Advisory Groups

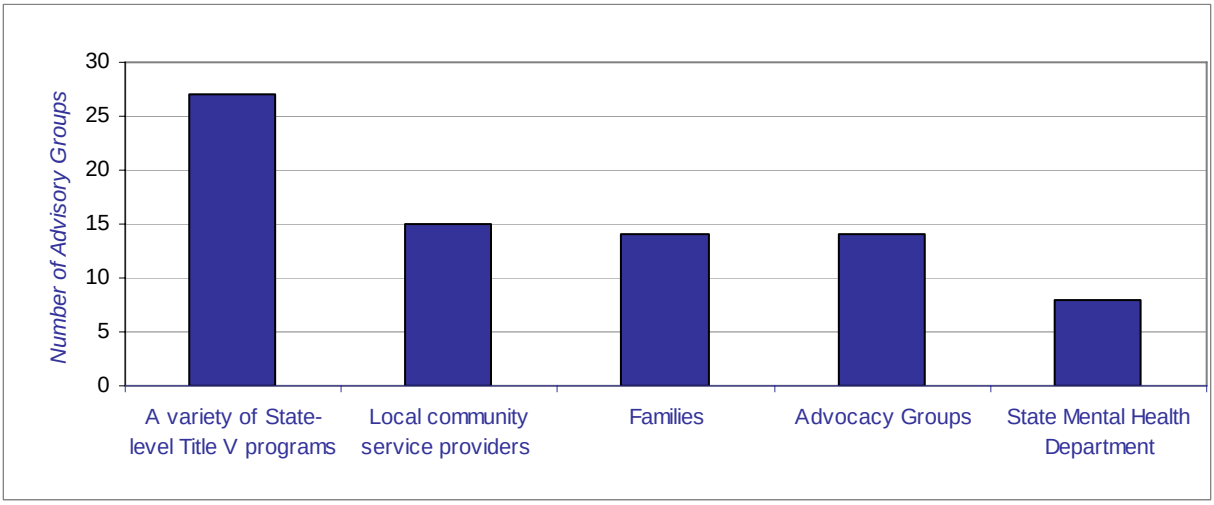
The second most common method of obtaining stakeholder input was through an advisory group. More than one-half of the Needs Assessment documents described the involvement of an

advisory group that was formed within the State. More than three-quarters of these groups were new bodies developed for the Needs Assessment process and were separate from any advisory committees that the Title V agency uses in ongoing program planning. Nine of these 34 Needs Assessments noted that they had separate advisory groups for the general MCH and CSHCN population groups.

Some Title V agencies were more likely than others to use an advisory group as a way to obtain stakeholder input. For instance, those States and jurisdictions with smaller populations were somewhat less likely to have an advisory group than States with medium or large populations. Title V agencies with a majority of their total child population living in metropolitan areas were more likely to have established a separate advisory group to address the needs of CSHCN than the States and jurisdictions whose child population resided primarily in nonmetropolitan areas.

Advisory group members most commonly cited were representatives from a variety of State-level MCH programs. As shown in Figure 5, Title V agencies included a variety of different types of organizations and individuals in the advisory groups that were developed for the 2005 Needs Assessment. Of the 43 advisory groups reported in the documents, the most common members were other MCH State-level programs (included in 27 advisory groups), local community service providers (included in 15 of the advisory groups), advocacy groups, and/or families (each included in 14 advisory groups). Indicative of a growing interest in women and children's mental health issues as a component of Title V priorities, eight advisory groups included representatives from their State mental or behavioral health agencies.

Figure 5. Advisory Group Membership (n=43*)



The most common purposes of advisory groups were to assist with the assessment of MCH needs and identification of priorities and to provide general feedback on the process. Other ways in which the advisory groups were used included engaging other stakeholders; providing guidance on how to collect information from stakeholders; and providing suggestions and feedback on survey, interview, and focus group questions.

c. Focus Groups and Indepth Interviews

As displayed in Figure 4 above, slightly more than one-half of the States and jurisdictions reported using focus groups as a way to get input from stakeholders. The most common groups of stakeholders targeted for focus groups were families and local-level providers (cited in 20 and 15 Needs Assessments respectively). Indepth stakeholder interviews were another way that States and jurisdictions sought the input of stakeholders. As shown also in Figure 4, this method was used by 23 States and jurisdictions. The types of stakeholders interviewed were most commonly local-level providers and State health department staff (in 10 and 9 Needs Assessments, respectively).

d. Local-level Needs Assessments

16 States incorporated information from local-level Needs Assessments into their 5-year Needs Assessment document (shown as one-quarter of the States and jurisdictions in Figure 4). This

local information most frequently included county MCH indicator data or information on priority needs selected through a process by local health departments or by coalitions of public and private stakeholders. States used different methods to collect this local-level data. For instance, Title V officials in California engaged its 61 local health jurisdictions in defining 27 standard indicators of need that would form the minimum dataset for the local Needs Assessments. The local agencies not only reported on the 17 standard indicators but were encouraged to report on additional quantitative and qualitative data relevant to their local population's needs, and they were required to collect information from a variety of local stakeholders and use it to develop a formal assessment of their local system capacity and community assets.

e. Other Methods

Other methods of obtaining stakeholder input included coordinating public forums (sometimes referred to as community or regional listening sessions) to obtain input from stakeholders (cited by 14 States and jurisdictions), disseminating drafts of their Needs Assessment to stakeholders to obtain comments (cited by 6 States and jurisdictions), and conducting legislative public hearings to obtain consumer input (cited by 4 States).

2. Promising Practices

During the telephone discussions with Title V officials, HSR was able to delve more deeply into the motivations, successes, challenges and lessons learned in terms of ways to engage stakeholders in the Needs Assessment process. These officials readily described a wide range of reasons that motivated them to involve stakeholders in the Needs Assessment process. Stakeholders were engaged to do the following:

- Strengthen collaborative efforts to address priorities through engaging stakeholders in contributing their ideas and knowledge and participating in decisionmaking.
- Raise awareness among external stakeholders of how their particular efforts could fit into a larger system of care.
- Give internal stakeholders an appreciation of the other State programs working with their population, which can help to improve program coordination and efficiency.

- Generate a list of real needs, so that funds will go where they are truly needed rather than just to whichever agency is the "squeakiest wheel."
- Help stakeholders to understand the big picture and appreciate the equally important yet different priorities separate from their own. This helps to reduce the conflict between constituency groups.
- Provide stakeholders with survey tools which can be easily adapted for local use.

Table 2 summarizes varying approaches that States reported they used to engage stakeholders and includes examples of key activities in which each of these States was engaged.

Table 2. State Approaches to Engaging Stakeholders

State	Methods	Examples of Key Activities
California	Focus groups, cross-agency meetings, stakeholder meetings, local-level assessment	The State provided intensive TA and guidance to help local jurisdictions to assess their system capacity and needs using a standardized dataset of local MCH indicators and training on how to obtain and use stakeholder input.
Colorado	Survey, presentation of data highlights via telephone conference, WebIQ input sessions	The WebIQ process allowed for a broad base of stakeholders to be engaged in the process without having to incur the costs of travel.
Connecticut	Collaborative meeting, listening sessions, key-informant interviews	Six listening sessions were conducted across five different counties.
Hawaii	Videoconference, e-mail, community meetings, focus groups, coalition meetings, interviews	To engage internal stakeholders, the State agency had a consultant talk to the staff about how the Needs Assessment is linked to day-to-day work; this helped the staff become more invested.
Louisiana	Regional meeting, online survey, Statewide summit, focus groups, telephone survey, indepth interviews	A different process was utilized for each subgroup, and then overall needs and priorities were determined at a Statewide summit.
New Hampshire	Qualitative interviews, mail survey	Due to limited data concerning low-income families of CSHCN, a special interview for families of CSHCN enrolled in SSI was designed and conducted.
Virginia	Interviews, public hearings, focus groups, online survey	The State generated great publicity through a press statement.

In terms of engaging stakeholders, Title V officials identified specific aspects of the process that were particularly important:

- **Engage stakeholders early and be clear about roles and responsibilities.** It is important to explain at the outset the time commitment required and precisely what is

needed from their input. Involving a range of stakeholders early in the planning process will give them a stake in both the Needs Assessment process and the final recommendations.

- **Share the conceptual framework with stakeholders.** Make sure that they have a "big picture" understanding of Title V and its mandate.
- **Be efficient.** Limit the time required of external stakeholders. If you ask too much of them, they most likely will opt out. For each meeting, be very specific about the objectives and stick to the agenda. Consider using existing collaborations and connections, rather than creating new committees and task forces.
- **Help stakeholders realize the benefit to their own work.** Conduct training sessions on topics such as problem analysis, logic model, and the pyramid and outcome measures. This will ensure that everyone is working from a common framework, and it will give participants skills they could use in their own programs. Another option is to present new data and information to stakeholders and engage them in a discussion of the implications. This attracts them to the meeting and helps them participate in decisionmaking.
- **Consider creative strategies.** The use of Web-based technology brings together stakeholders from around the State. It allows for good participation and cross-fertilization of ideas.
- **Involve parents at every stage of the process.** Parental involvement not only provides an essential perspective on the process but builds confidence and skills among parents and improves the value of their input in the future as advisors and parent advocates. States need to budget funds for stipends or incentives and plan for the time and effort required to identify and recruit parents.

During the follow-up telephone discussions, Title V officials identified a number of challenges to the effective engagement of stakeholders. Some States reported, for example, that participants were ambivalent because they did not understand the purpose of the assessment or their role in it. Stakeholders also have busy schedules, and participation in meetings may not always be their top priority. Engaging parents was another challenge because of the personal time and other costs that they would incur.

More detailed information on a few States' promising practices is highlighted on the next page.

California: Local Input into the Statewide Process

During the 2-year period that the California State Title V agency was engaged in its 5-year Needs Assessment process, there was extensive stakeholder involvement at the State and community levels. A variety of methods were used to engage stakeholders at the State level in defining needs, understanding emerging needs, and prioritizing them. These methods included focus groups, and surveys with youth, cross-agency meetings with representatives from a variety of State agencies including the Departments of Social Services, Education, and Mental Health.

Local-level needs assessment was a core component of the Title V Needs Assessment for the general MCH population. With the help of an outside consultant group, the Family Health Outcomes Project (FHOP), the Title V agency required each of its 61 local jurisdictions to conduct a community-level needs assessment. The State developed and distributed a guidebook for the local jurisdictions to structure each of their Needs Assessment processes and reports submitted to the Title V agency. Through the use of FHOP as an outside contractor, local agencies were trained using formal trainings; Web-based materials; and hands-on, individual assistance as needed.

The local jurisdictions used a variety of methods to obtain stakeholder input: approximately one-quarter of the local jurisdictions conducted focus groups with stakeholders, the majority conducted key-informant interviews with stakeholders, and one-half of the areas – particularly those in rural communities – distributed and analyzed surveys to obtain stakeholder input.[3] In total, 90 percent (55 of 61) of the local jurisdictions completed their local needs and capacity Assessments in 2004. The State agency reviewed all of these documents and the findings were incorporated into the final summary of needs presented by the State. (See the Appendix and www.ucsf.edu/fhop for materials used in the California local maternal and child health needs assessment process.)

Connecticut: Using Learning Sessions

Stakeholders' input in the Connecticut Title V 5-year Needs Assessment process was structured through the use of "listening sessions" (five with community groups and one with consumers) conducted in five different counties in the State. The listening sessions had a total of 79 participants representing local health agencies, advocacy groups, primary and early care providers, social service agencies serving CSHCN, and homeless and transitional housing agencies.

Fourteen consumers attended a consumer listening session held in New Haven. The participants were presented at the listening sessions with summary of the MCH indicators using a document prepared by the consultant group, called the Health Profile, for MCH populations. The focus of the discussion was the identification of gaps or barriers in the health systems that should be targeted for improvement in relation to the identified MCH needs.

3 Many rural communities indicated that holding meetings with groups of stakeholders was not feasible due to the costs and travel time involved. Through its contractor, the State helped to develop a standard survey that these rural agencies could use to obtain input from their stakeholders. (See the Appendix for a copy of this survey.)

Louisiana: Stakeholder Involvement Tailored to Information Needs for each MCH Subgroup

In Louisiana, each of the five population-specific subgroups of the leadership team used their own approach for obtaining stakeholder input (Samples of the worksheets used by each workgroup are contained in the Appendix.)

- **The Perinatal Health** subgroup collaborated with the ongoing regional and local Louisiana Infant Mortality Reduction Coalitions around the State to obtain stakeholder input on needs and system capacity. Each regional assessment involved the regional office of public health's epidemiologist and medical director, the State-funded coordinator for the Infant Mortality Reduction Initiative Team, and members of the ongoing regional Fetal and Infant Mortality Review Community Action Team and Case Review Team (which typically include local physicians, social workers, coroners, and community groups). The State Title V agency provided each team with a packet called the Perinatal Needs Assessment Template that contained local, regional, and State perinatal health statistics and asked each team to (1) identify their vision and goals, (2) conduct a Perinatal Periods of Risk assessment, (3) conduct a health system Capacity Assessment, (4) select their top three priority needs, and (5) list potential activities to address those needs with justifications based on what is known about the effectiveness and resources available for each activity.

- **The Child Health** subgroup targeted a broad range of community representatives (including advocacy groups, faith-based and other community groups, and regional State health department staffs) and providers. Community representative input was gathered through regional meetings where the State provided extensive local-, regional-, and State-level statistics on the health and well-being of children. The objective of each of these regional assessments was to state their vision and goals for the child health population, identify the top regional child health needs, document current system capacity, and recommend short- and long-term strategies for addressing these needs. Input from private health providers was obtained from an online Child Health Provider Survey. The survey asked respondents to rank priorities and solutions for addressing those needs from a given list, with the option to add and rank additional needs by examining the availability and accessibility of resources and services in their region or practice.

- **The Oral Health** subgroup obtained input from stakeholders primarily through questions included in the Provider Child Health Survey and through a statewide summit that was attended by approximately 125 individuals representing the health department the dental provider associations, the State Medicaid agency, community health centers, the State school of dentistry, Head Start Program Directors, parents, and the Rural Water Association. An outside facilitator was used during the Summit to determine priority needs and strategies to meet those needs.

- **The Adolescent Health** subgroup held focus groups with stakeholders at the community and State levels. Focus group participants were presented with health and related data on adolescent health, discussed these needs and their local relevance, and together ranked and prioritized the top priorities for adolescent health in their area. These groups were facilitated by an outside consultant and brought together a range of professionals working at the State and community levels represented multiple

agencies, ranging from STDs and HIV to juvenile justice and gay, lesbian, bisexual and transgender teens.

- **The CSHCN** group began their efforts to engage stakeholders early on with the establishment of an advisory group of individuals and agencies from around the State, including public and private physicians, allied health providers, and parents of CSHCN. This group guided how they would collect information from stakeholders and provided suggestions and feedback on the survey, interview, and focus group questions. Using an outside contractor at the State university to collect and analyze stakeholder input, the subgroup engaged a large number of providers and consumers in the Needs Assessment process by using methods tailored to each group. Pediatricians were surveyed by telephone and followup telephone interviews to assess the financial factors and other provider characteristics and practice patterns affecting access to services. The subgroup also conducted 19 focus groups where families of CSHCN provided their views on the strengths and weaknesses of the existing public and private systems of care.

New Hampshire: A Comprehensive Approach for CSHCN

In 2001, the CSHCN Program Coordinator in New Hampshire began a multistage process to gain input from stakeholders on the needs of CSCHN and their families and the priority system issues that the Program should focus on in the coming years. The first stage of the Needs Assessment for the CSHCN Program comprised qualitative interviews and focus groups with 110 professionals and family members representing more than 40 different constituent groups. In these open-ended forums, interviewers asked stakeholders to identify ongoing and emerging needs of CSHCN and their families, as well as the capacity of the current programs and services to meet those needs. The interviews were organized around four topic areas: continuing care issues and needed services for CSHCN and their families; new knowledge that will change and/or redefine the needs of this population; societal trends that will impact this population in the future; and strengths, gaps, and deficiencies in current programs and services for this population.

The next stage comprised a two-round mail survey of stakeholders to identify and rank priority issues impacting families of CSHCN and the potential for collaboration with families and other community organizations on these issues. This survey contained issues highlighted in the first stage and asked stakeholders to rate each issue as to its potential degree of impact on families and the potential for community and/or interagency collaboration to address the issue (on a scale of 1 to 5).

Given the limited data available from low-income families on their experiences and concerns with the systems of care for their CSHCN, the State also designed and conducted a special survey of families of CSHCN enrolled in the Supplemental Security Income program, using questions on system capacity similar to those in the National Survey of CSHCN. Questions focused on the extent of family partnering in decisionmaking about care, family satisfaction with care, adequacy of public or private health insurance, access to coordinated, ongoing comprehensive care within a medical home, ease of organization of services for the family, and the percentage of youth with special health care needs who receive the services necessary to transition into adult life.

The State then distributed a preliminary version of their analysis of all quantitative and qualitative data collected for the Needs Assessment and presented the highlights of these data during statewide telephone conferences, with more than 700 individuals participating. Following the briefing, a series of interactive stakeholder input sessions were conducted over a 2-month period utilizing the Internet-based technology WebIQ. The process was facilitated by a WebIQ Coach from a consulting firm. It was a "live" process, meaning that participants could ask questions of the leadership group, who would respond in real time. Individuals from a total of 48 State- and local-level programs and organizations participated in these meetings. Participants in these web conferences included State agency staffs, local health departments, other MCH contractors, advisory group members, provider groups such as the State Academy of Pediatrics, and interested nonprofits and advocacy groups.

D. Selecting Priorities for the Block Grant

A critical component of any Needs Assessment process is the ability to sort through the large amount of information collected and analyzed to identify the most important needs that should shape the direction of program planning. For the Title V Block Grant Program, States are asked to list 7 to 10 priority needs from the Needs Assessment and subsequently each year as part of the annual application or report. Examples of MCH focus areas of priority needs identified by the States in 2005 include the following:

- Reduce the barriers to health care access for pregnant women.
- Reduce the prevalence of childhood obesity.
- Improve access to mental health care providers for women and children.
- Increase access to medical homes for all children, including CSHCN.
- Reduce disparities in health care access for minority and ethnic subpopulations.

It is MCHB's hope that State-selected priorities such as these will serve as overall goals for the State MCH program and will be useful in guiding program planning and resource allocation to meet those goals.

Prior to this most recent 5-year Needs Assessment, MCHB provided a variety of formats of TA and training to the States on the process of selecting priority needs. This included the MCHB-funded publication, *Promising Practices in MCH Needs Assessment: A Manual Based on a*

National Study, which contains a discussion of how to incorporate the findings of the 5-year MCH Needs Assessment into State priorities. It also included regional training sessions that provided Title V agencies specific methodologies they could use to help rank and prioritize among identified needs. In all of these formats, MCHB stressed the importance of a process that would develop consensus and build support for the MCH priorities. MCHB also emphasized that States should use a prioritization method that relied on objective criteria to prioritize among the many identified needs in the State or Territory. One key method demonstrated to Title V agencies was the Q-sort method.

MCHB asks Title V agencies to describe their priority-setting process as part of their Title V 5-year Needs Assessment submission. HSR abstracted information from the Needs Assessment documents to examine the priority setting process States used, including whether a defined methodology was specified and whether the State linked the priorities to their needs data within the application document. As in the previous sections, the findings from the document review are summarized in the first findings section below, followed by the findings from the telephone discussions. The latter explore in more detail the processes used and the successes and challenges of the chosen prioritization methods.

1. Document Review Findings

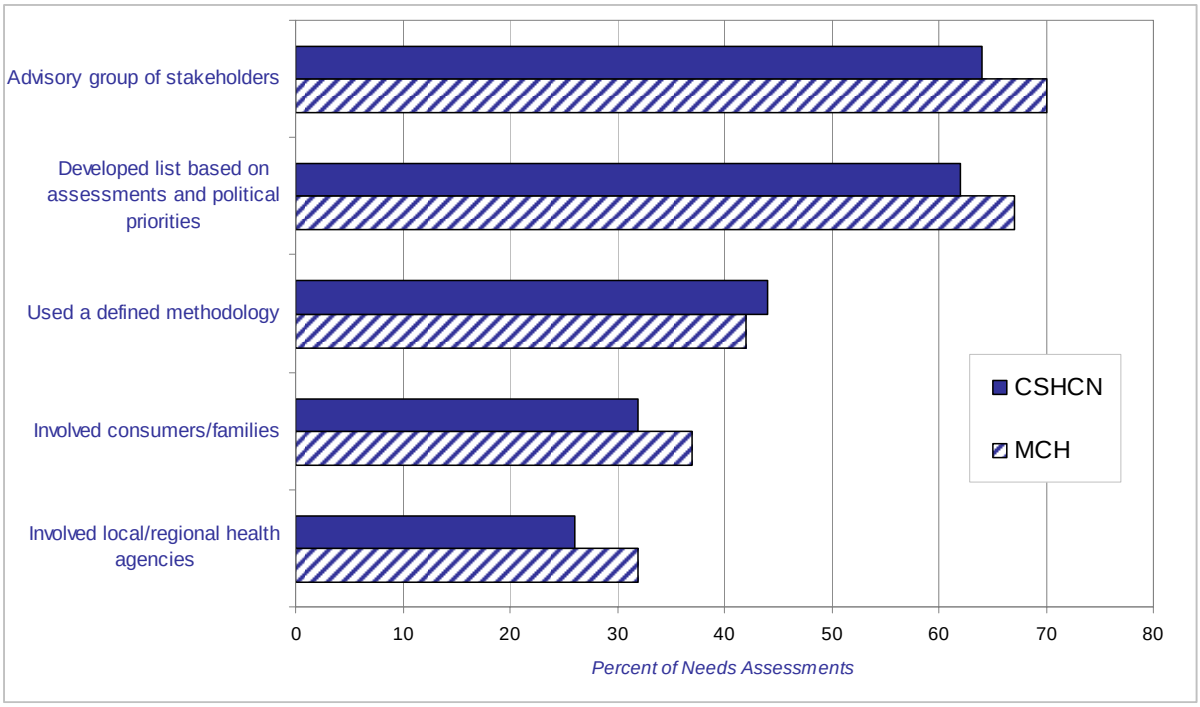
States and jurisdictions used a variety of methods to determine their priority needs. Figure 6 shows the most popular methods used for assessing the needs of the general MCH population and for the CSHCN specifically.

In determining priority needs for the general MCH and the CSHCN populations, the most popular method, used in more than 60 percent of the Needs Assessments, was to involve a statewide advisory group or group of stakeholders in the process. Title V agencies with medium and large child populations were more likely than those with small child populations to involve other stakeholders, including local and regional health agencies and/or consumers and families in the MCH priority-setting process. Similarly, States where a majority of the population resides in

metropolitan areas more often reported involving these organizations and individuals in their priority-setting process than their counterparts in States and jurisdictions whose population is primarily located in nonmetropolitan areas.

The majority of the Title V Needs Assessments used a process that involved the Title V agency developing a list of priority needs (primarily based on assessment of needs and or capacity or other issues specific to their State). Next most common was the use of a defined methodology for ranking and prioritizing needs – a systematic prioritization method that was used by slightly more than 40 percent of the Needs Assessments. Examples of these methodologies include using a Q-Sort process, using logic modeling, and setting criteria that issues have to meet in order to become priorities. The majority of Title V agencies with a larger proportion of their populations residing in metropolitan areas reported using a defined methodology for ranking and prioritizing the needs they identified through the Needs Assessment process, while only about one-quarter of those whose population is primarily non-metro reported used such systematic methods for selecting their priorities. At the same time, more than 30 percent of the Title V agencies involved families and/or consumers in the priority-setting process for the general MCH population, while more than one-quarter involved local and/or regional health agencies in this process.

Figure 6. Methods Used to Determine Priority Needs



2. Promising Practices

As noted above, through indepth tailored discussions with Title V officials in 12 States, more indepth information was able to be obtained about the priority setting process. These States used a variety of methods to determine and rank priorities in the Needs Assessment process, and most of them used multiple methods, as noted above in Figure 6. Almost all of these Title V officials in these 12 States described using ranking criteria and a scoring process at some stage in their selection of priorities of need though the parties involved in the priority setting process and the specific criteria varied greatly across States.

Title V officials identified aspects of the process that were particularly important in ensuring a successful prioritization process:

- **Engage an effective facilitator.** It was important to have a facilitator who was able both to keep the discussion moving and to make sure that everyone's voice was heard (even if they were put into a "parking lot" for further discussion).

- **Use logic models.** Although it was time-consuming to train people to use the logic model, it enabled stakeholders to think about the inputs and outcomes necessary to tackle the prioritization of needs.
- **Select measurable outcomes.** Title V agencies should ensure that the final priorities are not so broad that they lose meaning or are not measurable.
- **Good communication among subgroups and teams.** It is important that each subgroup or workgroup knows what the other group is doing so that there will be no surprises and so that participants will understand the larger process.

While every attempt was made to make the prioritization process "objective" through the use of specific criteria and review of relevant data, our analysis revealed that States were still faced with decisions being made based on "whoever talked the loudest," "whoever was at the table," and "whoever had the most resources." Similarly, some participants were adamant about their particular issue and were not happy with the prioritization results when their issue was not included.

Some Title V officials reported that the kinds of needs to be decided upon were not comparable. In these States, some of the needs were broadly stated, while others were very narrow or a subset of a broader issue or problem. One clear lesson cited by Title V officials is that while the phrasing and scope of the priority needs can vary across States, within one State or Territory's Needs Assessment process there should be consistency among the way needs are conceptualized and defined.

Indiana: Starting with Many Priorities and Systematically Identifying 10

Indiana used the same priorities from the two previous Needs Assessments, as well as national performance and outcome measures, and suggestions from the staff as the starting point for their Needs Assessment. This approach resulted in the identification of more than 100 potential priorities. The State determined the priority needs by evaluating the health statistics for each of the population groups and the capacity information. Capacity information was collected by Public Health Preparedness Regional Epidemiologists through interviews with First Steps, Step Ahead, the local health department, and Title V grantee staff members and other contacts in 90 of 92 counties. The survey questions incorporated questions of capacity specific to MCH areas of concern, such as availability of smoking cessation classes, exercise/recreational areas, dietitians/nutritionists, and health care providers.

The State identified issues of concern from these data. Twenty-six data issue fact sheets that provided data for 36 issues and county-level fact sheets with sentinel health statistics were created and incorporated into a Web-based Q-Sort survey, which was a key method of obtaining public input into the development of the priorities. E-mails with a link to the survey were sent to all health departments; Maternal and Children's Special Health Care (MCSHC) Grantee Project Directors; community health center directors; First Step coordinators; Step Ahead coordinators; other State agency contacts; and advisory groups for Genetics, Child Care Health Consultant Program, etc. A letter was sent by mail to 100 families participating in the Children's Special Health Care Services (CSHCS) Program to which a reimbursement had recently been paid (to ensure the family was actively using CSHCS).

Once the Q-Sort information was analyzed, MCSHC team leaders and other Indiana State Department of Health (ISDH) managers considered the survey data, the health and capacity data, the 2005 ISDH Priority Implementation Plan (which has as its goals decreasing infant mortality and prematurity rates, decreasing overweight and obese persons in Indiana, reducing asthma morbidity and mortality rates, enhancing access to primary care, and developing a culturally competent workforce), Federal Performance Measures, and issues that other organizations are doing statewide. Criteria used to prioritize among the problems identified focused on the following considerations: (1) How important is the problem? (2) Can the State health department do something about the problem? (3) What is the feasibility? (4) What is the availability of resources? (5) Does it fit with purposes of Title V, Healthy People 2010, the Governor's priorities, and other political considerations? They also considered the commitment of funding, staff time, and focus of effort that the priority might have.

Hawaii: Prioritization and Problem Analysis

Prioritization. A formal method for prioritizing health issues was developed in Hawaii to identify a minimum of five priorities for each population group. (A copy of Hawaii's tools used to select priority needs is in the Appendix.) The workgroups established for the Needs Assessment developed issue papers using the prioritization criteria for presentation before the Needs Assessment Steering Committee. The Steering Committee used the prioritization scoring to select 10 priority issues from a list of 12. The staff developed the issue papers from a set of established prioritization criteria, which included capacity-related indicators. Each of the white papers linked needs to capacity.

Problem Analysis. The Title V agency used a problem analysis model developed by The Family Health Outcomes Project at the University of California San Francisco, "Conducting a Formal Problem Analysis," to begin identifying key factors. TA was secured from the University of Hawaii Department of Public Health Sciences and Epidemiology to help the staff understand and work with the model. The purpose of the problem analysis is to develop a better understanding of the nature of the priority health issues based on research, by identifying the factors/determinants that impact the health issue and deciding which factors are most important to address and can be changed through strategies/programs. The problem analysis is conducted in conjunction with stakeholders to ensure that there is a common understanding of the problem that serves as a basis for collaborative planning. Input for the problem analysis was secured from a statewide stakeholder meeting held in October 2004 that included additional data sources, research, and key interventions. The CSHCN Program also used qualitative data collected through their statewide conference and subsequent focus groups and community meetings conducted on the neighbor islands.

Logic Model. Developing an understanding of the capacity of the current service system was also a key component of the problem analysis. Information from stakeholders was gathered on existing programs and interventions from the statewide Needs Assessments meetings and through interviews with key stakeholders. To compile the problem analysis information in a user-friendly format, the Behavior, Determinants, and Interventions logic model was used. The model was developed by Douglas Kirby of ETR Associates. Although the model is generally used to design program interventions, it is being adapted to describe and assess the existing system of services to address each priority health issue.

Washington: Collaboration Among Groups to Reach Consensus

In Washington State, the Needs Assessment was conducted by four workgroups made up of staff members from all sections of the Title V agency – one workgroup for each population group – involved in setting priorities. The priority-setting process involved defining not only desired health outcomes but also the important factors that could improve desired outcomes for each of the priorities. The workgroups used a logic model process to focus on outcomes instead of block grant indicators. They took the responses from the stakeholders and the logic models to determine indicators and activities for identified desired outcomes. This enabled the staff to see the connection between activities and

outcomes, which had not been clear in the past. If the connection was not evident, they questioned whether the priority outcome was really important.

Each workgroup developed 6–10 priorities using this process, for a total of 31 total priorities. These were sent to a steering committee, which reviewed the logic model work for consistency of process. The steering committee then proposed collapsing the 31 priorities into 10 priorities to eliminate the overlap between them. These 10 priorities were then sent back to the workgroups for approval. Any workgroup could object to the collapsed priorities, and the steering committee would then uncollapse that priority. The workgroups wholeheartedly accepted the new priorities, however, and even advocated collapsing them further to nine. The nine priorities were then sent out by the workgroups to their individual stakeholder groups, who gave their support for and validation of both the process used and the results.

E. Application of Needs Assessment Findings and Process to Ongoing MCH Work

As described earlier, the purpose of the Needs Assessment is twofold: to understand the public health challenges and infrastructure capacity to meet those challenges, and to apply the assessment results to ongoing work within the State or Territory. Therefore, this study explored how Title V agencies use the findings of their Needs Assessment process in general and to what extent the findings affect program planning and resource allocation in particular. HSR abstracted information from the application documents regarding whether, as of the completion of the Needs Assessment:

- New goals and objectives were identified and new workplans were developed
- Priorities and allocation of resources were linked
- The Title V agency planned to disseminate the findings of its Needs Assessment to stakeholders who may be supportive of MCH programming efforts.

As discussed further below, Title V officials from the 12 States offered further insight into why these changes did or did not occur and what factors affected these results.

1. Document Review Findings

While only eight Needs Assessments clearly noted that were linking the priority needs with the process that they would be using to make decisions regarding the allocation of resources, 16 Needs Assessments cited the development of a workplan, with planned or proposed activities identified, to address the State or Territory's priority needs. The latter was more common among States whose populations were primarily urban. Specifically, 14 of 33 Needs Assessments from States whose populations were primarily in metropolitan areas said that they had developed a workplan with identified activities to address the MCH priority needs identified through the Needs Assessment process. Conversely, among the 25 States and jurisdictions whose populations did not reside primarily in metropolitan areas, only two Needs Assessments noted that such a workplan or strategic plan had been developed or was under development.

Dissemination of Needs Assessment Results

Audiences

- Public and private agencies
- Members of advisory groups
- State Perinatal Advisory Council
- Health Department staff

Modes of Dissemination

- Fact sheets
- Papers
- User-friendly summaries
- Web site postings

Nine of the Needs Assessments identified the individuals or group to whom they planned to disseminate the results. Several of these documents did not identify specifically individuals or groups to whom they planned to report the results, but they did state that they planned to distribute the results. The remaining documents identified stakeholders in general to be the intended recipients. Some of the specific stakeholders that were mentioned include representatives from public and private agencies, members of advisory groups or expert panels, the State Perinatal Advisory Council, health department staff members, and members of Healthy Start coalitions. The modes of dissemination that were mentioned include distribution of fact sheets, papers, user-friendly summaries, and Web site postings.

2. Promising Practices

The telephone discussions were a useful way to learn how States applied their Needs Assessment findings to ongoing work. As shown below, seven of these States indicated that they are using or plan to use their Needs Assessment findings in their ongoing program planning, though in most cases the Title V officials said that the extent that they used the needs assessment findings in ongoing program planning and other work varied across their priorities. Table 3 presents examples of how several State officials described their use of the needs assessment findings:

Table 3. Use of Needs Assessment Findings in Ongoing Program Planning in Selected States

State	Uses of Needs Assessment Findings
California	The State developed a 4-year implementation plan for the MCH population. Local jurisdictions are required to focus on one priority; the CSHCN program is developing an action plan.
Colorado	The State is implementing a series of videoconferences to review the Needs Assessment findings and build partnerships to enhance local infrastructure to address these priorities.
Hawaii	Workgroups will continue to refine the problem analysis/logic models in conjunction with stakeholders and utilize the findings for future planning.
Indiana	The State allocated money to newly identified priorities and identified "focus" counties that are top priority for available resources.
Louisiana	The State built a strategic and operational plan based on the priority needs; a comprehensive workplan was developed for each need.
New Hampshire	The State used Needs Assessment results to compete for a grant and used stakeholders to build new partnerships.
Virginia	Broad priorities each will have their own process for being addressed. They may have trouble shifting program planning efforts due to political concerns.

States faced a number of challenges in moving from Needs Assessment to strategic planning and ultimately implementation. Some of these challenges include the following:

- **Political considerations.** It is politically difficult to eliminate a program that is not working or not a priority and start a new one. There are staff members, advocacy groups, and consumers who most likely will not want the change.
- **Funding.** Much of the MCH and CSHCN work is funded through categorical grants that require them to undertake specific activities or reach specific goals; the agency staff has

to work around those requirements when addressing priority needs. Also, in general, moving money into new areas is a slow and difficult process.

- **Power to make systematic changes.** Some decisions must be made at a level higher than the Title V agency. State legislators, for example, need to embrace the results and help implement change.
- **Other external factors.** Cuts in funding and changes in priorities that may be set by a new State administration (Governor or Health Commissioner) may hamper the Title V agency's ability to move forward on the Needs Assessment priorities.

The processes that several States have established to incorporate the Needs Assessment into their ongoing program planning cycle are highlighted.

California: Collaboration Among Stakeholder Groups Ensures Successful Planning

California's Title V agency developed a 4-year implementation plan for the general MCH population based on the identified priority areas developed from the Needs Assessment. This plan was a collaborative effort by local jurisdictions and a broad group of stakeholders. To develop this plan, the State staff conducted half-day site visits to five counties to get their input on what county activities relate to the State priorities and their ideas on best practices. The core leadership team used this information to draft an implementation plan with specific objectives and activities to be implemented at the State level for four of the seven priority areas. This draft plan was reviewed by the directors of the 61 local jurisdictions, and a revised draft was distributed to experts in the field. A second revised plan was then presented to a more than 40 stakeholders to get their input and ideas on best practices before the plan was finalized.

Policy and program staff members are using the plan to help the local agencies implement or redesign programming, and the epidemiology staff has been assigned to identify data and literature for each of these four priority areas, work on expanding data availability, and track and report on the available data and literature, on at least an annual basis.

At the local level, their own priorities are directly linked to their program plans and annual reports. Each jurisdiction is required to select one top priority from their Needs Assessment and focus on that area. FHOP has developed a guidebook to help the locals use the Needs Assessment in program planning (see www.ucsf.edu/fhop), and face-to-face training was provided as well. To hold the local jurisdictions accountable to their own program planning, each local agency is asked to monitor and document progress on at least their top priority as part of their annual report submitted to the State agency.

The State CSHCN agency, in partnership with a coalition of stakeholders, was awarded a Champions for Progress Incentive Award grant. Using these funds, the State is convening an ongoing group of key stakeholders bimonthly for 12 months to develop strategies and an action plan to address the CSHCN Title V performance measures and prioritized issues identified by the Title V Needs Assessment

process. The project is building on existing coalitions and projects as well as past efforts to develop a long-term, strategic plan for serving CSHCN; it will take the Needs Assessment several steps further to identify resources within California to carry out the activities defined in the strategic plan that flowed from the 5-year Needs Assessment.
Colorado: Title V Priorities Drive Local Planning
The State's Needs Assessment priorities are being incorporated into local health planning by each of the Title V agency's local contracting agencies. To encourage and support changes or enhancements to local programming to focus on identified priorities, the State Title V agency is implementing a series of videoconferences available statewide both to review the Needs Assessment findings and to promote partnerships to enhance local infrastructure to address these priorities. Examples of the first areas of focus include access to oral health care and teen motor vehicle safety.
Louisiana: Title V Managers and Stakeholders Transform Priorities into an Action Plan
The steering committee for Louisiana's Title V Needs Assessment continued working together for 1 year after the Needs Assessment was completed. With the help of a facilitator, they developed a strategic and operational plan built upon each of the 10 priority needs. Each person on the team has been assigned to one priority need and has developed a 5- to 10-page comprehensive plan for that need. The agency's management structure is now built on the priorities, and at each monthly management team meeting, they go over two or three of the priority-specific plans to assess progress and what may need to be changed or improved. Louisiana's Title V Director noted that the regional perinatal coalitions, who were the core teams assessing priority perinatal issues for the State, now are using the Needs Assessment findings to support development of a "strong hub of public health infrastructure" to address the infant mortality and perinatal health needs in each region.

F. Ongoing Needs Assessment Process

Although a comprehensive Needs Assessment is required by the MCHB every 5 years, there are several reasons why conducting an ongoing Needs Assessment could prove useful. These reasons include, but are not limited to:

- Staying in tune with trends and changes in MCH population needs
- Reducing the burden of the comprehensive Title V Needs Assessment
- Making timely adjustments to program planning and resource allocation
- Providing information to policymakers

In order to determine how and to what extent States are engaged in ongoing Needs Assessment efforts, HSR included several related questions in the data abstraction process. The telephone discussions provided more information on the players involved in ongoing Needs Assessment, what information is obtained and examined, how ongoing needs are linked to priorities and work planning, and what benefits and challenges are presented by the process.

1. Document Review Findings

Ongoing Needs Assessment was not an activity frequently mentioned in the Needs Assessment documents. Indeed, nearly two-thirds of the Needs Assessments (64 percent) did not discuss reviewing or monitoring progress on identified needs after the 5-year Needs Assessment. Only two Needs Assessments discussed quarterly Needs Assessment, five discussed annual Needs Assessment, and one discussed biannual Needs Assessment. Another one-fifth of the States included some discussion of ongoing Needs Assessment that did not fit into any of these categories. Most of this latter group noted the Title V agency's intent to perform ongoing Needs Assessment but did not indicate how often it would be conducted. One Needs Assessment described their focus on Needs Assessment as a "continuous activity carried out on a year-round basis."

2. Promising Practices

States elaborated on their plans for ongoing Needs Assessments during the telephone discussions, yet as HSR learned from the document abstraction effort, few States had a well-defined plan. In general, most States still are developing their methods for ongoing Needs Assessment or are performing limited Needs Assessment on an interim basis. States are aware that such an effort cannot be completed in 1 year, but they also realize there are limited resources (time, money and personnel) to perform an indepth, ongoing Assessment. Moreover, States confronted the challenge of making the ongoing Assessment meaningful. A few States explained that an ongoing Needs Assessment may not result in any significant changes in program

planning, because the data changes they would see from year to year would be too gradual to warrant any major shifts in focus.

Examples of some of the ongoing Needs Assessment activities currently being conducted or planned in the States are detailed in Table 4.

Table 4. Ongoing Needs Assessment in Selected States

State	Ongoing Needs Assessment Activities
Colorado	Annually track State and local performance on all national and State MCH measures. Develop and distribute MCH data profiles to each of the county health departments for use in local Needs Assessment and program planning.
Georgia	Update the Needs Assessment this year (not done annually). Bring back the members of their advisory committee and ask them how their priorities have changed since the 5-year Needs Assessment.
Hawaii	Conduct a subject-specific Needs Assessment (on a smaller scale).
Indiana	Have stakeholders complete the Q-Sort annually.
Louisiana	Annually examine the performance measures and other data, and publish a State MCH data book. Analyze the latest MCH-related data presented at monthly staff meetings (two to three times a year).
New Hampshire	Rerun data on a regular basis to watch for trends in performance on priority needs.

Chapter III. Lessons Learned and Recommendations

The previous chapter shows that that the Title V agencies used varying processes in their 2005 Needs Assessment and appear to have tailored the process they used to their agencies' needs, resources, population size and geography, existing relationships with local health agencies and stakeholders, and skills and experience on staff within the Title V agency. This final chapter takes a step back to analyze the key successes and lessons learned from the processes used by Title V agencies in the 2005 Needs Assessment. It draws from what Title V officials reported were the most successful aspect of their Needs Assessment processes, their views on obstacles or challenges in the process, and what they say they would do similarly or differently in the future as part of Needs Assessment and program planning for maternal and child health.

The key elements of the Needs Assessment process and lessons learned discussed below are presented as guides to help all States and jurisdictions as they begin to plan for the upcoming 5-year Title V Needs Assessment. The recommendations at the end of the chapter are designed to help States and MCHB work together to plan for the next Title V Needs Assessment in 2010. These recommendations are not attributable to the MCHB. Rather, they are drawn from what Title V Directors said were their training and information needs and what they liked and did not like about past technical assistance, training, and formal guidance offered by MCHB on this important aspect of the Title V Block Grant Program.

A. Key Elements of the Process

HSR's document review and telephone discussions with Title V officials revealed several key elements of a successful Needs Assessment process. These include skilled and dedicated staff members, strong partnerships, and access to and utilization of data. These critical components of the Needs Assessment process, as well as the negative impact on the Needs Assessment that the absence of these processes often created, are discussed below.

The dedication, commitment, and competency of staff members. Many States believed that having staff members with a combination of skills, ability, and determination ensured the effectiveness of their assessment process. A few States reported that having one staff member dedicated to the coordination of the Needs Assessment efforts allowed the State to conduct a more thorough, comprehensive process than in previous years. Two States also noted that the formation of an internal leadership team was critical to the overall success of the Needs Assessment and resulted in the staff being immediately invested in the process and product of the Needs Assessment.

Title V officials in several States said that requiring their Needs Assessment activities to be conducted across the various MCH divisions in the State helped foster improved communication and integration of activities for longer-term program planning. The Title V Director in one State said that having the entire Title V MCH program staff involved in the review of data and qualitative information was beneficial because regional stakeholders were delighted that the entire program management team from the State agency was out in the field talking to them. The particular State agency official noted that, "Having the [Title V] team go out and visit regions was a wonderful opportunity for connections."

> Talking about the multiple advantages of engaging a broad group of Title V Program Managers in the planning and conduct of the Needs Assessment, the Louisiana agency director said, "When the Program Managers went out to the communities or meetings of stakeholders, not only were they learning about emerging needs, they were also networking. We are now putting in place effective strategies that we heard about at the local level and using partnerships to develop them. We also better understand how useful the maternal and child health data are to our stakeholders."

Widespread participation and useful input by stakeholders. States took pride in their ability to mobilize local, private, and external providers and policymakers and engage them in

decisionmaking. In some States, the relationships that were built or strengthened during the Needs Assessment process now are being further enhanced through programmatic partnerships and policies. However, a number of States found engaging stakeholders to be their greatest challenge. Engaging the critical partners outside of the Title V agency was often difficult, and minimal participation of Medicaid officials was a specific issue. It was also a lot of work to engage consumers and stakeholders in key-informant interviews and focus groups; it presented further burdens on an already stretched staff and budget.

Good use of data. States that were able to pull together needs and capacity data for each population served by MCH programs and integrate the findings to develop realistic priorities believed that this was the greatest measure of their success. The use of an objective and organized method such as data detail sheets and the Q-Sort method helped give structure to and validate the prioritization process. Other States reported that the effort they put out to collect and blend qualitative and quantitative information on needs and system capacity helped them to achieve a successful Needs Assessment and a more indepth understanding of program direction needs than the annual review of MCH indicators for the block grant permits.

Some States, on the other hand, found the greatest challenge to be gathering and using data. In general, the data collection effort required substantial resources necessary to analyze and interpret the data. There was often limited accessibility to existing databases, because of either lack of staff to conduct the analyses or turf issues relating to the ownership of the data. For some subpopulations and health issues, data simply did not exist.

A clear conceptual framework. Washington State officials offer a very promising model of the Title V Needs Assessment that frames the assessment around a set of positive outcome goals. They pointed out that their new conceptual framework – which moved away from a deficit-oriented approach to defining needs to a positive health outcomes focus, using a logic model that tied together potential activities or interventions that a population needs to reach these outcomes – was the key to the success and utility of their 5-year Needs Assessment.

An inclusive priority-setting process using a defined methodology to rank the needs and select priorities. The States that described extensive staff and stakeholder buy-in to their Needs Assessment priorities were also more often those that balanced and integrated information from various sources before setting the priorities and distributed and presented this information to a broad group of staff members and stakeholders. Many of these States brought together a group of stakeholders for a meeting or conference near the end of the Needs Assessment process to help select the priorities using a defined methodology to rank the needs. Some used ranking criteria that they were trained on by MCHB or had adapted from other States. Others worked with their stakeholder to develop their own criteria. Regardless of the methodology chosen, Title V officials stressed that using a specific protocol and applying a set of criteria for ranking and prioritizing the issues were key to their ability to obtain broad-based support for their final priorities.

The ability to move from Needs Assessment to program planning and implementation. Title V agencies that appeared most excited by the Needs Assessment process and its results were also those that had built the Needs Assessment priorities into a strategic plan that informs their management plan, with specific objectives that are monitored in the agency's ongoing work and planning.

B. Challenges and Lessons Learned

Through the tailored discussions with Title V officials, a number of other important lessons were identified based on the successes and challenges that Title V officials experienced.

Priorities are useful only if they are translated into benchmarks that are tracked over time in program implementation. One State, for example, reported that in the future, they will not assume that there is movement on any of the priorities just because they are documented as priorities. Instead, the Title V Planner will be checking in with key staff members to ensure that they are making progress.

The appropriate use of consultants can be beneficial when specific expertise is lacking in the agency, but use of consultants should not replace Title V staff involvement in the process. Title V officials from several States said that they could not have conducted the comprehensive 5-year Needs Assessment as well without the help of consultants with expertise in certain areas such as meetings or focus group facilitation or in blending the qualitative and quantitative information that was collected. At the same time, one Title V official noted that contracting out the entire Needs Assessment process was not the best choice from their experience: "Contracting it means you end up doing half the work anyway, so you might as well do the whole thing yourself and learn a lot about the process."

Needs Assessment data analysis should be shared with stakeholders in a simplified format for them to use in supporting resources to address the maternal and child health population's needs. Several Title V officials emphasized that they had learned the importance of engaging stakeholders throughout the process and getting the data into their hands in a clear and useful format. They said meaningful stakeholder engagement was key to being able to impact systemwide planning and allocation decisions in the public and private sectors, emphasizing that the stakeholders are often the ones who can offer the best support for resources and services needed to address the State's maternal and child health needs.

C. Recommendations for MCHB

MCHB Training and Technical Assistance. Title V officials had a number of recommendations for MCHB regarding training and technical assistance needs, including:

- Strategic planning around priorities
- Data analysis (including use of software for qualitative data analysis)
- Examples and lessons from other States on their Needs Assessment processes

There were mixed opinions on how technical assistance should be provided. Several officials noted that it would be beneficial to have the MCHB staff (or their consultants) come to the States

and do a specific training unique to their situation and need, rather than a generic out-of-State training where one or two staff members attend. On the other hand, one Title V official pointed out that they liked the in-person technical assistance meetings held in each MCHB Region in spring 2006. She said that these forums provided the opportunity to share and learn from the experiences of other States and should be continued at least annually.

MCHB Written Guidance. Title V officials also commented on the content, structure, and timing of the formal written guidance and other materials that were posted on the MCHB Web site in advance of the 2005 Needs Assessment. One official said that the MCHB's 2003 guidance for the 5-year Needs Assessment is too repetitive and does not provide enough space for the information required. Several Title V officials suggested streamlining the guidance and instructions; for example, the guidance should provide a model that blends capacity and Needs Assessments into the priority-setting process. Additionally, the capacity assessment component still could be presented by pyramid level for each priority need, but some of the levels of the pyramid could be collapsed or analyzed together. One official suggested that the requirements in the guidance be simplified, because they are time consuming and the format is cumbersome.

Recommendations for MCHB

TA and Training

- Strategic planning around priorities
- Increasing stakeholder engagement
- Data analysis
- TA tailored specifically to States' needs

Guidance

- Too long, repetitive, time consuming
- Release additional guidance documents earlier in the process

Other

- Divide the current requirement for a 5-year comprehensive Needs Assessment into population-focused components that could be carried out sequentially over a 5-year period
- Provide targeted funds for an MCH epidemiologist
- Encourage States to engage partners at the local level

Several States also requested that any new guidance for the 2010 Title V Needs Assessment be released earlier in the process. For instance, they found the *Promising Practices* report to be helpful, but several officials said that by the time it was made available to the Title V agencies, it was primarily used to support the existing frameworks that they had put in place and was too late

to help them make key decisions such as the goals and leadership structure, how to engage stakeholders, or the methods and criteria for selecting priorities based on their assessment of needs and capacity.

Other Recommendations. States had several additional suggestions that were not related directly to training or the guidance. One respondent suggested that the comprehensive Needs Assessment should be divided into parts because asking for a comprehensive review of data on all the needs of all MCH populations is too large an endeavor and dilutes its potential impact. One State mentioned the need for targeted funds for an MCH epidemiologist whose sole function is to organize, implement, and monitor the Needs Assessment process in close collaboration with the Title V and CSHCN Directors. Finally, one respondent indicated that Title V agencies should be encouraged, perhaps through incentives, to go out to the community level to discuss findings of the Needs Assessment and do strategic planning, including setting goals and objectives with partners at the local level.

D. Conclusion

This report shows that in many ways the promising approaches remain similar to those found in the first HSR Report on *Promising Approaches to the Title V Needs Assessment*, which reviewed a sample of the 2000 Title V Needs Assessments. The overriding challenges of limited resources and multiple demands on the Title V agency staff remain, as does the challenge of blending the large amount of quantitative and qualitative data that are often amassed for the 5-year Needs Assessment. Yet throughout this report, several innovative models have been presented to address these challenges. For example, some States are limiting the amount of data they collect and analyze by focusing their assessment, using a process that begins with consensus on priority outcomes for women, children, and families rather than an investigation of the full scope of potential needs. Many States have incorporated epidemiologic expertise and guidance throughout the process, using Title V, Centers for Disease Control and Prevention, State health department, or local public health university support to fund a full- or part-time dedicated epidemiologist.

Others are addressing the challenges of effectively engaging stakeholders by bringing their staff into the communities to network with the stakeholders, using a variety of methods to reach out and engage stakeholders. Others are hiring experienced outside facilitators to moderate meetings with large numbers of stakeholders, where people with diverse perspectives or issue-specific concerns need to come together and reach consensus on the priority needs.

As the Title V agencies plan for the next 5-year Title V Needs Assessment, the promising approaches discussed in this report are a reminder that the Needs Assessment is not just a data-driven process. The success and usefulness of the Needs Assessment in improving the health and welfare of women, children, and families is largely dependent on the process that is used to examine the data and translate it for program planning. The promising approaches discussed in Chapter II are models for various aspects of the Needs Assessment process. The sample surveys, questionnaires, logic models, worksheets, priority setting tools, and other materials found in the Appendix serve as tools for States and jurisdictions to review and consider adapting as they make decisions in the coming months and years for framing their maternal and child health Needs Assessment process, developing a leadership structure to guide the process, engaging stakeholders, synthesizing needs and capacity information to develop a list of priorities, and using the priorities to drive program planning and promote new investments in effective strategies to address those priorities.