Title V Five Year Needs Assessment Training

March 5, 2014

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ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS
Quick Overview

How to Use Web Technology

• All lines have been muted. To un-mute your line please dial *6

• Asking a Question
  – You can type your questions into the chat box (shown right)
  – Raise your hand. Using the icon at the top of your screen (example shown right)

• Lastly active participation will make sure today’s presentation a success!
Objectives

After today’s webinar participants will be able to.

• Describe the Title V five-year needs assessment purpose and goals
• Articulate the major components of a comprehensive needs assessment
• Develop next steps/strategies for their five-year needs assessment plan
Title V Five Year Needs Assessment Training

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MCH Needs Assessment

1. Needs assessment is not new to MCH - it is the bedrock foundation of our field
2. The five-assessment is not a chore it is a gift, an opportunity to build lasting capacity
3. It is about data, yes, but also about voices
4. Positive evolution allows us to be held to a higher standard; as priorities and action plans will flow from this, it must be done well
MCH Arises from Needs Assessment

- Charge to the Children’s Bureau in 1912:
  
  “. . . to investigate and report on all matters relating to child life and welfare among all classes of our people . . .”

- THIS is the bedrock foundation on which all of MCH is based

- It is our responsibility to seek, to know, to act and to be held accountable
Five-Year Requirement is a Gift

• You do not do this “because you have to”
• You do not do this to file it on the shelf
• This may be the most important thing you do because it drives everything else you do
• The statutory requirement gives you the support you need to express and exert your authority, your responsibility, to MCH
• It is a gift, it is an opportunity
Mission Critical

• “assuring the health of all mothers and children” begins with assessing what is needed to promote and protect their health
  – Needs of individuals
  – Needs of families
  – Needs of systems and system components
  – Needs of societies
Mission Critical

• A good first task is to lay out a timeline and a set of action steps, backing up from the due date of July 2015

• Get your ducks in a row:
  – Personnel
  – Resources
  – Partners
  – Data sources
Data are Necessary . . .

- Employ every source you can get your hands on, internal and external
  - Population data (census)
  - Vital records (births, deaths, etc)
  - Disease registries
  - Surveys (YBRS, BRFSS, SLAITS, PRAMS)
  - Hospital discharge and medical encounter
  - Other agencies (education, social services, Medicaid, transportation, criminal justice, housing, environmental protection, planning, etc)
Data are Necessary...

• Reports that reflect the status of health and related indicators at the state or county level
  – NACCHO or RWJ County Health Rankings
  – Annie E Casey KidsCount
  – Kaiser State Health Facts
  – United Health America’s Health Rankings

• Internal program data
  – CSHCN, WIC, family planning, screening programs, home visiting, mortality reviews, school, oral, mental health
but not Sufficient

• You must also *listen* in an organized and deliberate fashion
  – Utilize all natural, available opportunities
    • Existing advisory boards, coalitions, commissions
    • Get on the agenda of other meetings
    • Use your local networks
  – Organize a “listening tour”
    • Town halls
    • Focus groups
but not Sufficient

- You must *listen* . . .
  - Conduct a specific survey or add items to other surveys
  - Social media
  - Interactive web-pages
  - Photovoice
  - “incident” or “event” reports from local agencies, grantees
but not Sufficient

• You must *listen* . . .
  – Engage thought leaders beyond the usual suspects
    • Judges
    • Law enforcement
    • Economic development agencies
    • Chambers of Commerce
    • Philanthropic organizations, local foundations
    • Editorial boards
    • Broad-based coalitions
    • Professional associations
Data and Knowledge Gathering

• Plan for this to be an iterative process
  – You’ll stumble on data that are provocative that you need to ask people about
  – You’ll hear things that you’ll have to try to confirm with the data
• Do NOT shy away from learning about any and all needs that families experience
• Do NOT be afraid to learn about system challenges
Data and Knowledge Gathering

• Be open to learning about assets, strengths, new ideas, innovations, emerging practices
• Be combing the literature for new ideas, new challenges
• The goal is to conduct as comprehensive an assessment of the MCH needs in your state as is possible and in the doing, to build your capacity for ongoing assessment and monitoring
Scale and Scope

• Obviously, you will scale this up or down as resources allow but remember not to squander the opportunity

• At the end you want to be able to paint a picture, tell the story and to be able to continuously, in real time, monitor their health and your progress in promoting and protecting that health
Scale and Scope

• If you do this right, you will learn about many things that affect the health of the families in your state
• One or more of your priorities can be to work across and with other agencies to make changes to the overall system that will positively impact MCH
It’s all about Managing Change

• Ultimately, needs assessment is about **CHANGE**
  – Anyone on this call who believes nothing is changing in their state must have fallen asleep

• As leaders for this most important population, we must be prepared to understand, anticipate and manage change in order to best support the desires of our families for health and well-being
Assessing Needs just the Beginning

• One of the primary reasons for conducting ongoing needs assessments is to assure you are responding to the most important priorities

• Priority setting is actually the hardest part of this process, so be sure to allow plenty of time for it
Priority Setting

• You have limited resources
  – Money, time, staff, reach
• You have historic constituents
  – Legislature, powerful interest groups, clients
• You may have agency leadership that doesn’t want to rock the boat
• You may have staff reluctant to change
• But **CHANGE** WE MUST if we are to be responsive
2015 MCH Needs Assessment

• You can do this!
  – This is the fifth time that 59 of you have tackled this and we get better every time

• You must do this!
  – Not because someone is making you but because this is our responsibility as MCH leaders

• If we aren’t listening to our families, who is?
One last word . . .

• There are lots of good examples out there (we’ll hear one in a minute)
• You are not alone
• We all must work collectively to assure that our ability to do this work continues
• The needs assessment can and must drive the setting of priorities, the action plans, the monitoring and ultimately, the accountability
We’re all in this together!

Thank you for your attention!

dpeters@health.usf.edu
Title V Maternal and Child Health
2010 Needs Assessment:
The Massachusetts Experience

Ron Benham, MDiv - Title V Director, Director of Bureau of Family Health and Nutrition
Karin Downs, RN, MPH - MCH Director, Director of Division of Pregnancy, Infancy, and Early Childhood
Acknowledgments

• Hafsatou Diop, MD, Director Office of Data Translation, BFHN
• Susan Manning, MD, CDC MCH Epidemiology Assignee
• Kathy Messenger, Sr. Budget Planner, BFHN
• Interns – BU School of Public Health, Brandeis, Heller School
• Staff of BCHAP, BSAS, BFHN
• Ripples Group
• Community partners, families, youth, staff of community service agencies
Overview

• Role of public health
• Setting the stage
• Needs assessment guiding principles
• Organizing frameworks
• Needs assessment methods
• Final List of Priorities (2010-2015)
• Final List of State Performance Measures (2010-2015)
• Summary of needs assessments components
• Lessons Learned
Role of Public Health

• To establish public policy to achieve health equity
• To promote population-based strategies including:
  – Coordinating interagency efforts
  – Creating supportive environments to enable change
  – Collecting data, monitoring programs and conducting surveillance
  – Addressing individual factors and promoting positive behavioral change
  – Engaging with communities and building capacity
Setting the Stage: MA Population Growing but Economy Hit by the Recession


U.S. Bureau of Labor Statistics (not seasonally adjusted)

Needs Assessment Guiding Principles

• Promote health, well-being and continuity of care for all MCH populations
• Promote life course perspective
• Address health equity & social determinants of health
• Ensure strong community and family engagement
• Optimize prevention
• Ensure transparency through open communication & sharing of information
• Promote cross-cultural dialogue to inform effective systems of care
• Identify & respond to emerging trends & issues
• Work at multiple levels to ensure change – systems, community, family & individual
CDC Health Impact Pyramid
Factors that Affect Health

- **Socioeconomic Factors**
  - Poverty, education, housing, inequality

- **Changing the Context**
  - *to make individuals’ default decisions healthy*
  - Fluoridation, trans fat, smoke-free laws, tobacco tax

- **Long-lasting Protective Interventions**
  - Immunizations, brief intervention, cessation treatment colonoscopy

- **Clinical Interventions**
  - Rx for high blood pressure, high cholesterol, diabetes

- **Counseling & Education**
  - Eat healthy, be physically active

Adapted from T. Frieden, AJPH, April 2010
Life Course Perspective

- Prenatal Care
- Internatal Care
- Early Intervention
- Primary Care for Women
- Primary Care for Children
- Prenatal Care
- Internatal Care

Poor Birth Outcome

Age 0 5

Puberty

Pregnancy

Lu 2003

White African American
Disparities exist in the health outcomes due to differential access to economic opportunities, community resources and social factors.
Needs Assessment Methods

• Use of old and new approaches to gather a broad, diverse range of information about strengths, gaps, capacity and needs

• Putting a face on the numbers - qualitative information used to augment quantitative data
  – Key informant interviews - internal and external
  – Focus groups
  – Paper, email and on-line surveys
  – Public hearings
Needs Assessment Timeline

- **Document Preparation**
  - 40+ Interviews
  - 7 Focus Groups
  - 3 Surveys
  - 50+ Programs reviewed

- **Stakeholder Engagement**

**Sections**

- **Sections 1 & 2** Process & Partnership
- **Section 3** MCH Populations
- **Section 4** Capacity
- **Section 5** Selection of State Priorities
- **Section 6** Selection of State Measures

**Solid Draft & Presentation materials**

**Final CNA & summary**

**Draft Edits & Updates**

**Public Hearings (6)**

**External Interviews/Focus Groups**

**Internal Interviews**

**Project Kickoff**

**Sections 1 & 2**

- Steering Group Mtg #1 (July 24th)
- Steering Group Mtg #2 (Oct 5th)
- Steering Group Mtg #3 (Dec 14th)
- Steering Group Mtg #4 (Jan 26th)
- Steering Group Mtg #5 (May 25th)
Prioritization Framework

**Idea Generation**
- Idea/potential growth opportunity generation
- Broad set of major opportunity areas

**Primary Evaluation**
- Impact: Large, Small
- Feasibility: Low, High

**Detailed Evaluation**
- Life Course
  - Infancy
- Social Determinants of Health
- Population Served
  - Direct Enabling Population Infrastructure
  - Health Equity

**Actions**
- Future State
- Current State
- Performance Measures

**Stakeholder feedback**
## Data Inputs by Population

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<tr>
<th>Population</th>
<th>Data Sources</th>
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Public Input Activities

• **Key Informant Interviews:**
  • Internal – 43 participants
  • External – 35 participants

• **Focus Groups (15 groups):**
  • WIC Mothers – 6 participants
  • Teen Mothers – 12 participants
  • Suburban Mothers – 20 participants
  • Urban Black/Hispanic Mothers – 27 participants
  • Home Visiting – 48 participants
  • Disparities – 27 participants
  • CYSHCN – 30 participants
  • Youth – 7 participants

• **Surveys:**
  • Youth – 184 participants
  • Families of CYSHCN – 459 participants

• **Public Hearings:** 33 attendees at six hearings
Public Communication – Fact Sheet

The Title V Maternal and Child Health Program is the nation’s oldest federal-state partnership. For over 75 years, the Maternal and Child Health program has provided a foundation for ensuring the health of the nation’s mothers, women, children and youth, including children and youth with special health care needs, and their families.

**TITLE V FUNDING** In Fiscal Year 2012, Massachusetts received $11.3 million in federal funds. States must match every $4 of Federal Title V money they receive by at least $3 of State and/or local money. Massachusetts provides significantly more state funding ($16.00 state for every $4.00 Federal).

**Funding Sources FY12**
- $45,116,396 72% State
- $11,336,389 22% Federal
- $11,619 1% Other

**Title V Services provided directly to:**
- Pregnant Women 17,525
- Infants < 1 year 59,420
- Children 1 - 22 years 423,272
- Children with Special Healthcare Needs 125,023
- Others 86,904
- **FY11 Totals** 714,144

**NEEDS ASSESSMENT** A state-wide, comprehensive needs assessment is conducted every 5 years. Based on the findings, Massachusetts identifies priorities to address the needs of the MCH population and guide implementation of the MCH Block Grant. The Needs Assessment can be viewed at: [https://mchdata.hrsa.gov/visitreports/Default.aspx](https://mchdata.hrsa.gov/visitreports/Default.aspx).

2013 Title V Block Grant priorities and other key maternal and child health objectives are on the reverse side of this fact sheet. For more information about the Bureau of Family Health and Nutrition please visit [www.mass.gov/dph/family-health](http://www.mass.gov/dph/family-health).

**Your interest is welcome. Your comments are requested.**

**Massachusetts FY13 Priority Needs:**
1. Promote healthy weight across the lifespan.
2. Promote emotional wellness and social connectedness across the lifespan.
3. Coordinate preventive oral health measures and promote universal access to affordable dental care.
4. Enhance screening for and prevention of violence and bullying.
5. Support reproductive and sexual health by improving access to education and services.
6. Improve the health and well-being of women in their childbearing years.
7. Reduce unintentional injury and promote healthy behavior choices for adolescents.
8. Expand medical home efforts to systems building and securing access and funding for children and youth.
9. Support effective transitions from (1) early childhood to school and (2) adolescence to adulthood for Children and Youth with Special Health Care Needs.
10. Improve data availability, access, and analytic capacity.

**Contact:** Ron Benham, Director BFHN Ron.Benham@state.ma.us

**Additionally, Title V Maternal and Child Health Program seeks to:**
- Assure access to quality care, especially for those with low-incomes or limited availability of care
- Reduce infant mortality
- Ensure access to comprehensive perinatal care to women (especially low-income & at risk pregnant women)
- Increase the number of children receiving health assessments, follow-up diagnostic and treatment services
- Ensure access to preventive care and rehabilitative services for certain children
- Implement family-centered, community-based, systems of care for children with special healthcare needs
- Provide toll-free hotlines & assistance in applying for services to pregnant women with infants and children who are eligible for Title XIX (Medicaid).

**Community Support Line**
800-882-1435

Needs Identified through Public Input

Maternal
- Breastfeeding support
- Support in bonding/attachment and engaging fathers
- Social/emotional support
- At-home postnatal supports
- Useful, accessible sources of information

Disparities
- Assistance in addressing racism in accessing health care
- Economics impacts outcomes
Needs Identified through Public Input

**Youth**
- Improved access to information
- Support to find and build relationships with health care providers
- Counseling/resources on risk behaviors
- Support/protection around bullying

**CYSHCN**
- Better communication, training among providers, programs, schools, families needed
- Support for transitions
- Easy access to current, accurate information
- Funding for community based programs
Initial List of Potential Priorities

Cross Population
1. Undertake a holistic & integrative wellness initiative focused on nutrition, physical activity, and emotional health to promote healthy weight for mothers, infants and children and youth including those with special health needs.
2. Promote healthy parenting, bonding and optimum infant and child emotional development by supporting social and emotional wellness and identifying and addressing stressors to reduce rates of depression, substance use, and suicide for women and adolescents (especially high risk) and encouraging optimal parental health.
3. Coordinate preventive measures and access to affordable care for mothers and children to reduce disparities in dental care and improve oral health.
4. Enhance screening and prevention of violence, especially against women, and bullying among children and adolescents to reduce the number of victims of violence and the larger impact on the community.
5. Promoting healthy paternal involvement (in a culturally sensitive manner) to improve the positive influence on children and adolescent health.
6. Supporting reproductive and sexual health across the lifespan to improve access to education and understanding of choices.
7. Transition medical home efforts to systems building and securing access & funding for children & youth to expand the number of children in MA covered by a medical home.

Women
8. Improve the health and well being of women in their childbearing years.

Adolescents
9. Support effective transitions in (1) early childhood to school and (2) adolescence to adulthood to improve lifetime developmental, emotional, and physical health, including for CYSHCN.
10. Build understanding of injury and risky adolescent behaviors as preventable public health issues to reduce unintentional injury and promote healthy behavior choices for adolescents.

CYSHCN
11. Improve management of asthma in school-aged children through collaboration with schools and education of childcare providers.

Capacity
12. Improve data availability, access and analytical capacity to enhance MADPH’s ability to recognize and respond to emerging health issues and to facilitate communities to utilize data resources to inform their own population priorities.
13. Promote workforce capacity within the health sector including primary care providers, mental health providers, community health workers, and other specialists.
14. Develop and implement an effective marketing/outreach strategy that; Provides optimal clarity on programs; Targets messages to specific segments; Leverages key “teachable moments”; and Takes advantage of new mediums, especially the internet to increase responsiveness and improve education capacity for current and emerging health issues across all populations.
15. Develop strategies to monitor and anticipate changes following the impact of national health reform and MA health care reform on access to quality health care for all Massachusetts residents to promote access to affordable, quality health care through interventions around primary care, financial access, and specialty services.

Considered and removed before voting
16. Promote healthy behavior choices for adolescents, such as through comprehensive sexual education, to reduce high-risk behaviors. (combined with unintentional injury)
17. Enhance care and care opportunities for infants and toddlers through taking a more active role in childcare standards and practices and advocating the positive influence of early childcare (focus of other groups)
18. Broaden understanding of autism treatment and services to ensure youth with ASD receive early treatment at the most appropriate level (focus of other groups)
19. Integrate all CYSHCN programs into a holistic, easy-to-access service to improve program access to care and reduce the burden on families (internal initiative)
20. Develop and apply a framework to reduce disparities targeting the increasingly diverse MCH populations in MA (became a principle)
21. Improve community engagement of MCH-serving programs through: Essential Allies/Advisory Board; Priority Community Groups; Youth Development; and School Engagement to leverage better community resources that work towards similar health outcomes. (became a principle)
22. Promote continuity of care and Life Course Model with a emphasis on social determinants of health to improve coordination of services across all MADPH programs across the lifespan. (became a principle)
23. Enhance MADPH’s ability to recognize and respond to emerging health issues to lessen the potential impact on maternal and infant health (combined with data and analytics)
Criteria for Evaluating Priorities

What is the likely impact?
- Incidence & prevalence
- Degree of long-term outcomes
- Disparities whether socio-economic, cultural, geographic, racial, or ethnic.
- Preventable/actionable
- Increases or enhances collaboration

What is the feasibility of success?
- DPH subject matter competency
- Political and organizational will
- Resource availability
- Closeness to the core mission of MCH
- Availability of partners & external resources
- Synergy effect between priorities
- Increases or enhances collaboration
Healthy weight leads in both feasibility and impact

What is the likely impact?

What is the feasibility of success?
Public Hearings Across the State

- Holyoke 3/31
- Worcester 3/23
- Needham 4/8
- Tewksbury 3/25
- Boston 4/1
- New Bedford 4/7

- Held 4:00-6:00PM
- 33 Attendees at six sites
- Review of Findings and Needs
- Open Comments Collected andReviewed
Final List of Priorities (2010-2015)

- Promote healthy weight
- Promote emotional wellness/social connectedness across lifespan
- Coordinate preventive oral health measures and promote universal access to affordable dental care
- Enhance screening for and prevention of violence and bullying
- Support reproductive and sexual health by improving access to education and services
- Improve the health/well-being of women in their childbearing years
- Reduce unintentional injury and promote healthy behavior choices for adolescents
- Expand medical home efforts to systems building and securing access & funding for children and youth
- Support effective transitions from (1) early childhood to school and (2) adolescence to adulthood for CYSHCN
- Improve data availability, access, and analytical capacity
Guiding Principles for Developing State Performance Measures

• Quantifiable
• Understandable
• Outcomes over process measures
• Low burden of collection
• Indicative, if not inclusive
• Use existing internal and/or external measures when possible
• Opportunity for measurable improvement
• Expectation of robust activity in that area
<table>
<thead>
<tr>
<th>SPM</th>
<th>Description</th>
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<tbody>
<tr>
<td>SPM1</td>
<td>The percentage of <strong>pregnancies</strong> among women aged 18 years and older that are <strong>intended</strong></td>
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<tr>
<td>SPM2</td>
<td>How DPH promotes emotional wellness by using data to inform policy and programs; building partnerships; supporting workforce development; improving family support; and raising awareness</td>
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<tr>
<td>SPM3</td>
<td>The percentage of <strong>females</strong> aged 18–45 years reporting <strong>binge drinking</strong></td>
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| SPM4 | The percentage of women with a recent live birth reporting that they had their **teeth cleaned** recently (within 1 year before, during, or after **pregnancy**)
<p>| SPM5 | The percentage of women with a recent live birth reporting that a <strong>healthcare worker talked with them</strong> during any of their prenatal care visits about physical <strong>abuse</strong> to women by their husbands or partners |
| SPM6 | Develop a comprehensive <strong>healthy weight</strong> strategy and performance measure |
| SPM7 | The rate (per 100,000) of <strong>hospitalizations</strong> due to <strong>asthma</strong> among Black, non-Hispanic and Hispanic children aged <strong>0-4 years</strong> |
| SPM8 | The rate (per 100,000) of <strong>motor vehicle deaths</strong> among youth aged <strong>15-24 yrs</strong> |
| SPM9 | The percentage of <strong>high school students</strong> having missed a school day due to <strong>feeling unsafe</strong> at or on the way to <strong>school</strong> |
| SPM10 | The percentage of <strong>high school students</strong> reporting no current <strong>use</strong> (in past 30 days) of either alcohol or illicit drugs. |</p>
<table>
<thead>
<tr>
<th>Priority</th>
<th>National</th>
<th>State</th>
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<tr>
<td>1. Promote healthy weight</td>
<td>NPM4 WIC BMI, NPM11 Breastfeeding</td>
<td>SPM6 Healthy weight strategy and performance measure</td>
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<tr>
<td></td>
<td>NPM8 Teen Births ages 15-17</td>
<td>SPM1 Intended pregnancies, SPM2 Promote emotional wellness and social connectedness, SPM3 Female binge drinking, SPM5 Prenatal visit covered physical abuse</td>
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<tr>
<td>2. Promote emotional wellness and social connectedness across lifespan</td>
<td>NPM16 Suicide Deaths ages 15-19</td>
<td>SPM2 Promote emotional wellness and social connectedness</td>
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<tr>
<td>3. Coordinate preventive oral health measures and promote universal</td>
<td>NPM9 Dental Sealants for youth</td>
<td>SPM4 Teeth cleaned within 1 year of pregnancy</td>
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<td>access to affordable dental care</td>
<td></td>
<td></td>
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<tr>
<td>4. Enhance screening for and prevention of violence and bullying</td>
<td>n/a</td>
<td>SPM5 Prenatal visit covered physical abuse, SPM9 Feeling unsafe at or on the way to school</td>
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<tr>
<td>5. Support reproductive and sexual health by improving access to</td>
<td>NPM8 Teen Births ages 15-17</td>
<td>SPM1 Intended pregnancies, SPM2 Promote emotional wellness and social connectedness, SPM3 Female binge drinking, SPM5 Prenatal visit covered physical abuse</td>
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<td>education and services</td>
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<td>6. Improve the health and well being of women in their childbearing</td>
<td>NPM4 WIC BMI, NPM11 Breastfeeding, NPM8 Teen Births ages 15-17, NPM15 Smoking in last trimester, NPM18 First trimester prenatal care, NPM17 VLBW at facilities for hi-risk</td>
<td>SPM2 Promote emotional wellness and social connectedness, SPM3 Female binge drinking, SPM5 Prenatal visit covered physical abuse</td>
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<td>years</td>
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<td>7. Reduce unintentional injury and promote healthy behavior choices</td>
<td>NPM10 Motor vehicle deaths ages 10-14</td>
<td>SPM3 Female binge drinking, SPM8 Motor vehicle deaths ages 15-24, SPM10 Adolescents’ substance abuse</td>
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<td>for adolescents</td>
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<tr>
<td>8. Expand medical home efforts to systems building and securing access</td>
<td>NPM2 CYSHCN family partnership, NPM4 CYSHCN with insurance, NPM5 CYSHCN community systems, NPM6 CYSHCN transition services, NPM13 Children with insurance</td>
<td>SPM7 Asthma hospitalization disparity</td>
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<tr>
<td>&amp; funding for children and youth</td>
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<tr>
<td>9. Support effective transitions from (1) early childhood to school</td>
<td>NPM2 CYSHCN family partnership, NPM3 CYSHCN with Medical Home, NPM4 CYSHCN with insurance, NPM5 CYSHCN community systems, NPM6 CYSHCN transition services</td>
<td>SPM2 Promote emotional wellness and social connectedness, SPM7 Asthma hospitalization disparity, SPM10 Adolescents’ substance abuse</td>
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<td>and (2) adolescence to adulthood for CYSHCN</td>
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<tr>
<td>10. Improve data availability, access and analytical capacity</td>
<td>(covered by national data reporting)</td>
<td>(All Measures)</td>
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Needs Assessment Components

Assess Needs
- Sample
- Massachusetts Data Sources
  - Tracking Data/Trends using:
    - Vital records
    - Census
    - Registries
    - Hospital discharges
    - Linked data sets
    - Adult and youth health surveys
    - Program participant/payer information
    - Community assessments
    - Special studies
    - Data from other agencies and external studies
  - Input from Parents and Consumers
  - Input from Providers, Academics, Others
  - Input of DPH and Other State Agency Staff
  - Surveys of target populations
  - Focus Groups

Select Priority Needs
- Needs Assessment Components
  - Assess Needs
  - Select Priority Needs
  - Implement Programs
  - Measure Performance:
    - National and State Measures
  - Improve Health Outcomes

Implement Programs
- Direct Services
  - Gap-filling personal services to MCH populations
    - Ex: Family Planning, Community Based Services for Women and Adolescents

Enabling Services
- Help to access health care/ information
  - Ex: Outreach, Children with Special Health Care Needs (CSHCN) Family Support and Care Coordination, SSI Benefits Outreach, Pedi Palliative Care

Population-Based Services
- Preventive or personal health services available to all pregnant women, mothers, infants or children
  - Ex: Newborn Metabolic, Hearing and Lead Screening, Injury and Violence Prevention, Oral Health, Poison Control Center

Infrastructure Services
- Develops, maintains and supports access to MCH services

Measure Performance:
- National Performance Measures
  - NPM 1 - Screening & followup for metabolic disease
  - NPM 2 - CSHCN family partnership/satisfaction
  - NPM 3 - CSHCN with Medical Home
  - NPM 4 - CSHCN with adequate insurance
  - NPM 5 - CSHCN community systems ease of use
  - NPM 6 - Transition services for youth with SHCN
  - NPM 7 - Immunization
  - NPM 8 - Teen Births ages 15-17
  - NPM 9 - Dental Sealants
  - NPM 10 - Motor vehicle deaths ages 10-14
  - NPM 11 - Breastfeeding
  - NPM 12 - Newborn Hearing Screening
  - NPM 13 - Children without health insurance
  - NPM 14 - WIC child BMI over 85th percentile
  - NPM 15 - Smoking in last trimester
  - NPM 16 - Suicide deaths ages 15-19
  - NPM 17 - VLBW at facilities for hi risk
  - NPM 18 - First trimester prenatal care

State Performance Measures
- SPM 1 - Intended pregnancy
- SPM 2 - Emotional wellness
- SPM 3 - Female binge drinking
- SPM 4 - Teeth cleaning for women
- SPM 5 - Teen partner violence
- SPM 6 - Healthy weight strategy
- SPM 7 - Asthma disparity
- SPM 8 - Motor vehicle deaths 15-24
- SPM 9 - School safety
- SPM 10 - Youth substance use

National Outcome Measures
- OM 1 – Infant Mortality (IM)
- OM 2 – Disparity Black and White IM
- OM 3 – Neonatal Mortality
- OM 4 – Post-Neonatal Mortality
- OM 5 – Perinatal Mortality Rate
- OM 6 – Child Death Rate

State Outcome Measures
- SOM 1 – Disparity Black and White Homicide Rate
Lessons Learned

• Interviews with internal program staff proved valuable to help guide the process
• Defining the lens/framework up front helped organize data collection analysis
• Obtaining meaningful public input was challenging, but worth the effort
• Engaging an active steering committee was critical to achieving a broad sense of purpose and “buy in”
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