



National **MCH** Workforce
Development Center
Advancing Health Reform Implementation

A Snapshot of Current Title V Workforce Needs

June 27, 2014

About the National Maternal and Child Health Workforce Development Center

The National MCH Workforce Development Center at UNC Chapel Hill (the Center), in cooperation with the Maternal and Child Health Bureau (MCHB), and in partnership with the Association of Maternal and Child Health Programs (AMCHP) and national experts in maternal and child health (MCH) innovation and quality improvement, offers state and territorial Title V leaders training, collaborative learning, coaching and consultation in implementing health reform using a variety of learning platforms.

Major transformations in the US health system, driven since 2010 by the Patient Protection and Affordable Care Act (ACA), offer opportunities for improving public health systems, the health care delivery system, and ultimately health outcomes for MCH populations. These transformations provide a critical opportunity for Title V programs to help lead efforts to implement the ACA and other major health system reforms. The Center engages and deploys the expertise of key partners to develop and evaluate evidence-based training and technical assistance necessary for strengthening capacity and skills at two levels: (1) the current MCH workforce and, (2) MCH graduate and undergraduate students with interests in MCH, to promote effective leadership as these health transformations affect programs and services for the MCH population.

Building on the central role of Title V programs in assuring the health of the MCH population, the Center focuses on four key themes of the ACA and health system transformation:

- (1) **Improving access to care;**
- (2) **Using quality improvement tools** to drive transformation;
- (3) Fostering **integration within public health and across organizational boundaries** including primary care, mental health, early intervention and community-based service delivery systems;
- (4) Furthering **population health management, including effective change management and other leadership skills** to ensure health improvement for MCH populations.

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Maternal and Child Health, Title V and Health Transformation

Major transformations in the health care and health financing sectors offer unprecedented opportunities for improving public health systems, state and community health care delivery, and ultimately, health outcomes for MCH populations. Title V programs are uniquely positioned to help lead and influence major health system reform initiatives as they affect women, children and families. Yet state and territorial Title V MCH programs face many challenges in the implementation of health reform. For example, policymakers may make decisions about health reform without understanding the potential impact on women and children. The development of strong partnerships and effective communication among Title V and Medicaid, CHIP and insurance exchanges are essential for successful implementation of health reform initiatives that impact Title V populations.

With training and support, Title V programs are well-positioned to **improve access to care, use quality improvement tools** to drive transformation, and foster **integration within public health and across organizational boundaries** including primary care, community-based service delivery systems and other key sectors. **Strong leadership and effective change management** must undergird Title V activities in each area.

Strengthening the National Maternal and Child Health Workforce

Data were gathered from a variety of sources to illuminate the specific needs for training and technical assistance that could be offered by a national MCH workforce development center focused on health transformation. Sources included:

- Qualitative data from 190 member surveys completed in 2012 by a geographically representative sample of members of AMCHP¹,
- All Maternal and Child Health Services Title V block grant state narratives from 2011 and 2012 annual reports and 2013 and 2014 applications², and
- Key informant interviews conducted in early 2014 with state and federal title V staff. Five HRSA regions were represented. Eight states were represented in the key informant interviews. Four states were not Medicaid expansion states; four states were. Three states were rural and five states were urban. Most state systems were decentralized, although one was centralized and two were mixed (Appendix C).

The AMCHP surveys were used to identify initial themes related to health reform and the Center's core areas. Those results were used to identify key search terms for reviewing all block grant reports. Key informant interviews with eleven staff members from eight state Title V programs (MCH and CYSHCN) selected from a geographically representative sample of states and 18 HRSA/MCHB Federal staff members in Central and Regional offices further illuminated the themes from the initial two data sources. Appendices A-D provide further detail about the methods used to collect these data, including the key informant interview script.

This report provides an in-depth discussion of the current challenges and opportunities facing the MCH workforce. It also includes descriptions of the types of training, tools and evidence-informed guidance necessary for advancing an MCH agenda in the current health care environment. This snapshot assessment of the current state of the MCH

¹ AMCHP 2012 Member Assessment Data, Questions 31 and 32; response rate was 34% of eligible members.

² Application for 2013/Annual Report for 2011 and for Application for 2014/Annual Report for 2012 from the Title V Information System website, Maternal and Child Health Bureau. <https://mchdata.hrsa.gov/tvisreports/>.

workforce is being used by the Center to build a variety of interdisciplinary resources in 1) Access to Care, 2) Quality Improvement, 3) Systems Integration and 4) Change Management. Three levels of training and technical assistance are available through the Center: 1) Universal, for all Title V staff and MCH trainees related to the four core areas; 2) Targeted, for self-selected Title V staff and partners; and 3) Intensive, for up to three annual cohorts of 8-10 states/territories. All Universal and selected Targeted trainings are available on *Transformation Station*³, a mini-website within the AMCHP.org website. Selected resources will also be cross-listed on the MCH Navigator (www.mchnavigator.org).

A Snapshot of the Contemporary Maternal and Child Health Environment

The picture that emerges from this report is one of a complex and rapidly changing environment for the Title V workforce. Leaders describe the impact of health reform as a transformative force in their programs that builds on the existing momentum in Title V toward results-based accountability and the simultaneous transition from direct services to population health assurance. In the midst of this transformation, state and territorial Title V programs also face significant staffing challenges (primarily in the form of the loss of seasoned MCH professionals) and the need to adopt new theories and paradigms for their work. One leader noted that the luxury of “letting the dust settle” was not one afforded by the current climate. Many leaders described the level of health reform knowledge necessary to effectively function in the current environment as daunting. This environment, as described below, illuminates specific workforce training needs that can be addressed using innovative interdisciplinary approaches from the Center’s core areas of expertise, as well as some areas that fall outside the current scope of the Center, but may be important to consider going forward. The workforce training needs identified in this report, and related Center training and support, are described in the Synthesis Table on pp. 14-15.

The Evolving Identity of Title V

The shifting role and identity of Title V emerged as a recurring theme in this report. Health transformation has hastened and sometimes complicated ongoing conversations about the role of Title V as providers of direct services or as providers of population health assurance (or both) for states and territories. This section reports the perceptions of Title V leaders regarding their evolving roles.

The shift over the past decade from a direct service delivery orientation to a preventive, population-based assurance role has been challenging but responsive to new national programs and policies and the changing economic climate. Some states mentioned efforts to refocus on the *Ten Essential Public Health Services*.⁴ Many Title V staff recognized the unique vantage points from which they identified gaps in clinical services and insurance coverage for populations such as undocumented residents, children and youth with special healthcare needs (CYSHCN), underinsured adults, and women in the perinatal period. Staff from several state programs described the problem of pregnancy-related churn⁵, created by

³ <http://www.amchp.org/Transformation-Station/Pages/Home.aspx>.

⁴ Ten Essential Public Health Services. Centers for Disease Control and Prevention website. <http://www.cdc.gov/nphsp/essentialservices.html>. Accessed April, 26, 2014.

⁵ Northwest Health Law Advocates. *Pregnancy-related Churn in Washington State under the Affordable Care Act*. Retrieved 04/18/14 from <http://nohla.org/infoAnalysis/advPolicy/PregChurn9513.pdf>.

an overlap in eligibility between private and public insurance programs. Fortunately, in many states and territories, Title V programs are also uniquely positioned to assist with insurance enrollment for hard-to-reach populations.

Previously, local health departments may have interacted with the MCH population in clinical settings for direct services. Now, with the need for publicly-funded direct service delivery potentially reduced, health departments have strengthened partnerships with hospitals, private providers and other stakeholders. For example, interviews confirmed that collaboration and alignment with federally qualified health centers and rural health providers are important to ensure access to care for MCH populations. In addition, several state leaders reported that their focus on health outcomes and quality are a catalyst for developing partnerships with both public and private insurance providers.

The anticipated repurposing of funds for programs and services for CYSHCN is a specific source of concern for several state leaders. Health reform has focused new attention on direct clinical services being provided or paid for by Title V CYSHCN programs in contrast with population-based programming. As a result, the future role of Title V in continuing to meet the critical needs of this population and their families is evolving, bringing new opportunities and challenges for state Title V CYSHCN program directors and their staff. Title V leaders report that monitoring benefit packages and services available to CYSHCN is one important role for them to play in ensuring access to care and care coordination for CYSHCN. The transition in Title V program roles provides an opportunity for a well-equipped MCH workforce to lead these changes in proactive, strategic ways that benefit MCH populations.

Funding Uncertainty

Related to these evolving roles, MCH leaders are concerned that loss of funding may harm the sustainability of their programs and have a negative impact on the populations they serve. In addition to actual reduced funding, staff also described the difficulty of planning long-term programs in the face of continued *potential* loss of funds to support the programs. Title V leaders expressed the need to reinforce their ability to demonstrate the value of MCH programs and to utilize the strengths of Title V to leverage and enhance partnerships. They felt that it was important to counter the perception that access to health insurance equals access to health care, and reiterated that access to safety net programs, traditionally provided by MCH, are still necessary to ensure population health and access to care for some populations.

New Roles for MCH Professionals

A significant challenge for Title V leaders is ensuring that Title V continues to have a “place at the table” where decisions relevant to MCH populations are made. Collaboration with colleagues from Medicaid, the insurance industry, accountable care organizations and private providers is not new for Title V leaders. But the level of engagement required in the health transformation environment is significantly greater than just a few years ago. Some leaders also expressed concerns about their ability to fully participate in health transformation conversations and decision-making due to a strained political climate in their states, including directives that they not take a “place at the health reform table.” Finally, the recent loss of key Title V staff to both layoffs and retirements was also noted as a further impediment to the efforts of Title V to effectively lead health transformation efforts.

Paradigm Shifts

In addition to the compelling impact of health transformation on Title V, paradigm shifts in the MCH field have added layers of complexity to the daily practice of the MCH workforce. For example, life course theory⁶ has been widely embraced by Title V and presents an important springboard for MCH to lead in an integrated healthcare environment. But it has been challenging to implement programs that respond to life course theory and to develop metrics for measuring their effectiveness.

Life course theory, continuing emphasis on health equity, and emerging paradigms that encourage MCH professionals to expand their programs into arenas outside of health, such as education and housing, challenge the workforce to learn new theoretical constructs and apply them. MCH 3.0 and anticipated changes to the structure of the MCH block grant have also created an opportunity for adaptive leadership.

Current Maternal and Child Health Workforce Needs

The section that follows reports specific workforce needs identified by Title V staff, all of which are related to the current workforce environment described above. The workforce needs fall into four categories: 1) information about health reform, 2) adaptive skills to lead through change, 3) skills to work effectively within integrated systems, and 4) skills to measure the quality and return on investment of current programs. Each will be described in detail below. Center training opportunities related to the needs are described in the Synthesis Table on pp. 14-15.

Information about Health Reform

The MCH workforce at all levels requires access to clear, MCH-specific, timely information about health care reform's impact on MCH programs, reimbursement models, and coverage and enrollment for MCH populations. Developing an MCH workforce that is "literate" in the intricacies of health reform is a critical need for several reasons. First, health reform "literacy" allows MCH leaders to conduct one of their primary roles: ensuring access to health care at the population level. Title V agencies monitor health care delivery shifts in order to identify populations not effectively served within the new health reform environment. Secondly, with detailed knowledge about reimbursement models and coverage/enrollment bottlenecks, the MCH workforce may more effectively advocate for MCH populations in the new environment of more integrated systems. Finally, because stakeholders often look to public health and MCH leaders for information about health reform, the workforce must be knowledgeable and resourceful enough to serve in this role.

Title V programs also need specific information about enrollment and coverage options for MCH populations (e.g., pregnant women). In some states, Title V agencies play an important role in enrolling families and individuals in health insurance and helping families understand coverage options. Finally, Title V programs also need specific, regular training about benefits packages for CYSHCN because insurance coverage may not be adequate to meet the needs of this population and supplemental Title V services may be required.

⁶ Lu M, Halfon N. Racial and ethnic disparities in birth outcomes: a life-course perspective. *Maternal and Child Health Journal*. 2003; 7(1):13-30.

Access to Care

Rural states in particular continue to have profound provider shortages. Key informants emphasized Title V's important role in identifying these shortages, particularly now that many previously uninsured individuals are gaining access to coverage. Relationships between Title V and their local and regional public health partners were identified as essential to identifying gaps in services and monitoring insurance coverage. As a result, Title V programs may advocate for services to fill the gaps identified through their partnerships from an informed position.

Key informants also expressed concern about the lack of insurance coverage and the need for Title V to serve as a safety net provider for marginalized populations such as undocumented immigrants and individuals not eligible for Medicaid but too poor to purchase insurance through health exchanges.

The table below highlights the primary themes that emerged from all three data sources related to health reform implementation and access to care.

Major Themes Related to Health Reform Implementation & Access to Care
Assurance Role <ul style="list-style-type: none">• Lack of providers in many areas and need for specialized care for CYSHCN• Finding and serving undocumented populations• Developing partnerships with local health departments, providers, rural health• Monitoring and identifying gaps in service
Basic Knowledge of Health Care Finance <ul style="list-style-type: none">• Private financing and implications of new insurance packages and approved benefits• Literacy (content expertise) about Medicaid, the ACA and health exchanges• Alignment across systems, understanding the roles of all players to maximize resources• Understanding Medicaid managed care and other emerging funding mechanisms
Knowledge of Health Reform <ul style="list-style-type: none">• Impact on Title V services• Reimbursement models

Adaptive Skills to Lead through Change

In order to leverage opportunities presented by health reform, the MCH workforce must be skilled at leading through adaptive challenges. The Title V workforce will be a stabilizing force if it can effectively apply leadership skills to assist programs, agencies and systems to embrace the opportunities afforded by health transformation.

The clearest examples of needs expressed by states in this area were related to discerning and effectively responding to the question of Title V's identity (discussed on pp. 5-6, "The Evolving Identity of Title V"). Redefining the important role for Title V is a critical adaptive leadership challenge; this report documents that Title V leaders understand the transformative effects of health reform and are nimble enough to adapt their roles to continue to meet the needs of MCH populations. However, Title V leaders expressed almost universal uncertainty about how to respond in the face of so many simultaneous changes. They requested extensive change management training and resources.

The rapidly changing environment (described in "A Snapshot of the Contemporary Maternal and Child Health Environment," pp. 5-7) provides the foundation upon which to build the Center's training opportunities in adaptive

skills. Resources will focus on providing tangible skills and tools leaders can use in the face of shifting identity, new roles, financial concerns, paradigm shifts and the broader environment of health transformation.

The table below highlights the primary themes that emerged from all three data sources related to change management.

<p>Major Themes Related to Change Management</p> <p>Evolving Roles from Direct Service to Assurance</p> <ul style="list-style-type: none"> • Population health focus and Ten Essential Public Health Services • Evolution of programs • Impact of ACA on Title V Programs • Need for flexibility of Title V Funding <p>Successful Implementation of the Affordable Care Act</p> <ul style="list-style-type: none"> • Enrollment process, coordination and collaboration with partners • Education and enrollment about health reform, particularly for CYSHCN <p>The Value of Maternal and Child Health</p> <ul style="list-style-type: none"> • Demonstrating the value of Title V to state/territory decision-makers • Focusing on results-based accountability • Broadening scope and capacity of epidemiology teams <p>Sustainability</p> <ul style="list-style-type: none"> • Sustaining programs with limited and/or declining resources • Identifying the right partners to do more with less <p>Leadership Skills</p> <ul style="list-style-type: none"> • Moving forward within a difficult political climate • Championing changes while engaging others • Advocating and raising awareness of services needed by vulnerable populations • Critical thinking skills, problem solving, strategizing for implementing effective change • Collaborating with new and current partners
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Skills to Work in Integrated & Newly Aligned Systems

According to MCH leaders, the contemporary MCH environment requires new relationships and strategic alignments with partners from other sectors. To achieve success, the workforce needs practical tools to guide informed and intentional decision-making in the context of current and changing systems that impact MCH populations. MCH leaders need to learn about systems science and systems tools that can effectively bridge traditional workforce silos and contribute to multi-sector policy discussions. The primary interest lies in being able to effectively define concepts related to systems, and map systems to identify gaps and leverage points in current program development for MCH populations.

Title V leaders need information to apply systems knowledge in the following areas:

- Public health and clinical medicine
- MCH and chronic disease
- Early childhood
- Health care financing
- Patient-centered medical homes
- Home visiting services
- Transition services for CYSHCN

Leaders envision that the effective use of systems tools will lead to informed decision-making and better alignment of resources and programs. Improved capacity to use systems integration resources will provide a source of leverage for Title V expertise, especially regarding life course theory and its application to programs beyond maternal and child health. Systems development tools will also effectively integrate MCH into both the work of public health and the health care system more broadly.

The need for incorporating the perspectives of families and family representatives into the MCH workforce was also highlighted under the broader umbrella of systems integration. Parent networks, such as Family Voices, serve as an early monitoring mechanism to alert Title V to unmet needs and duplication across systems. Continued family involvement in health transformation is essential for effective program and policy development related to newly aligned systems.

The table below highlights the primary themes that emerged from all three data sources related to systems integration.

Major Themes Related to Systems Integration
Collaboration with Other Programs <ul style="list-style-type: none"> • Medicaid • Accountable Care Organizations • Parent networks
Integrated Care Systems <ul style="list-style-type: none"> • Life course services and patient-centered medical homes • Collaborating with partners to address population health needs and outcomes

Tools and Skills Needed to Improve Impact and Measure Effectiveness and Outcomes

Measurement and Data Challenges

Multiple challenges emerged in the areas of data measurement, collection and integration. Many interviewees reported that their state programs may benefit from training to help them effectively conduct return on investment (ROI) analyses of MCH programs. As a result of the paradigm shift toward results-based accountability, the MCH workforce seeks to build on its data collection expertise to become skilled in collecting data appropriate for accountability documentation, and perhaps train epidemiologists to develop accountability metrics and calculate the ROI for MCH programs.

Additionally, for states and territories with provider shortages and underserved areas, the ability to monitor health outcomes of populations and accurately identify service gaps is critical. Moreover, several key informants requested assistance in establishing and collecting “upstream” indicators for population health such as those related to early childhood environmental exposures, preconceptional health and family violence. Although outside the scope of the Center, challenges in obtaining timely data from their state Medicaid programs were shared by key informants. Variation in data collection periods and geographic boundaries undermine the ability to share data across systems to measure quality and outcomes.

Quality Improvement

Title V agencies reported widely varying capacities to conduct quality improvement initiatives. Some states already have firmly integrated quality improvement capacity in their programs; others reported hiring consultants to train staff on quality improvement practices. Some states reported that their first experience with quality improvement was as participants in the Collaborative Improvement and Innovation Network (CoIIN) to reduce infant mortality, or the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grants. Regardless of the level of integration of quality improvement principles within the agency, the support of high-level leadership is essential for implementing quality improvement.

At all levels of the quality improvement spectrum, the need for further training and the development of metrics that are specific to the long-term outcome measurement of maternal and child health (in addition to rapid-cycle improvements more often seen in clinical medicine) were identified as necessary to continue the momentum of quality improvement. For example, more timely reporting of infant deaths is needed to effectively use quality improvement to impact outcomes. Even in Title V programs with a strong interest in quality improvement, the MCH workforce continues to feel challenged by the application of these techniques until programs clarify the metrics for long-term outcomes and address concerns about data capacity.

Additionally, MCH leaders asked for training that includes how to use quality improvement techniques in traditional public health settings rather than asking the MCH workforce to adapt clinical quality improvement examples to their own public health challenges. Leaders also identified the need to train multiple individuals within agencies to provide peer support to others, working from both the executive level and program level simultaneously to embed these principles throughout the MCH workforce.

The table below highlights the primary themes that emerged from all three data sources related to quality improvement.

Major Themes Related to Quality Improvement
Training Should Include: <ul style="list-style-type: none">• Applications of rapid cycle projects for MCH program goals and objectives• Measurements for “moving the needle”• Metric development (focus on community-level, not clinical data)• Consideration of timing delays of major data sources• Diverse training needs across states and territories• Personalized training levels to match individual state/territory’s current level of QI integration
Relevance for MCH <ul style="list-style-type: none">• Use lessons learned from CoIIN (Infant Mortality) and MIECHV (Home Visiting)• Consider limitations within data systems MCH currently uses to measure progress (Medicaid, state & national surveys, insurance information, vital statistics, internal MCH tools)
Data and Performance Metrics <ul style="list-style-type: none">• Specific measures and metrics for MCH (root causes, longer-term, community-based)• Data Integration (Medicaid, insurers)• Collaboration with stakeholders

Maternal and Child Health Workforce Needs for Future Professionals

In addition to identifying current MCH workforce needs, Title V leaders also identified the following skills and competencies as critical for current MCH students who are in the pipeline to become the future leaders of the MCH workforce:

1. Data analysis (including skills in needs assessment, development of metrics and evaluation)
2. Health financing (specifically Medicaid and funding mechanisms arising from the ACA)
3. Quality improvement
4. Systems integration
5. Health policy

Additional core competencies for new graduates entering the MCH field were similarly identified.

Knowledge domain:

- Life course theory
- Cultural competence
- Social determinants of health
- Collective Impact
- Systems building and integration

Skills domain:

- Critical thinking
- Writing
- Speaking and presenting
- Results-based accountability (e.g. return on investment analysis, cost-benefit analysis, cost-utility,)
- Quality improvement

The Center's Pipeline Program engages graduate and undergraduate students enrolled in MCH Leadership Training Programs in a unique Paired-Practica Program to enhance students' skills and knowledge in the areas identified above. By providing individuals in the workforce pipeline with the tools to effectively serve the MCH population in a health reform environment, the Center advances the capacity of the Title V workforce to implement policies, programs, and systems that optimize the health and well-being of women, children, and their families.

In addition, the Center plans to develop learner skills and competencies identified in this report in a course bundle to be offered to pipeline students and as part of Universal trainings available on *Transformation Station*. The bundle will offer content in all four core areas with an emphasis on Title V and health transformation.

Center Solutions: Meeting the Training Needs of the MCH Workforce

As this report documents, the training needs of the MCH workforce reflect the challenges in the current complex environment that have been further intensified by health transformation. Many needs highlighted in this snapshot of the Title V workforce can be addressed by the training, technical assistance and support offered by the Center. The Center is prepared to integrate the expertise of multiple core areas in order to provide responsive and innovative solutions to meet these needs through a diverse array of interdisciplinary tools and resources.

The Center's integrated training and technical assistance approach is based on the science of implementation and is an innovative use of implementation science in MCH on a national scale. The Center utilizes the widely used Active Implementation Framework⁷ to integrate resources and technical expertise across the four core areas. The framework bases its stages of implementation (Exploration, Installation, Initial Implementation, and Full Implementation) on the work of the National Implementation Research Network (NIRN) and is grounded in the literature on intensive technical assistance, implementation science and sustainability.

Reaching Our Audience

The training modalities listed below are in order of preference expressed by the sample of leaders interviewed for this report. Leaders noted that the preferred forum for any particular training or assistance is also influenced by factors such as content and cost.

1. Face-to-face training/technical assistance in the home agency
2. Training at national meeting, preferably at the AMCHP annual conference
3. Title V grant reviews
4. Virtual learning collaboratives/communities of practice
5. Interactive webinars
6. MCH Navigator
7. Additional resources such as: HRSA-funded public health training centers, Johns Hopkins University Leadership Services, and the National Leadership Academy for the Public's Health

Guided peer collaboration and support were singled out as ideal mechanisms to support the acquisition of new workforce skills, including the potential use of real-time "chat" technology for Title V Leaders. In addition, key informants also emphasized the value of informal opportunities to meet and share best practices. Opportunities to learn from peers were preferred. Territories cautioned that technology-based learning forums make it difficult for them to fully participate in workforce development activities due to technological and language limitations.

Current and future MCH professionals can access many of the Center's universal trainings and descriptions of additional resources on *Transformation Station*, which also allows users to request consultation or technical assistance from the Center. The Center will also develop "communities of practice," allowing recipients of Center services to form guided peer networks to enhance their workforce and health transformation activities.

Synthesis of Challenges, Needs and Center Resources

⁷ <http://nirn.fpg.unc.edu/learn-implementation>.

The table below synthesizes the broad training needs presented in this report and cross-references them with existing or planned Center resources. The challenges identified in the report correspond to the “Workforce Challenge” column on the left.

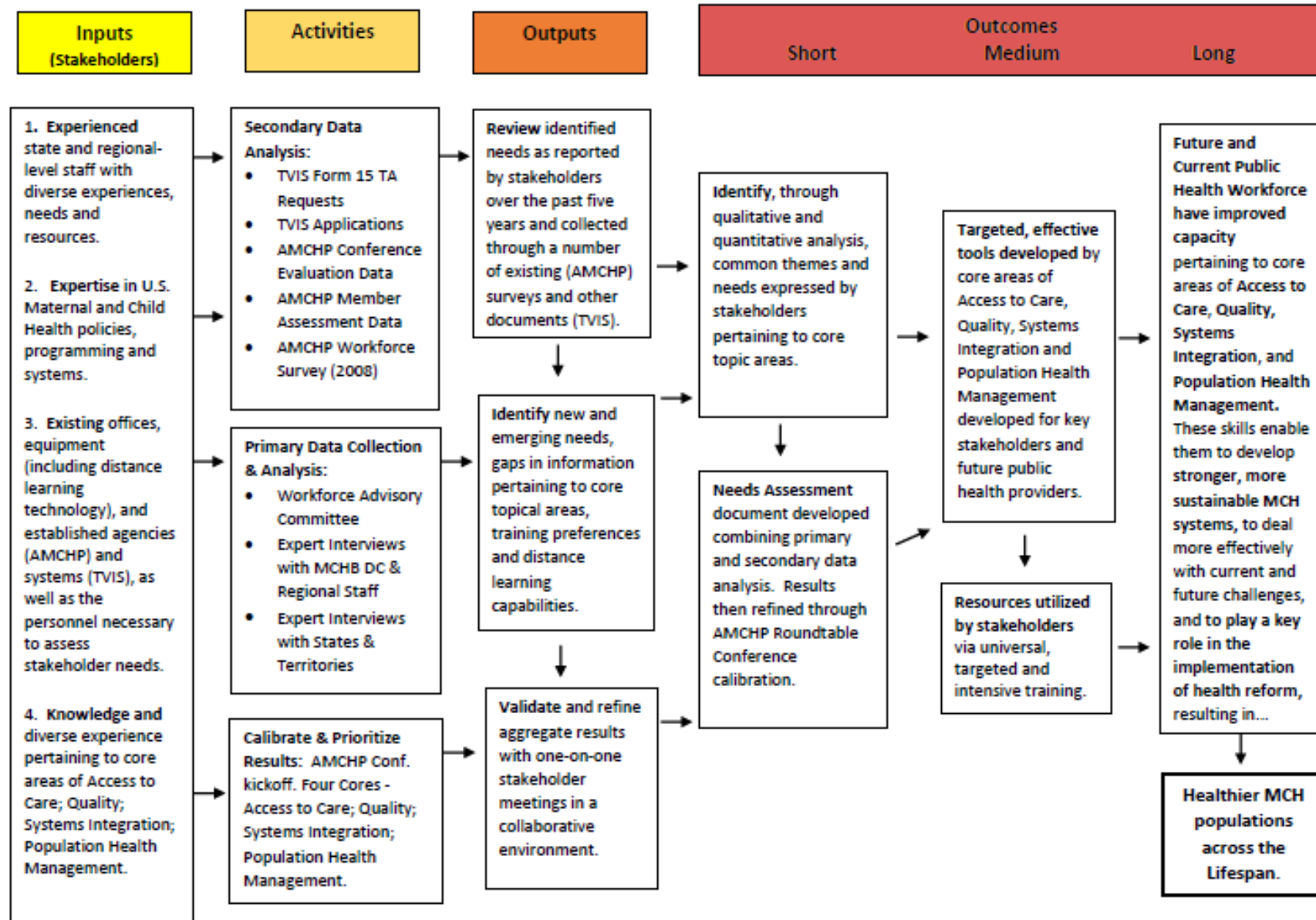
Workforce Challenge	Training or TA Need	Center Resource(s)	Modality	Lead Core Area(s)
Completing transition from direct service to assurance roles (pp. 5-6)	Adaptive leadership; health reform knowledge	Coaching, community of practice, universal, targeted and intensive trainings	Small-group leadership coaching, peer support, in-person trainings, webinars, online modules	Change management, Access to Care
Loss or potential loss of funding for MCH programs (p. 6)	Adaptive leadership; health reform knowledge	Coaching, community of practice, universal, targeted and intensive trainings	Small-group leadership coaching, peer support, in-person trainings, webinars, online modules	Change management, Access to Care
High levels of engagement outside MCH required to maintain “place at the table” (p. 6)	Systems science and alignment; health reform knowledge; adaptive leadership	Coaching, community of practice, universal, targeted and intensive trainings	Small-group leadership coaching, peer support, in-person trainings, webinars, online modules	Change management, Access to Care, Systems integration
Implementation of programs applying new paradigms (pp. 6-7)	Systems science and alignment; health reform knowledge; adaptive leadership; quality improvement framework	Coaching, community of practice, universal, targeted and intensive trainings	Small-group leadership coaching, peer support, in-person trainings, webinars, online modules	Change management, Access to Care, Systems integration; Quality Improvement
Need for high levels of “literacy” in health transformation, especially in regard to impact on MCH, enrollment, coverage and CYSHCN (p. 7)	Health reform knowledge	Universal, targeted and intensive trainings	In-person trainings, webinars, online modules	Access to Care
Understand system realignments and scopes of service (p. 9-10)	Systems science and alignment	Universal, targeted and intensive trainings; technical assistance	Online resources, in-person trainings, webinars	Systems integration

Results-based accountability tools such as return on investment, accountability metrics, to help articulate the value of Title V (p. 10)	Knowledge and skills in results-based accountability; adaptive leadership; health reform knowledge	Targeted and intensive trainings; technical assistance; Coaching, community of practice	Online resources, in-person trainings, webinars; small-group leadership coaching, peer support, in-person trainings, webinars, online modules	Quality improvement; Change Management, Access to Care
Quality improvement training specific to MCH needs (pp. 10-11)	Knowledge and skills in quality improvement specific to MCH needs	Universal, targeted and intensive trainings; technical assistance	Online resources, in-person trainings, webinars	Quality improvement

Moving Ahead

In order to remain current and respond to the real-time needs of states and territories, the Center will continue to actively assess the needs of its users informally through participation in regional HRSA conference calls, close contact with AMCHP staff regarding Title V needs, active engagement with the Center’s advisory committee and feedback from states involved in Intensive and Targeted trainings. For example, in order to glean information from the U.S. territories regarding their training needs, Center staff plan to participate in upcoming regional meetings with the MCH leaders from the territories to identify and explore ways to better meet their unique needs. As the Center moves ahead, it will continue to assess and respond to current Title V workforce needs in this era of change and transformation.

Appendix A: National MCH Workforce Development Center Needs Assessment Logic Model



Appendix B: Methods

Secondary Data Analysis. A logic model (Appendix A) was developed to identify common themes and concerns expressed by state and territorial leadership in relation to health reform.

A review of AMCHP 2012 Member Assessment Data (Questions 31⁸ and 32⁹) as well as evaluation data from previous conferences identified major themes. Simultaneously, a text search of the Title V MCH Block Grant TVIS System¹⁰ (Technical Assistance Section) for key terms provided by Workforce Center Core teams was completed (Appendix C). Themes were identified and triangulated across data sources.

Primary Data Collection and Analysis. The following criteria were used to identify states for key informant interviews:

1. At least one state or territory from each of the ten Health Resource Service Administration (HRSA) regions
2. At least two territories
3. The final selection included both rural states and those with a large urban¹¹ population density (U.S. Census, 2013)
4. The final selection included states that were expanding Medicaid in 2014 and those that were not
5. The final selection included states with a mix of centralized and decentralized public health systems

A random order of states was generated through a shuffle procedure in SAS 9.3¹². States¹³ were ordered within each HRSA region and compared on the three criteria (urban/rural, Medicaid expansion status, public health structure). Twelve states/territories were initially targeted for inclusion. Participation was voluntary.

Five HRSA regions were represented. Eight states were represented in the key informant interviews. . Four states were not Medicaid expansion states; four states were. Three states were rural and five states were urban, although one of these was very close to rural status. Most state systems were decentralized, although one was centralized and two were mixed (Appendix D).

Federal and regional level Maternal and Child Health Bureau staff also participated in the key informant interview process during March and April 2013. The script was modified to solicit perceptions from a regional perspective. Key central office and regional MCHB staff participated. Participation was voluntary. Ten interviews were completed with eighteen MCHB staff; all HRSA regions were represented.

Audio files for all interviews were transcribed and responses were analyzed using CDC EZ-Text¹⁴.

⁸ What is the most significant issue your program will face in the next five years?

⁹ What is the most significant issue you think the field of MCH will face in the next five years?

¹⁰ Title V Information Systems. Health Resources and Services Administration Maternal and Child Health Bureau. Retrieved 04/28/14 from <https://mchdata.hrsa.gov/tvisreports/>

¹¹ Urban was defined as having 70% of the state population living in an urban setting.

¹² SAS 9.3, SAS Institute, Inc., Cary, NC.

¹³ Kentucky, a member of HRSA Region 4, was excluded from this process because University of Kentucky public health employees were leading the needs assessment effort.

¹⁴ Carey, James W.; Wenzel, Patrick H.; Reilly, Cindy; Sheridan, John; Steinberg, Jill M.; and Harbison, Katherine G. (1998). "CDC EZ-Text": Software for Collection, Management and Analysis of Semi-structured Qualitative Databases (Version 3.06). Atlanta: Developed by Conwal Incorporated for the Centers for Disease Control and Prevention.

Appendix C: State Key Informant Interview Characteristics

State	Urban or Rural (US Census Data 2012)	US Region	Medicaid Expansion Status, as of 1/2014	Centralized or Decentralized Public Health System
1	Rural	East	Yes	Centralized
2	Urban	East	Yes	Decentralized
3	Rural	South	No	Decentralized
4	Rural	South	No	Mix
5	Urban	Midwest	Yes	Decentralized
6	Urban	South	No	Mix
7	Urban	West	Yes	Decentralized
8	Urban	West	No	Decentralized

Appendix D: Key Informant Interview Scripts

Q. 1: What barriers or challenges are you encountering with implementing health care reform in your state?

Probe 1: According to our records, [your state] has chosen to expand/not expand Medicaid? Is this correct? (Yes or No)

Probe 2: If [your state] is currently not expanding Medicaid, do you feel that there may be changes to this position in your next legislative session?

Q. 2: What kinds of health reform knowledge and/or experience does the MCH public health workforce need?

Probe 1: What skills do you want new public health graduates or new hires to have?

Probe 2: What skills do you want your current staff to have?

Q. 3: What technical assistance could the MCH Workforce Development Center provide to support efforts to overcome these challenges?

Probe 1a: What type of training modalities are preferred by your staff? (Face-to-face, webinars, learning collaboratives, etc.)

Probe 1b: Who should be targeted? Leadership, mid-level managers, collaborators, etc.

The next set of questions is specific to the topic of **Population Health Management** or **Change Management** which is defined, for the purpose of this interview, as tools and resources that enable an MCH leader to guide and manage their teams, collaborate, innovate and integrate systems to reflect life course strategies. **Examples may include planning and change tools, collaboration, partnership and coaching skills, cultural competency resources and conflict resolution training.**

Q.4: What health reform/ACA-related change efforts are you currently engaged in that have to do with population health?

Probe 1: What is the one most important change you will lead over the next 18 months? Why?

Q.5: What does population health management mean in your context now and how do you see that meaning changing over the next three years?

The next set of questions pertains to the use of **Quality Improvement** in your state. Quality improvement (or continuous quality improvement), for the purposes of this interview, means the act of improving the efficiency and effectiveness of MCH public health services. This includes empowering leadership and staff about the use of QI tools and principles to improve program performance. **Examples of QI tools include the use of methods and concepts such as the PDSA Cycle, Fishbone Diagram, Value Stream Map, and QI Spread and Sustainability Plans.**

Q.6: What is your leadership team currently doing to establish the importance for CQI and create buy-in from staff to embed QI within your agency/program?

Probe 1: What MCH programs have you targeted for Quality Improvement efforts?

Probe 2: Please describe the internal process or processes your agency/program uses to continuously monitor program performance and utilize QI tools and principles to improve.

Q.7: What are some areas which you would like your leadership team or your staff to receive additional resources/Technical Assistance or training regarding embedding QI within your agency/program?

The next set of questions explores **Access to Care** issues for your state. This topic pertains to populations in your state that might be uninsured or underinsured and specific strategies for improving access to care for all MCH populations.

Examples include understanding policy and program levers within the ACA and health reform that improve access to care for MCH/CYSHCN populations; enhanced and sustained collaborations with key entities such as Medicaid, CHIP, and insurance exchanges; shared best practices and lessons learned.

Q.8: What do you see as the core role of state Title V programs in assuring access to care for the MCH population in an ACA environment?

Q.9: What elements of ACA implementation have **you been involved in** within your state overall and particularly as it relates to assuring access to care for MCH populations?

Probe 1: What information, skills and competencies do you feel are necessary in order for you, as a state Title V program leader, to be a public health leader in an ACA ‘world’ or environment?

The final set of questions explores the use of **Integrated MCH Systems** to optimize the use of resources while maximizing health outcomes for the MCH population. **Examples include telehealth delivery systems for rural communities; the integration of chronic disease and Title V programs and services; sharing data across programs; visualizing integrated systems and public health/primary care collaborations.**

Q.10: How do your current Title V program efforts aimed at systems integration and moving toward a life course approach align with health reform efforts in your state?

Q.11: What problems and progress are stakeholders experiencing as they work to integrate public health and primary care delivery for the MCH population?

Q.12: What changes are needed in your state’s MCH system to best implement Health Care Reform to serve the needs of your children and families?

Probe 1: What systems have you developed, or would you like to develop, to better serve the children and families in your state?

Probe 2: What knowledge, skills and/or competencies do you feel you need to establish such systems?

Q.13: Now thinking more generally about the word “system”, please discuss what system, if any, your Title V program has in place to track what’s working/not working about ACA implementation for MCH populations.

Probe 1: Do you have plans for addressing any gaps?

Probe 2: What knowledge, skills and/or competencies do you feel you need to establish such systems?

Q.14: (Final Question) - Is there anything else that you would like to tell me about needs, challenges or successes that your state has had so far in the implementation of Health Care Reform pertaining to your MCH population?