


# Five Years of Experience with Capacity Assessment for State Title V (CAST-5)

*Summary Report*

June 2005

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For the  
Maternal and Child Health Bureau  
Health Resources and Services Administration  
U.S. Department of Health and Human Services



**Cite as:**

Ruderman M, Grason H, and Hess C, 2005. Five Years of Experience with Capacity Assessment for State Title V (CAST-5). Baltimore, MD: Women's and Children's Health Policy Center, Johns Hopkins Bloomberg School of Public Health.

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WCHPC was established in 1991 to address current policy issues found in national legislative initiatives and evolving health systems reforms impacting on the health of women, children, and adolescents. The mission of the Center—which operated during its first five years as the Child and Adolescent Health Policy Center—is to draw upon the science base of the university setting to conduct and disseminate research to inform maternal and child health policies and programs, and the practice of maternal and child health nationally. The Center's work involves developing conceptual models and frameworks to guide its research and analytic projects, developing new methods and tools for health system assessment and analysis, conducting evaluations of innovative programs, convening symposia and teaching forums, and publishing a series of policy research and technical resource briefs specifically designed to support activities in MCH practice and policy development. The WCHPC is located at the Johns Hopkins University Bloomberg School of Public Health in the Department of Population and Family Health Sciences.

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## **Acknowledgments**

The authors are indebted to the many state Title V leaders who gave generously of their time to share their CAST-5 experiences and suggestions with us in preparation for this report: Candace Johndrow (Pennsylvania); Marilyn Seabrooks (District of Columbia); Janice Hicks and David Suttle (Virginia); Linda Kenney and Jamey Kendall (Kansas); Annette Phelps, Betsy Wood and Carol Graham (Florida); Lisa Bujno (New Hampshire); Paula Eurek (Nebraska); Joan Wightkin (Louisiana); Molly Emmons (Oregon); Traci Berreth (Idaho); Janice Jones and Jan Jernell (Minnesota); and Evelyn Wilson (Missouri).

Many other Title V leaders have provided feedback on CAST-5 over the last five years, including Annette Mente and Charlene Gaspar (Hawaii), Kayla Tinker (South Dakota), Kay Leeper (Iowa), Rick Horrell (Missouri CSHCN), and Donalda Dodson (Oregon). Tom Miller (Alabama), Joan Eden (Colorado), and Karen Hughes, Adriana Pust and Kathy Peppe (Ohio) provided invaluable assistance as the first CAST-5 “guinea pigs” and pilot test sites. Judy Gallagher, of Health Systems Research, Karen VanLandeghem, Donna Barber, Kathy Peppe, and Gillian Silver all have provided helpful feedback from their experiences facilitating CAST-5 assessments.

Finally, all of the work on CAST-5 has been made possible through the support of the Maternal and Child Health Bureau and the Association of Maternal and Child Health Programs. Special thanks go to Cassie Lauver, of the MCHB, for continuing to support states in their capacity assessment efforts.

## **Introduction**

Capacity Assessment for State Title V (CAST-5) is a set of assessment and planning tools designed to assist state maternal and child health (MCH) programs in examining their organizational capacity to carry out the 10 MCH Essential Services.<sup>1</sup> CAST-5 is an initiative of the Johns Hopkins University Women's and Children's Health Policy Center (WCHPC) and the Association of Maternal and Child Health Programs (AMCHP), in partnership with the Health Resources and Services Administration Maternal and Child Health Bureau (MCHB). A Preliminary Edition of CAST-5 was first pilot tested in the summer of 2000 and published in early 2001. A revised Second Edition was released in February 2004.

Many state MCH leaders planning for capacity assessments have requested information about other states' use of CAST-5—how they structured the assessment, whether they hired an outside facilitator, the time and other resources required, and how they used the results. Interest in CAST-5 increased in mid-2004 as Title V programs began to prepare for their 5-year needs assessments, which require an examination of MCH system capacity. The Maternal and Child Health Bureau provided funds to the JHU Women's and Children's Health Policy Center in spring 2005 to compile information about states' experiences with CAST-5.

An initial email query was sent by AMCHP to all of its members to ascertain states' use of CAST-5. Follow-up interviews with states that indicated they had used CAST-5 were conducted by the WCHPC.<sup>2</sup> Additional information was pulled from a similar effort in the summer of 2002 that obtained feedback on the Preliminary Edition in preparation for drafting the revised Second Edition and other technical assistance resources.

In all, 24 states have used CAST-5. In one state, CAST-5 was used twice, once by the Children with Special Health Care Needs (CSHCN) program and once by the MCH program. The WCHPC had information on 8 of those states from the 2002 interviews and reviews of CAST-5 summary reports. Eleven interviews were conducted in February through April 2005. Additional information was culled from written materials provided by recent CAST-5 users and facilitators. These interviews and reports make clear that states have used CAST-5 for a variety of reasons and in many different configurations—but the benefits they report and the challenges they faced are strikingly similar.

***For more information on CAST-5:***

**[www.amchp.org/cast5](http://www.amchp.org/cast5)**

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<sup>1</sup> These programs often are referred to as Title V programs to reflect the source of their funding in Title V of the Social Security Act.

<sup>2</sup> Interviews were conducted by Holly Grason, Marjory Ruderman, and Cathy Hess in February and March 2005.

## What Does It Mean to “Do CAST-5?”

It is clear from states’ reports that “doing CAST-5” can mean very different things in different contexts. CAST-5 is made up of several different tools and worksheets, all designed to be used flexibly as a modular toolset. Uses of CAST-5 range from unstructured, informal use in planning to highly structured processes that follow each CAST-5 tool in sequence. Many states have opted to use only selected CAST-5 tools, or to use all of the tools but limit the scope by focusing on a subset of the 10 Essential Services. In addition, several states have adapted CAST-5 tools for use in other planning and assessment processes, and some have created their own paper-based or online forms and worksheets for recording assessment results. (These adaptations are described further on page 10.)

*“The beauty of CAST-5 is that you can pick out pieces and do them separately.”*  
—CAST-5 participant

## Goals for Use of CAST-5

Goals for use of CAST-5 are known for 15 states. Eight states in the past year have used CAST-5 explicitly to fulfill the capacity assessment component of the required Title V 5-year needs assessment. Other stated goals include:

- Assessing capacity as part of a senior staff manager retreat;
- Bringing people together to develop strategies for collaboration across programs;
- Examining capacity related to specific functional areas (e.g., data capacity, collaboration and communication);
- Incorporating MCH-specific capacity information into the National Public Health Performance Standards Program;
- Analyzing capacity after major agency reorganization and identifying ways to address a capacity “crunch”;
- Finding ways to capitalize on existing resources and integrate capacities and activities of different program units;
- Increasing staff understanding of core public health functions and services and incorporating the 10 MCH Essential Services into planning documents;
- Incorporating capacity information into strategic and business plans;
- Familiarizing staff with the CAST-5 process for potential future use at the program level; and
- Informal use in planning.

Figure 1 (page 6) matches states to their primary or initial CAST-5 goals. For some states, additional goals emerged during the assessment process.

**Table 1. States' Use of CAST-5**

**A. Use of the Preliminary Edition of CAST-5**

State	Year Used	Scope and Depth	Time Frame	Structure of Assessment
Alabama	2000 1 <sup>st</sup> pilot test	Assessed 3 Essential Services related to data and assessment, community partnerships, and direct services. Used all CAST-5 tools. Additional informal use in planning.	2 days.	One full group.
Arizona	Unknown	Informal use in planning only.	N/A	N/A
Colorado	2000 2 <sup>nd</sup> pilot test	Assessed 3 Essential Services related to policy and planning, assurance, and evaluation. Used all CAST-5 tools.	Two days.	2 workgroups broke out to assess one Essential Service each.
Connecticut	2004	Used Core Questions only.	Unknown.	One full group.
District of Columbia	2003	Assessed 5 Essential Services related to data and assessment, policy and planning, evaluation, and research. Used all CAST-5 tools <i>except</i> Capacity Needs Tool.	2-day retreat.	One full group.
Georgia		Assessed selected Essential Services using the CAST-5 Process Indicators Tool.	Approximately 8 months to complete assessment, using quarterly population team meetings and in-between "homework."	Organized in population teams.
Hawaii	2002	Assessed all 10 Essential Services. Used all CAST-5 tools.	4-day time span.	4 workgroups carried out key portions of the assessment.
Iowa	2002	Assessed all 10 Essential Services. Used all CAST-5 tools.	Approximately 5 meetings over a 1-year time span.	Small workgroups completed key portions of the assessment.
Missouri (CSHCN)	2002	Assessed all 10 Essential Services and used all CAST-5 tools.	Approximately 10 meetings, held once per month. Each meeting covered one Essential Services.	One assessment team.
Missouri (MCH)	2005	Assessed all 10 Essential Services. At the state level, used all CAST-5 tools. At the local level primarily used the SWON Analysis.	At the state level, met for 8 one-day meetings over a 3-month time span. At the local level, one annual meeting of variable length.	One assessment team.
Ohio	2000 3 <sup>rd</sup> pilot test	Assessed all 10 Essential Services. Used all CAST-5 tools.	1-day, full group meeting at the outset of the process, another at the end, with subgroup meetings in between.	Subgroups were each assigned an Essential Service(s). Additional participants were brought into the subgroup meetings.
South Dakota	2002	Assessed 9 Essential Services. Used all CAST-5 tools.	1-day, full group meeting at the outset of the process (with some workgroup breakouts), one full group meeting at the end (with some breakouts), and workgroup meetings in the interim.	Broke into three workgroups for key portions of the assessment.

**Table 1 (continued).**

**B. Use of the Revised Second Edition of CAST-5**

<b>State</b>	<b>Year Used</b>	<b>Scope and Depth</b>	<b>Time Frame</b>	<b>Structure of Assessment</b>
California	2005	Unknown.	Unknown.	Unknown.
Florida	2003 Pilot test	Assessed all 10 Essential Services. Used all CAST-5 tools.	2.5 days.	4 workgroups carried out key portions of the assessment.
Idaho	2005	Assessed all 10 Essential Services. Used all CAST-5 tools.	3 meetings over a 6-month period. On-line completion of Capacity Needs Tool.	Broke into 3 groups for completion of Process Indicators.
Kansas	2004	Adapted the CAST-5 Capacity Needs Tool and SWOT Analysis.	Capacity assessment completed in one day as part of a three-meeting needs assessment process.	Organized in three population teams.
Louisiana	2005	Assessed all 10 Essential Services using Process Indicators Tool, SWOT Analysis, and Capacity Needs Tool.	Participating staff members were given a few weeks to complete the tools.	No group process used; participants each individually completed tools for one or two Essential Services.
Maryland	2005	Assessed all 10 Essential Services. Used all CAST-5 tools.	3-day meeting.	Broke into groups to complete the Process Indicators.
Minnesota	2003 Pilot test	Assessed all 10 Essential Services. Used all CAST-5 tools.	2-day meeting. Planning committee completed preliminary answers to the Core Questions in advance.	Workgroups carried out key portions of the assessment.
Montana	2005	Unknown.	Unknown.	Unknown.
Nebraska	2004	Assessed all 10 Essential Services. Used CAST-5 Core Questions, Process Indicators Tool, and SWOT Analysis.	4 half-day meetings over a 6 week period.	One full group.
New Hampshire	2004	Assessed all 10 Essential Services. Used all CAST-5 tools.	2-day meeting followed by a 1-day meeting one month later.	Small workgroups met simultaneously.
Oregon		At the county level assessed 5 Essential Services using the CAST-5 Process Indicators and SWOT Analysis only. At the state level, CAST-5 Process Indicators, SWOT Analysis, and Capacity Needs tools were used.	County-level meetings with combined CAST-5/NPHSP completed in 1 to 1.5 days. State-level capacity assessment completed in one half day. All took place over a one-year period.	Workgroups carried out key portions of the assessment.
Pennsylvania	2005	Assessed all 10 Essential Services. Used all CAST-5 tools.	4 half- to full-day meetings over approximately a 9-month period. On-line completion of Capacity Needs Tool preceded the final meeting.	Two groups.
Virginia	2004	Assessed 6 Essential Services. Used all CAST-5 tools.	One orientation call plus 2-day retreat.	Full group broke into two workgroups for some components. Core Questions completed by participants in advance.



**Figure 1. Goals for Using CAST-5**

Part of 5-Year Needs Assessment	Pennsylvania	Idaho	Kansas	Virginia	Nebraska	Oregon	New Hampshire	Maryland
Incorporate information about capacity into planning activities and Block Grant reporting (other than 5-year NA)	Hawaii	Florida	Louisiana					
To complement NPHPSP done at state or local level	Oregon							
Analyze current capacity and allocation of resources (e.g., after reorganization)	New Hampshire	Hawaii						
Analyze capacity in a specific functional area (e.g., data, collaborative partnerships)	Hawaii	Minnesota						
Bring together different program areas for greater collaboration	Hawaii	Pennsylvania	Florida					
Educate staff about, and reinforce use of, MCH core functions and services	Virginia	Hawaii	Florida	Louisiana				
Familiarize staff with CAST-5 for potential use at program level	Virginia	Hawaii						
Pilot tested CAST-5 Preliminary Edition	Alabama	Colorado	Ohio					

## Links with Other Planning Initiatives

Eight states have used CAST-5 as part of their Title V 5-year needs assessments. In most cases, the CAST-5 assessment has been a discrete process, done in conjunction with the wider needs assessment but as a separate component; the findings, but not the methodologies, have been integrated. In some cases, a contractor hired to conduct the overall needs assessment has subcontracted with a CAST-5 consultant to facilitate the capacity component (e.g., in Pennsylvania). Title V leadership in Kansas elected to fully integrate the capacity assessment into their needs assessment process, using adapted CAST-5 instruments to build on earlier activities. Most states also report using their CAST-5 findings in their annual Title V Block Grant reporting.

A growing number of states and localities have experience with the National Public Health Performance Standards Program (NPHPSP), which consists of performance assessment instruments built around standards and measures for state and local public health agencies. Like CAST-5, the NPHPSP is organized around the 10 Essential Services and is designed as a self-assessment. However, the NPHPSP addresses the entire scope of public health programming, while CAST-5 focuses on maternal and child health programming. Another key difference is that the NPHPSP results in a set of scores that are submitted to the Centers for Disease Control and Prevention (CDC), which generates a standardized summary report; the results submitted to CDC are considered public data and are accessible for research purposes.

Many states have asked about the link between the NPHPSP and CAST-5. To date, only one state (Oregon) has undertaken a linked CAST-5/NPHPSP assessment (see Case Example on page 10). Respondents from Oregon indicated that integrating CAST-5 with the NPHPSP made it a richer experience. County-level participants in Oregon reportedly enjoyed the discussion format of CAST-5, although some of the content was less applicable to the local level than the state level. Although Oregon is the only state that has integrated the MCH and general public health assessments in this way, in at least three other states the MCH Director participated in a NPHPSP assessment relatively close in time to a CAST-5 assessment. Ideally, relevant results from CAST-5 can be brought in to the NPHPSP process and vice versa.

### Case Example: Using CAST-5 to Guide Local Public Health Agency Planning in Missouri

The Missouri MCH Program has been using CAST-5—the SWON Analysis Tool\* in particular—to implement its technical consultation role with the 115 Local Public Health Agencies (LPHAs) in the state.

Each county receiving MCH funding enters into a contract with the state health department annually. The contract identifies specific health problems that the LPHA will address with these resources and outlines actions planned through local needs assessments. In addition to state requirements that the LPHA address health concerns where indicators denote specific deficiency when compared with statewide data, the MCH Program requires that at least one program objective be directed to a Capacity Building Outcome for the community system of care. To help the LPHAs identify their highest order infrastructure needs and develop remediating plans, the state program's District Nurse Consultants and the Community Support Consultant meet annually with each LPHA Administrator and the MCH nurses (on site at the health agency) to complete the CAST-5 SWON Analysis for all of the 10 Essential MCH Services. Some LPHAs have dedicated time and effort in addition to these annual half-day meetings to complete the tools and consider targeted action steps based on review of the CAST-5 Capacity Needs Tool.

This assessment process is seen as helping LPHAs to conceptualize their work in terms of the 10 MCH Essential Services, to visualize a “written map” of the strengths, weaknesses, opportunities, and capacity needs in their programs and communities, and to evaluate their effectiveness and identify areas for improvement. Some LPHAs have used their findings to provide information to their Boards and to help direct services to needs. Of particular interest to the state MCH Program has been helping the LPHAs to consider the full spectrum of potential partners for MCH work within the community system. The SWON assessments and related plans are reviewed and updated annually.

*\* Missouri continues to use the SWON Analysis (strengths, weaknesses, opportunities, and needs) from the Preliminary Edition of CAST-5. In the Second Edition of CAST-5, this tool has been renamed the SWOT Analysis (strengths, weaknesses, opportunities, and threats).*

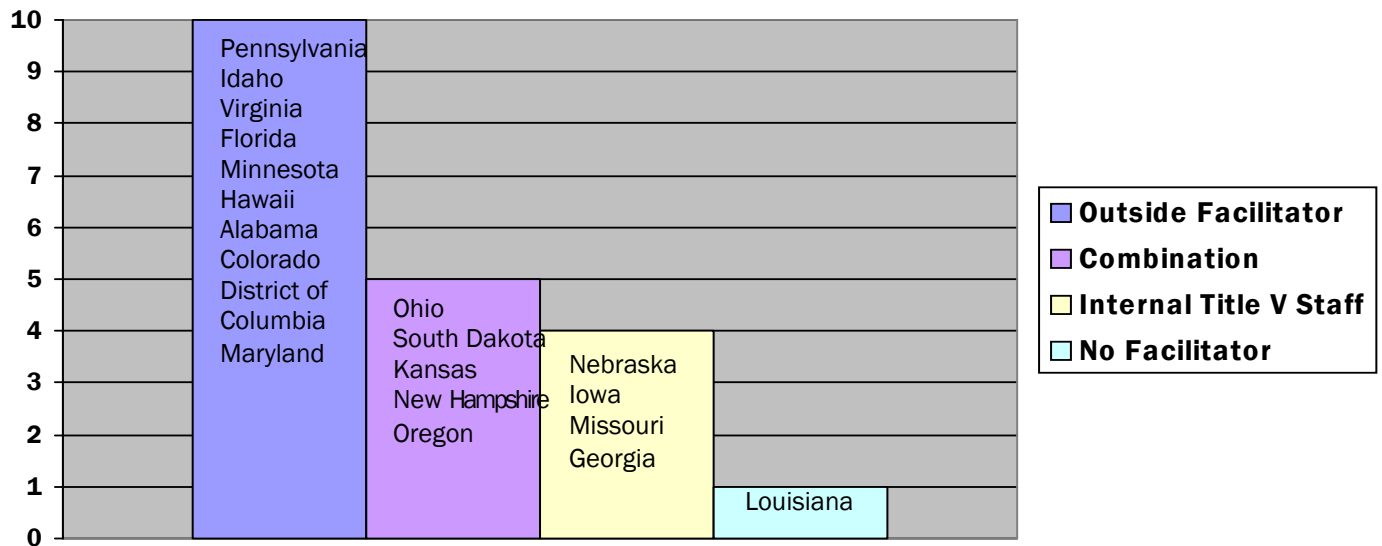
## Use of Facilitators

Although CAST-5 was designed to be useable by states without outside assistance, the majority of states that have used CAST-5 have hired outside consultants. In some cases, the consultants have primarily assisted with planning for the assessment, while in others they have facilitated the entire process. A few states have used a combination approach, hiring consultants to facilitate key meetings at the outset and then return to wrap up and synthesize results, with internal Title V staff facilitating interim meetings. Figure 2 (below), categorizes states by their facilitation approach.

All but two of the outside facilitators and consultants<sup>3</sup> reportedly hired by states have been trained as “CAST-5 Resource Colleagues”; those two also did receive some consultation from a trained Resource Colleague. Resource Colleagues attended a two-day workshop held by the WCHPC in October 2001. To date, six Resource Colleagues have been hired as external consultants/facilitators, accounting for 11 states collectively (excluding 3 pilot test sites). Additionally, one trained resource colleague served as an internal facilitator for CAST-5 in her own state.

States that hired external facilitators consistently reported that doing so was highly valuable. Some states reported that CAST-5 seemed complex and/or overwhelming, and having an outside resource to walk them through the process was a great help. On the other hand, some interviewees reported that using CAST-5 actually was far less complicated than it initially seemed.

**Figure 2. Use of External and Internal Facilitators**



<sup>3</sup> “Facilitators and consultants” refers both to individuals and consulting firms hired to assist in a state’s capacity assessment.

## Scope and Depth of Assessments

CAST-5 can be applied at the level of the MCH system, the Title V program, or individual program areas. Most states have applied CAST-5 broadly, encompassing non-Title V programs and agencies. In two states, CAST-5 was used at the local as well as at the state level. Regardless of the level at which the assessment is carried out, states may choose to limit the scope by focusing on specific areas of performance or functioning. Out of 25 CAST-5 processes in 24 states, seven are known to have limited the scope of the assessment by focusing on selected Essential Services; often, the Essential Services chosen reflect areas of known need within the MCH program (such as data or community partnerships). Thirteen assessments have included all 10 Essential Services. One state used CAST-5 in a process that was not structured around the 10 Essential Services; one used only the Core Questions (which are not organized by Essential Service); one used CAST-5 only informally in planning; and the remaining two states did not provide information. (See Table 1 on page 4.)

The state context clearly influenced the suitability of different approaches. A respondent from one state, where Title V-funded activities were widely dispersed with no identified MCH program administrative unit, noted that they assessed all 10 Essential Services, but not all of them seemed germane given their state's organizational context; if they had it to do over again, they would be more selective. However, another state reported that they were glad to have included all 10 Essential Services, because otherwise they would have chosen to omit an Essential Service that ended up figuring prominently in their findings. The respondent from that state noted that using a subset of the Essential Services carries the potential pitfall of missing important information and ideas.

Out of 22 states (comprising 23 uses of CAST-5) for which this information is known, 15 assessments have incorporated all of the CAST-5 tools. These tools include the Core Questions, Process Indicators Tool, SWOT Analysis,<sup>4</sup> and Capacity Needs Tool. Additional worksheets are provided to assist in prioritizing needs and creating an action plan. Other states have used only selected tools:

- 2 states used the Process Indicators, SWOT Analysis, and Capacity Needs tools (without the Core Questions).
- 2 states have used the Core Questions, Process Indicators, and SWOT Analysis tools (without the Capacity Needs Tool).
- 1 state used the Core Questions only.
- 1 state used the Process Indicators only.
- 1 state used adapted Capacity Needs and SWOT Analysis tools.

There are advantages and disadvantages to any assessment approach. The broader the scope and the greater the depth of the assessment, the more time and resources required. Lengthier assessment processes risk participant burnout and attrition. On the other hand, assessments of limited focus can leave participants feeling that important areas of activity have been ignored—a problem that can be addressed to some extent by being very clear from the outset about the purposes and limitations of the assessment.

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<sup>4</sup> In the Preliminary Edition of CAST-5, the SWOT Analysis was called the SWON Analysis.

## Adaptation of the CAST-5 Tools and Process

A number of states have adapted the CAST-5 tools and/or process to better fit their needs. In 2004, the contractor for two states' needs and capacity assessments created a web-based survey form for the CAST-5 Capacity Needs Tool. At the time this report was drafted, one state had not yet used the online instrument, but the other state's respondent noted that it was difficult for participants to fill out on their own; participants had trouble understanding the content's relevance to their work, and it was unclear how to document variability in capacity across program areas. Interestingly, these issues often come up in face-to-face meetings, as well; one of the benefits of having a trained facilitator on hand (whether external or internal to the MCH program) is the ability to foresee and address these kinds of challenges.

Other states have adapted CAST-5 tools in order to integrate them into other planning and assessment processes. For example, one state wished to examine the capacities required to address the population health needs identified in the 5-year needs assessment. Working with a CAST-5 consultant, the state's MCH leadership and needs assessment facilitators elected to use the CAST-5 Capacity Needs Tool and SWOT Analysis. The response form for the Capacity Needs was retooled to build on the instruments used in earlier needs assessment meetings. A presentation and handouts on CAST-5 framed the Capacity Needs assessment in relationship to the work at the previous meetings and highlighted how the results would fit in to the larger needs assessment process. The main difficulty with this process was applying the Capacity Needs Tool at the system level; assessing system-level capacity in very specific terms is more challenging than assessing the capacity of a single agency or program.

MCH leadership and consultants in Oregon undertook the most extensive adaptation of CAST-5 to date in order to integrate it into a NPHPSP assessment (see sidebar). For three of that state's county-level assessments, CAST-5 Process Indicators were integrated into the NPHPSP indicators for 5 of the 10 Essential Services. Facilitators used a scoring system borrowed from the NPHPSP to generate responses for the CAST-5 indicators, and they created databases to tally the results. At the state level, the CAST-5 Capacity Needs Tool was used to assess capacity related to 3 Essential Services that rated poorly in an earlier NPHPSP assessment. According to interviewees, because the conceptualization of the

### Case Example: Linking CAST-5 and the NPHPSP in Oregon

A consulting firm was contracted to facilitate one state-level and 9 county-level NPHPSP assessments in Oregon.

In 2 of the counties, CAST-5 Process Indicators for 5 of the MCH Essential Services were integrated with the NPHPSP indicators. The consultants adapted the NPHPSP numerical scoring system for use with the CAST-5 indicators and created a database to enter and tally those results. (NPHPSP data are sent to CDC for tabulation and generation of a standardized report.) The CAST-5 SWOT Analysis also was used. Between the 1<sup>st</sup> and 2<sup>nd</sup> county, consultants revised the CAST-5 indicators to be less "wordy." In an additional county, plans are to use only the CAST-5 indicators for the same 5 MCH Essential Services.

Each county-level assessment had between 30 and 50 participants, including external partners. After completing the indicators for one Essential Service as a full group, participants broke into 3 workgroups to complete the indicators for 3 Essential Services each. (Only 5 of the 10 Essential Services included CAST-5 indicators.) On day two of the 1.5 day meetings, a smaller management group and key partners convened to complete the SWOT Analysis and next steps.

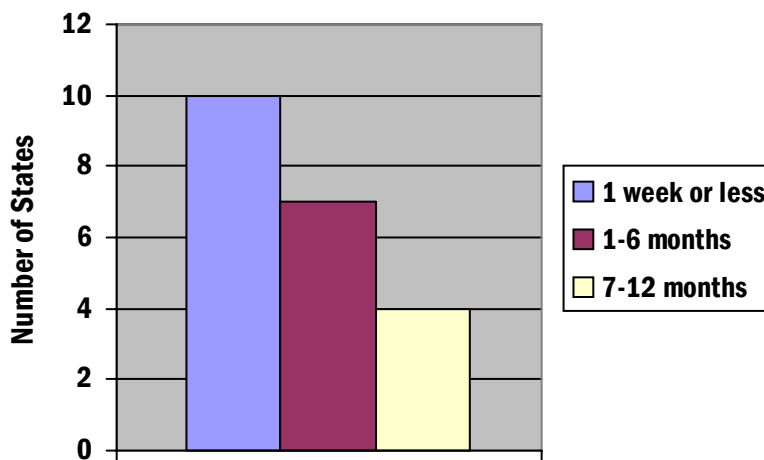
At the state level, three Essential Services had previously been found to be weak in a NPHPSP assessment. The CAST-5 Capacity Needs Tool was applied to these Essential Services during a half-day meeting with 110 participants from Family Health (MCH, WIC, family planning, and immunizations). Breakout sessions employed workgroups of about 20 people each.

Essential Services is specifically designed to be consonant with the scope and nature of public health activities at the state level, CAST-5 was easier to use for state- rather than local-level assessment. Participants reported preferring the discussion format of CAST-5 to the scoring format of the NPHPSP.

### Timeframe and Structure

By far the greatest number of states (10) have used CAST-5 in a series of meetings occurring within one week—typically a 2 to 4 day retreat. Many of these meetings included both discussions with the full assessment team and breakout sessions with smaller workgroups. Seven states have structured their assessments to occur in a series of meetings over the course of one to six months; these assessments often begin and end with meetings of the full assessment team (possibly including breakout sessions), with workgroups meeting in the interval. Four states have stretched out their assessments over longer periods of up to a year. While such extended time frames reduce the intensity of the process and perhaps the fatigue of the participants, they also reportedly make it more challenging to keep up the momentum.

**Figure 3. Time Span for Use of CAST-5\***



*\*N=21; for 4 states, the time span is unknown or not applicable (informal use only).*

### Cost

Little is known about the costs of, and funding sources for, states' use of CAST-5. A few states have requested and received technical assistance funds from MCHB for their capacity assessments. The costs of implementing CAST-5 vary widely depending on many variables, including the number of participants, the number and location of meetings, and the role(s) of outside consultants (e.g., planning, meeting facilitation, preparation of pre- and post-meeting materials). Nine states reported approximate costs of their assessments. Three

states incurred no cost beyond existing staff resources. Five states spent between \$2,000 and \$15,000 for one- to three-day assessments. One state spent significantly more for 5 meetings with large numbers of participants and a web-based survey component.

## Participants

Selecting participants invariably involves a trade off between the number of people and perspectives to include and manageability of group size. Assessments with the smallest numbers of participants (fewer than 15) typically included senior management only. Not surprisingly, larger assessment teams tended to include a wider range of perspectives—both program staff and senior management, different types of staff (e.g., data analysts, planners, program managers), non-Title V programs and divisions (e.g., WIC, early intervention, vital statistics, Medicaid, chronic disease, injury prevention, environmental health), other state agencies, nongovernmental participants (e.g., advocacy groups, private providers), and local health agency staff. States that included many different program areas reported great benefit from bringing them together for discussion and cross-fertilization of ideas. Participants with experience in strategic planning and other group processes tended to feel more comfortable with this kind of group process.

**Table 2. Size of Assessment Teams\***

Small (up to 25)	Medium (25-40)	Large (40-110)
Alabama	Idaho	Florida
Colorado	Minnesota	Hawaii
DC	Maryland	Kansas
Georgia		Minnesota
Iowa		New Hampshire
Louisiana		Oregon
Missouri (CSHCN)		
Nebraska		
Ohio		
Virginia		
Pennsylvania		

\*In some states, the number of participants changed over time or was unclear. As a result, size of assessment team is not reported for some states.

Although larger assessment teams bring broader perspectives, they also pose unique challenges. One state with approximately 50 participants working over an extended time frame reported that the numbers of participants dwindled over time. The interviewee suggested that some of the attrition might have been prevented if there had been more advance orientation to the assessment and its relationship to the participants' own work. Another state with a large assessment team and an extended time frame found that participants in initial meetings tended to send substitutes to subsequent meetings; 25-30 percent of participants were new to the process each time.

The larger the number of participants, the more important it is to break out into smaller groups for portions of the assessment. One interviewee reported that group composition was very important to the dynamics of the deliberations; mixing supervisors with their own staff was an impediment to open discussion. This interviewee also noted participants should be selected to ensure the proper mix of viewpoints and the inclusion of "strategic thinkers."

Generally, interviewees saw great benefit from inviting "external stakeholders" to participate. One state with 40 participants coming nearly exclusively from divisions within the state health agency reported that it would have been useful to have invited staff from the Department of Human Services, which holds a lot of needed data. On the other hand, states have found that bringing in "outsiders" poses special challenges and planning needs, and may influence the group dynamics or results of the process (see the section on Lessons Learned, page 15). One state reported that the capacity assessment was confusing for external stakeholders. Another state reported that some external partners were negative at the outset, but as they became more comfortable with the process, the dynamics changed for the better. In two states in which MCH is not a "program" but a funding source, participants needed time to become familiar with the definition of MCH and interpret the questions. (One of these states ultimately chose to define MCH as "the state health and human services system.") Finally, one MCH Director suggested that states may wish to include more than a single person representing the "local community" or "consumers" in order to ensure a broad representation.

### **Benefits of CAST-5**

By far, the most often-cited benefit of CAST-5 is the level of discussion sparked by the assessment tools. Participants consistently report that the opportunity to convene different agencies and/or program areas leads to enhanced collaboration and cross-fertilization of ideas. CAST-5 also is seen as an opportunity to educate non-MCH programs and agencies—or even new Title V staff—about "who we are and what we do."

Other benefits cited by interviewees:

- The CAST-5 tools can be used as a checklist in assessing and guiding the program over time.
- The assessment taught stakeholders about the realities of capacity needed to implement strategies.



- The assessment resulted in improved understanding and morale.
- Once you have gone through the whole process, it is easier to select specific components that can be used for particular program areas or in periodic reassessments of the overall MCH program.
  - Program area directors who participated in the assessment have shown interest in using the CAST-5 tools at the program level.
  - Interviewees who used CAST-5 to assess only selected functional areas/Essential Services reported that they are interested in using CAST-5 again to assess the areas they omitted the first time.
  - Interviewees expressed interest in using CAST-5 again to assess capacity related to a specific goal or population health issue.

### **Dissemination of Assessment Results**

Most states generate a summary report of CAST-5 findings and follow-up plans. Typically, these reports are disseminated to participants and other MCH staff, either in hard copy or electronically. One state that focused its assessment on data capacity produced a report specifically for its newly-created MCH Epidemiology team. All states that have implemented CAST-5 in the last year plan to integrate the results into their 5-year needs assessment reports.

### **Assessment Impact and Follow Up**

MCH Directors report that using CAST-5 both helped to set new directions and reaffirmed organizational approaches that were already underway. One interviewee reported that CAST-5 gave participants new ideas about roles and strategies they had not previously considered within their purview. Often, perceptions and ideas that were building already were further reinforced and refined through the CAST-5 work. For example, one state's CAST-5 results helped build momentum to implement a series of data and planning trainings and create data and assessment teams to enhance analytic capacity in the MCH program. In some states, reorganization of the agency, or even the entire public health system, has opened up an opportunity for concrete information on MCH capacity to influence system-level infrastructure building and maintain a focus for MCH activities. Many states report that their capacity assessment results are helpful in reinforcing and validating their efforts to advocate for infrastructure resources and conceptually tie infrastructure needs to program and population health outcomes.

Without a long-term case study approach, it is difficult to document concrete changes arising directly from the capacity assessment. Typically, the impact of CAST-5 is reported more abstractly, in terms of enhanced education, collaboration and focus around key organizational functions and needs. In a few cases, the CAST-5 process was intended to lead into further development of work plans or other “next steps,” but it appears that this

follow-up work was not completed, or the action plans were not implemented. Even in these states, however, positive effects on collaboration and focus were reported.

### **Lessons Learned and Recommendations for Other States**

CAST-5 users were asked what they would suggest to other states considering using CAST-5.

- ***Understand from the outset that you can “tweak” the tools and adapt them to your needs.*** Because the tools were designed to be used in many different organizational and governmental contexts, some concepts and examples embedded in the tools may not be applicable to all users. Facilitators and participants who understand that the content and suggested uses of the CAST-5 tools are intended to guide, rather than prescribe, feel more comfortable with the assessment process.
- ***Strategically assign people to workgroups to ensure that different perspectives and expertise are represented and to take into account dynamics that might impede open discussion.*** States report that taking the time to think through workgroup assignments is well worth the effort. Keep in mind that workgroups should not be composed *solely* of the people with the most knowledge about the particular area being assessed; learning and collaboration across program areas and functions can be enhanced with a mix of perspectives and expertise.
- ***Carefully prepare all participants in advance.*** All participants should be oriented to the strategic issues and directions for the agency or program before beginning CAST-5, to promote strategic thinking during the assessment. Additionally, all participants should have an opportunity to review the assessment tools in advance to become familiar with the concepts and “lingo.”

For optimal engagement of external stakeholders, participants should have ample advance orientation to the context for the assessment, their role in the process, and how the results will be used. They also may need an orientation to the role of the Title V program in the larger MCH system. Depending on the breadth and structure of the assessment, there may be certain portions of the process that would most benefit from the participation of external stakeholders; it may be appropriate not to include all participants in all portions of the process. One state with exceptional participation of external stakeholders reported that participants found the capacity assessment confusing, possibly because the CAST-5 Capacity Needs Tool, which assesses specific organizational resources, is geared toward a health agency perspective.

- ***Adequate planning time is crucial.*** Prepare the assessment tools in advance; some content can be adapted. For example, an interviewee suggested customizing the list of organizational relationships in the Capacity Needs Tool so that it is tailored to the specific state. Response categories also might be tailored to capture variability in responses by program area. In addition, it is worthwhile to lay the groundwork for a supportive team of managers who buy in to the process.

- **“Just do it.”** Most MCH Directors interviewed stated that they found CAST-5 beneficial and would do it again. Many had looked into other methods of capacity assessment and found CAST-5 to be their best option. Interviewees recommended that states go to sessions on CAST-5 at the AMCHP annual meeting, speak to others who have used CAST-5, and then “do the Nike thing” and “just do it.”

### **Supporting States in Use of CAST-5**

Interviewees made several specific suggestions for further development of CAST-5 resources:

- Develop materials specifically for use with external stakeholders.
- Develop guidance on linking the “functional assessment” with population health concerns.
- Develop guidance on integrating CAST-5 into the NPHPSP assessment process.
- Hold a session at the AMCHP annual meeting for states to share their CAST-5 experiences, possibly grouping “like states.”
- Build information on CAST-5 into the Partnership Meeting, especially in the session for new Title V directors.
- Provide guidance on “translating” the CAST-5 findings into the format that the MCHB provides in the Guidance for Capacity Assessment.
- Provide improved orientation to the CAST-5 tools and process (e.g., a PowerPoint presentation).

### **Conclusion**

Given the number of states that have used CAST-5, and the myriad ways in which they have used it, states now can draw on a rich field of experience in designing future MCH capacity assessments. Through cross-state mentoring and information sharing, CAST-5 assessments will continue to evolve and become more efficient and effective. As yet, few local-level MCH capacity assessment processes using CAST-5 have been conducted. Translating the concepts embedded in CAST-5 and the 10 MCH Essential Services for community level public health operations is an evolving challenge—one that will be met through innovation and sharing of promising practices across states and localities.